

# Medical Fee Guideline Training Module

Medical reimbursement policies for  
non-network medical services provided in the  
Texas Workers' Compensation system

Applicable for dates of service on or after March 1, 2008

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# Goal and Objectives

The goal of this training module is to provide participants with information about billing and reimbursement policies and guidelines for non-network professional medical services provided in the Texas workers' compensation system. The information provided in this module does not apply to pharmaceutical medicine, dental services, or facility services.

## Objectives

At the conclusion of this training module, you will be able to:

- Understand the statutory foundation for the Texas workers' compensation system;
- Understand the basic concepts relevant to Texas workers' compensation medical reimbursement policies;
- Know how to stay current with changes in Medicare policies that affect professional medical services provided in the Texas workers' compensation system;
- Use Web resources for correct coding, reimbursement, and payment policy decisions;
- Apply mathematical formulas to determine the maximum allowable reimbursement for professional medical services provided in the Texas workers' compensation system;
- Bill, code, and reimburse correctly for professional medical services based on Medicare related policies applied to Texas workers' compensation;
- Bill, code, and reimburse correctly for Division-specific professional medical services unique to the Texas workers' compensation system.

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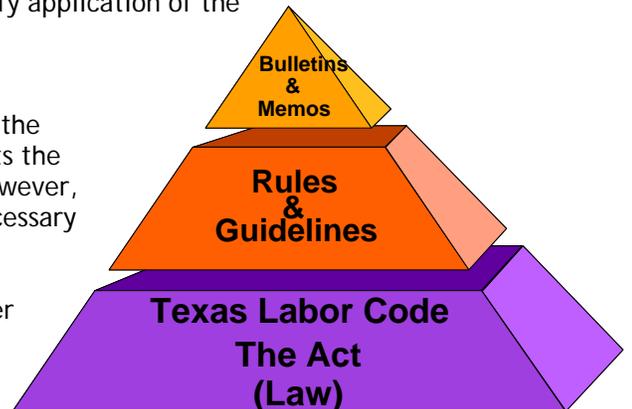
# Statutory Foundation for the Texas Workers' Compensation System

Texas Labor Code (Texas Workers' Compensation Act) (Law)  
Division of Workers' Compensation Rules

The Texas workers' compensation system is regulated by the Texas Workers' Compensation Act (Act), Texas Labor Code, Section 401.001 et seq., and Division of Workers' Compensation (Division) rules, 28 Tex. Admin. Code, Chapter 41, et seq. The Act, sometimes referred to as the Law, is the foundation for the system. Rules are written to implement the law. Commissioner Bulletins and memos are published to clarify application of the Act, rules or Division policy.

The Texas Legislature usually writes the Act in broad terms, providing the basic concepts for the regulation of the Texas workers' compensation system and allows or directs the Division to write rules that put the law into practice. However, the Act may be explicit enough that rules may not be necessary to determine how the Act will be implemented.

Rules are not designed to define processes. Commissioner Bulletins and other memos may define processes, correct errors in published documents, or provide clarification for system participants to allow them to successfully participate in the workers' compensation system.



You can find the Act and Rules on the Texas Department of Insurance, Division of Workers' Compensation website at: <http://www.tdi.state.tx.us/wc/indexwc.html>

The screenshot shows a web browser window displaying the Texas Department of Insurance website. The page title is 'Division of Workers' Compensation from the Texas Department of Insurance - Microsoft Internet Explorer'. The address bar shows 'http://www.tdi.state.tx.us/wc/indexwc.html'. The main content area features a navigation menu with tabs for 'Insurance & HMO', 'State Fire Marshal', and 'Workers' Compensation'. Under 'Workers' Compensation', there are sub-links for 'Division of Workers' Comp', 'Classification', 'Networks', 'OIEC', and 'Research'. A search bar is present with the text 'Search Worker Comp' and a 'Go' button. Below the search bar is a 'Quick Start' menu with various categories like 'Employees', 'Employers', 'Health Care Providers', etc. A 'HIGHLIGHTS' section is visible, containing three columns of text with links. The 'Act' link in the left sidebar is circled in orange.

# Four Basic Concepts

## Basic Concept #1: Use of Medicare (Centers for Medicare and Medicaid Services) Policies

For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants must apply the Medicare program reimbursement methodologies, models, and values or weights, along with its coding, billing, and reporting payment policies in effect on the date a service is provided, with any additions or exceptions set forth in the rules at 28 TAC §§134.1; 134.2; 134.203; and 134.204.

## Basic Concept #2: Act and Rules vs. Other Treatment and Payment Guidelines and Policies

Texas workers' compensation payment policy rules work in conjunction with other Division rules (e.g., preauthorization), fee schedules and payment policies (Medicare), and treatment guidelines (ODG). All provisions of the Act and rules should be followed when providing medical treatment and services, coding, billing and reimbursement. If conflicts exist between the Act and rules and other fee schedules and payment policies, or adopted treatment guidelines, the Act and rules take precedence.

For example, unlike Medicare, there are no deductible or co-payment requirements in Texas workers' compensation. Similarly, Medicare has an appeals process. However, the Division has a medical dispute resolution process, which replaces the Medicare appeals process and should be applied.

In addition to the examples above, Division Disability Management rules require the use of the Official Disability Guidelines (ODG) for providing medical treatment and services to a workers' compensation claimant. Division billing and reimbursement policies require the use of Medicare "reimbursement methodologies, models, and values or weights, along with its coding, billing, and reporting payment policies." ODG recommendations and Medicare policies may overlap. In these cases, the Disability Management rules take precedence over Medicare payment policy provisions as directed by Division rule 137.1 Disability Management Concept.

Contact the Division if you are unsure as to specific potential conflicts. (512-804-4636 or [mcrscgenfax@tdi.state.tx.us](mailto:mcrscgenfax@tdi.state.tx.us))

<p>A payment policy used in the Medicare program must not be utilized for <i>Medical Fee Guideline</i> purposes if it will result in discrimination, which is prohibited by Insurance Code, Article 1451.104. See Advisory 2003-11 for more information.</p>
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## Basic Concept #3: Continuous Updating

Whenever a component of the Medicare program is revised and effective, use of the revised component is required for compliance with Division rules, decisions, and orders for services rendered on or after the effective date of the revised component, or after the effective date

or the adoption date of the revised component, whichever is later, without any additional Division rule modification(s). In other words, when a Medicare payment policy changes, the change is also applicable to the Texas workers' compensation system.

For example, when Medicare adopts new AMA CPT Codes or a documentation policy, the Division requires use of the new codes or documentation policy consistent with the limitations listed in the preceding paragraph.

## **Basic Concept # 4: Medically Necessary and Reasonable Health Care for Injured Workers**

Any health care rendered in the Texas workers' compensation system is based on the injured worker's entitlement to reasonable and necessary medical benefits related to the compensable injury, as stated in §408.021 of the Act:

An employee who sustains a compensable injury is entitled 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:

- (1) Cures or relieves the effects naturally resulting from the compensable injury;
- (2) Promotes recovery; or
- (3) Enhances the ability of the employee to return to or retain employment.

Care provided consistent with the ODG Treatment Guidelines is presumed to be reasonable and necessary.

Notwithstanding payment policies and Medicare medical review policies, in the Texas workers' compensation system, a given treatment or service should be covered if it is related to a compensable injury, medically necessary, and medically reasonable. For example, Medicare benefits exclude reimbursement for hearing aids; however, a hearing aid may be a medically necessary and reasonable item for an injured worker and thus reimbursable in the Texas workers' compensation system.

Medical necessity is established on a case-by-case basis through one of the following processes:

- Insurance carrier's retrospective review of documentation;
- Preauthorization / concurrent review;
- Voluntary certification; or
- Medical dispute resolution by Independent Review Organization (IRO) process.

# Billing and Coding

There are no substantive changes in billing and coding procedures between the 2002 Medical Fee Guideline, §134.202, and the current Medical Fee Guidelines, §134.203 Medical Fee Guideline for Professional Services and §134.204 Medical Fee Guideline for Workers' Compensation Specific Services. However, §134.203 addresses a critical change in the methodology for deriving the Maximum Allowable Reimbursement (MAR). This methodology is explained in the Reimbursement section of this module.

Rather than revising §134.202, the two new sections (§134.203 and §134.204) create a separation of the conversion factors and Medicare-based fee schedules from workers' compensation specific services and reimbursements that are currently combined in §134.202.

## The following are general procedures (rules) for billing and coding for non-network workers' compensation services.

- Health care providers may not bill an insurance carrier more than they would normally charge for similar treatment outside the workers' compensation system, unless the charges are negotiated or mandated charges [Labor Code §413.043].
- Health care providers are required to submit medical bills in accordance with the Act, §134.203 and §134.204, and other Division rules relevant to billing and reimbursement (Chapter 133. General Medical Provisions). This includes applicable Medicare billing and documentation requirements.
- Health care providers are required to submit bills using the most appropriate codes in effect on the date(s) the service(s) are rendered. Current Procedural Terminology (CPT) codes and Healthcare Common Procedure Coding System (HCPCS) codes are listed in the most current American Medical Association's (AMA) *Physicians' Current Procedural Terminology* (CPT code book) and are also available through commercial publishers. Use the appropriate Medicare and Division modifiers following the CPT or HCPCS Level II code. When more than one modifier is applicable to a single code, list each modifier on the bill.

Instructions for completing the CMS-1500 and the Division Form-62 (Explanation of Benefits) is in Chapter 2 of the Texas Clean Claim & eBill Workers' Compensation Companion Guide.  
<http://www.tdi.state.tx.us/wc/ebill/index.html>

## Tools and Resources

Listed below are some tools and resources you may find relevant to coding and billing. Your particular choice of resources will vary with your business needs.

- Chapter 133. General Medical Provisions
- Chapter 134. Guidelines for Medical Service, Charges and Payments
- Texas Clean Claim & eBill Workers' Compensation Companion Guide  
<http://www.tdi.state.tx.us/wc/ebill/index.html>

- Current year ICD-9-CM book
- Current year CPT book
- Current year HCPCS II book
- CPT Coding Assistant
- National RBRVS sources
- Current National Correct Coding Policy Manual
- CMS Downloadable Fee Schedules
- CMS Program Memoranda and Transmittals
- CMS Local Coverage Determination Policies
- Part B Texas (Trailblazer) Communication/Education/Manuals
- Part B Texas (Trailblazer) Newsletters
- Part B Texas Medicare Physician Fee Schedule Database
- Texas Medicaid Fee Schedules for durable medical equipment and medical supplies, and home health services
- DME MAC Jurisdiction C Fee Schedules  
<http://www.cignagovernmentservices.com/jc/coverage/fees/index.html>
- Computer with CD-ROM and Internet Access

## Reimbursement

Unless there is a contractual fee arrangement between an insurance carrier and a health care provider, or an amount specified by the Division, the insurance carrier must reimburse the provider the least of:

- the Maximum Allowable Reimbursement (MAR) amount;
- the health care provider's usual and customary charge; or
- a fair and reasonable amount consistent with Division §134.1 [§134.203(h)]

Fair and reasonable reimbursement must be consistent with reimbursement for similar procedures provided in similar circumstances, and be based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available [§413.011.(d)].

### Division “Maximum Allowable Reimbursement” (MAR)

The Division MAR for a service is the result of the following factors:

1. **RVU = Relative Value Unit.** The RVU reflects relative differences in work, resource use, or charges for individual services; and one or more conversion factors. In most cases, this is a nationally established number for each procedure code.

#### The RVU includes:

- A work expense
- A practice expense (PE); and
- A malpractice expense (MP).

The **facility** RVU applies when the professional service is performed in a hospital (e.g., inpatient, outpatient, and emergency room), ambulatory surgical center, or skilled nursing facility setting. The **non-facility** RVU applies when the professional service is performed in a physician's office or any place of service other than those listed above.

2. **GPCI = Geographic Practice Cost Index.** This is a nationally established

number for the locality where the service is provided.

For every service assigned a value by Medicare there is a specific MAR in the workers' compensation system. The MAR will vary depending upon the geographic area where the service is provided.

There are eight GPCIs (localities) in Texas:

- Brazoria County
- Dallas County
- Galveston County
- Harris County
- Jefferson County
- Tarrant County
- Travis County
- All Other Texas Counties (Rest of Texas)

GPCIs for all other states can be found on the CMS website.

<http://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx>

### 3. Conversion Factor (CF)

The CF is a dollar amount used in calculating the Maximum Allowable Reimbursement for medical services.

While Medicare establishes the CF used in the Medicare system, the Division establishes the CF used in the Texas workers' compensation system.

The following table establishes the Division conversion factors, for calendar years 2009 and 2008, to be applied to each of the listed service categories. These CFs will be adjusted each subsequent year based on the federally adjusted Medicare Economic Index (MEI). The MEI is defined in the Definitions section of this training module.

Service Categories	2009 Conversion Factors	2008 Conversion Factors
Evaluation & Management	\$53.68	\$52.83
General Medicine	\$53.68	\$52.83
Physical Medicine and Rehabilitation	\$53.68	\$52.83
Radiology	\$53.68	\$52.83
Pathology	\$53.68	\$52.83
Anesthesia	\$53.68	\$52.83
Surgery when performed in an office setting	\$53.68	\$52.83
Surgery when performed in a facility setting	\$67.38	\$66.32

# Calculating MAR for CPT Codes with Medicare RBRVS Values (Evaluation and Management, Medicine, Surgery in a non-facility setting, Radiology, Pathology, and Physical Medicine)

You may derive the MAR by using web-based resources, by doing the RBRVS mathematical calculation yourself, or by using a commercial product. The following information is for *illustration purposes only*.

The mathematical formula for deriving the MAR is:

$$\begin{aligned} &[(\text{Work RVU} \times \text{Work GPCI}) \\ &+ (\text{PE RVU} \times \text{PE GPCI}) \\ &+ (\text{MP RVU} \times \text{MP GPCI})] \\ &\times \text{Division Conversion Factor} \\ &= \text{Division MAR} \end{aligned}$$

Web-based resources, such as the Centers for Medicare & Medicaid Services, <http://www.cms.hhs.gov/center/physician.asp>, and Trailblazer Health Enterprises, LLC, [www.TrailBlazerhealth.com](http://www.TrailBlazerhealth.com), provide the elements used in determining the Medicare allowable reimbursement, but you have to do some additional calculations to derive the Division MAR.

## Example 1 - Calculating the MAR using the CMS website

The Centers for Medicare and Medicaid Services (CMS) provides the RVUs and GPCIs needed to calculate the Division MAR.

Centers for Medicare & Medicaid Services

Search now Search

Home Medicare Medicaid SCHIP About CMS Regulations & Guidance Research, Statistics, Data & Systems Outreach & Education Tools

People with Medicare & Medicaid Questions Careers Newsroom Contact CMS Acronyms Help Email Print

CMS Home > Medicare > Physician Fee Schedule Look-up > Physician Fee Schedule Search

Physician Fee Schedule Search

Get RVUs by Single HCPC for Nation

HCPC Code 12001

$$(1.72 \times 1)$$

$$+ (1.77 \times 0.879)$$

$$+ (.15 \times 1.065)$$

$$3.44$$

$$\underline{\times \$53.68}$$

$$\$184.66$$

Searching Criteria	
Year	2009
HCPC	12001
Modifier	All modifiers
Carr/Loc	Nation
Fields Option	All Fields

1 record found.

HCPC	Modifier	Short Description	Proc Stat	PCTC	Not Used For Medicare	WORK RVU	NA Flag for Trans Non-Fac PE RVU	Transitioned Non-Fac PE RVU	NA Flag for Fully Imp Non-Fac PE RVU	Fully Implemented Non-Fac PE RVU	NA Flag for Trans Facility PE RVU	Transitioned Facility PE RVU	NA Flag for Fully Imp Fac PE RVU	Fully Implemented Facility PE RVU	MP RVU Amt	Facility PE Used for OPPS Pmt Amt	Malpractice Used for OPPS Pmt Amt
12001		Repair superficial wound(s)	A	0		1.72		1.77		1.7		0.74		0.73	0.15	0	0

Get GPCIs for Locality: 0440299

Searching Criteria	
Year	2009
Carrier Locality	0440299 Rest of Texas
Fields Option	All Fields

Carrier/ Locality	GPCI Work	GPCI PE	GPCI MP
0440299	1	0.879	1.065

To calculate the Division MAR for procedure code 12001 (Repair superficial wounds) in a non-facility setting using the data provided by CMS:

Step 1. Access the *Medicare Physician Fee Schedule Look-up* on the CMS website at [www.cms.hhs.gov](http://www.cms.hhs.gov).

Step 2.

To find the RVU for the procedure:

Provide your search criteria selecting the year, "Single HCPCS Code" and "Relative Value Units."

To find the GPCI:

Provide your search criteria selecting the year, "Single HCPCS Code" and "Geographic Practice Cost Index (GPCI)."

Step 3.

To find the RVU for the procedure:

On the next page, select "Default Fields."

To find the GPCI:

On the next page, select "Specific Locality" and "Default Fields."

Step 4.

To find the RVU for the procedure:

Continue the process by providing the HCPCS (for this example we are using 12001

Repair superficial wounds in a non-facility setting), and select the appropriate modifier if applicable.

To find the GPCIs for the procedure:

Continue the process by selecting the "Carrier Locality" (for this example we are selecting "Rest of Texas").

Step 5.

To find the RVU for the procedure:

Submit your search criteria to find the RVUs for the procedure.

To find the GPCIs for the procedure:

Submit your search criteria to find the GPCIs for the locality.

Step 6. Proceed with the calculations.

[(Work RVU x Work GPCI)  
+ (PE RVU x PE GPCI)  
+ (MP RVU x MP GPCI)]  
x Division Conversion Factor  
= Division MAR

**HCPC code 12001**

(1.72 x 1)  
+ (1.77 x 0.879)  
+ (.15 x 1.065)  
3.44  
X \$53.68  
\$184.66

The MAR for CPT code 12001 (Repair superficial wounds) in a *non-facility setting* provided for the "Rest of Texas" in 2009 is **\$184.66**.

To calculate the Division MAR for procedure code 12001 (Repair superficial wounds) in a *facility setting*, follow the steps above using the *Facility* RVUs in place of the *Non-facility* RVUs.

When the procedure code is valued but not reimbursed by Medicare, the reimbursement information cannot be found on the TrailBlazer website. Therefore, mathematical calculation is necessary.

**Example 2- Calculating the approximate MAR using the TrailBlazer Health Enterprises, LLC website**

To calculate an approximate Division MAR using the TrailBlazer Health Enterprises, LLC website, divide the Division CF by the CMS CF (2009 Medicare CF - \$36.0666) to get the Division ratio. Then multiply the Medicare Participating Amount by the Division ratio.

Division CF = Division ratio

CMS CF

$$\frac{\text{Division ratio} \times \text{Medicare participating amount}}{\text{Division MAR (approximate)}}$$

To calculate the Division MAR for procedure code 12001 (Repair superficial wounds) in a *non-facility setting* using the Trailblazer website:

- Step 1. Go to the TrailBlazer Health Enterprises, LLC website at [www.TrailBlazerhealth.com](http://www.TrailBlazerhealth.com).
- Step 2. If you have already registered on this site, sign in. If you have not, you must register to use the site. There is no cost to use this website.
- Step 3. Use the Search function on the Homepage to search for 'Fee Schedules' and locate the Medicare Fee Schedule.
- Step 4. Select the year of the fee schedule you want (2009), your state (Texas), and your locality (Rest of Texas) in the appropriate windows.
- Step 5. Enter the procedure code (CPT) (and modifier if applicable) about which you seek information.
- Step 6. Find the Medicare CF and divide it into the Division CF (2009 CF - \$53.68) to derive the Division multiplier.
- Step 7. Find the *non-facility* Participating Amount and multiply the amount by the Division ratio.

Fee Schedule Search			
Year:	2009	Procedure Code:	12001
State:	Texas	Modifier:	
Locality:	[Rest of Texas]	<b>Search</b>	

Non Facility Fees		Facility Fees	
Participating Amount:	\$123.91	Participating Amount:	\$91.26
Non Participating Amount:	\$117.71	Non Participating Amount:	\$86.70
Limiting Charge Amount:	\$135.37	Limiting Charge Amount:	\$99.71

$$\begin{aligned}
 & \text{TX CF} \div \text{MC CF} = \text{TX \% of MC} \\
 & (\$53.68 \div \$36.0666) = \\
 & 1.488 \\
 & 1.49 \text{ (rounded from 1.488)} \times
 \end{aligned}$$

Co Surgeons:	0	?	
Physician Supervision of Diagnostic Procedures:	09	?	
Relative Value Units		Surgery Information	
Facility Settings:	0.740	Global Days:	010
Non Facility Settings:	1.770	Pre-Operative %:	10%
Work:	1.720	Intra-Operative %:	80%
Malpractice:	0.150	Post-Operative %:	10%
		Endoscopic Base Code:	
		Diagnostic Imaging Ind:	99
		Conversion Factor:	36.0666
		Update Factor:	1.011
		Imaging Ind:	9
		P4P Ind:	1
		Geographic Practice Cost Indices	
		Work:	1.000
		Practice:	0.879
		Malpractice:	1.065

The MAR for CPT code 12001(Repair superficial wounds) in a *non-facility setting* provided for the "Rest of Texas" in 2009 is approximately \$184.63.

To calculate the Division MAR for surgery in a *facility setting* using the TrailBlazer Health Enterprises, LLC website, repeat steps 1-6 using the Division CF for surgery in a facility setting (2009 CF - \$67.38), then in Step 7, find the Facility Participating Amount and multiply the amount by the Division ratio.

**Fee Schedule Search**

Year: 2009      Procedure Code: 12001  
 State: Texas      Modifier: [v]  
 Locality: [Rest of Texas]      **Search**

Non Facility Fees		Facility Fees	
Participating Amount:	\$123.91	Participating Amount:	\$91.26
Non Participating Amount:	\$86.70	Non Participating Amount:	\$86.70
Limiting Charge Amount:	\$99.71	Limiting Charge Amount:	\$99.71

**TX CF ÷ MC CF = TX % of MC**

**(\$67.38 ÷ \$36.0666) =**

**1.868**

**1.87 (rounded from 1.868) X \$91.26**

Surgery Information	
Global Days:	010
Pre-Operative %:	10%
Intra-Operative %:	80%
Post-Operative %:	10%

Endoscopic Base Code:	
Diagnostic Imaging Ind:	99
Conversion Factor:	36.0666
Update Factor:	1.811
Imaging Ind:	9
P4P Ind:	1

Relative Value Units		Geographic Practice Cost Indices	
Facility Settings:	0.740	Work:	1.000
Non Facility Settings:	1.770	Practice:	0.879
Work:	1.720	Malpractice:	1.065
Malpractice:	0.150		

### Example 3- Calculating the MAR using a commercial product

Using a commercial product is an option for deriving the MAR. Such commercial products provide Medicare reimbursement information, including Medicare payment policies, and can perform the calculation for you.

## Calculating MAR for Anesthesiology

Medicare computes MAR for anesthesiology differently than the Texas workers' compensation system. CMS sets a national Medicare anesthesiology conversion factor, which is adjusted slightly, depending on locality (<http://www.cms.hhs.gov/center/anesth.asp>). The Texas workers' compensation system does not use the Medicare conversion factor. The Division uses the same conversion factor for anesthesiology as for other Professional CPT service groupings.

To calculate the MAR for anesthesiology services rendered in 2009 in which there are four time units and three base units, use this formula:

$$\text{MAR} = (\text{Time} + \text{Base}) \times \text{Division CF } (\$53.68)$$

Example:

$$\text{MAR} = (4 + 3) \times \text{Division CF } (\$53.68)$$

$$\text{MAR} = 7 \times \text{Division CF } (\$53.68)$$

$$\text{MAR} = \$375.76$$

<http://www.cms.hhs.gov/center/anesth.asp>

## Calculating MAR for DME -- Healthcare Common Procedure Coding System (HCPCS) Level II Codes

HCPCS codes are used for durable medical equipment (DME), prosthetics, orthotics, and supplies, including injectables.

To calculate the MAR, use 125% of the fee schedule amounts found in the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Fee Schedule (DMEPOS).

If there is no Medicare rate in the DMEPOS schedule, then use 125% of the fee schedule amounts found in the Texas Medicaid DME Fee Schedule for Durable Medical Equipment / Supplies, for HCPCS codes. Please note that the Division has not adopted Medicaid payment policies.

Refer to the 2009 contracted carrier for the Centers for Medicare & Medicaid Services (CMS) (Cigna Government Services) to determine reimbursement amounts for DME, prosthetics, orthotics, and supplies, including injectables.

For example, in 2009, crutches, HCPCS code E0110-NU, are reimbursed \$74.94 according to the Medicare DMEPOS schedule. In the Division system, reimbursement will be  $(\$74.94 \times 1.25) = \$93.68$ .

<http://www.cignagovernmentservices.com/jc/coverage/fees/index.html>

[Company Overview](#)  
[DME MAC Jurisdiction C](#)  
[Part B - ID, NC, & TN](#)  
[Contact Us](#)

**Medicare Contracts**  
 > DME MAC Jurisdiction C Home Page  
 > Part B - Idaho, North Carolina, & Tennessee Home Page

**National Provider Identifier (NPI)**  
 > NPI Information and Education

**Helpful Links**  
 > Medicare Contractor Provider Satisfaction Survey (MCPSS) Overview

**2009 - 1st Quarter Texas DMEPOS Fee Schedule**

HCPCS:	Mod 1:	Mod 2:	Category:	Fee Schedule:
E0110	NU		IN	\$74.94
E0110	RR		IN	\$14.27
E0110	UE		IN	\$56.20

## Calculating MAR for Clinical Pathology and Laboratory Services

Some pathology service codes are found in the Medicare Physician Fee Schedule (MPFS). In such instances, calculate reimbursement in the same way as described in "Calculating MAR for Evaluation and Management, Medicine, Surgery, Radiology, Pathology, and Physical Medicine."

If a pathology service code is not found in the MPFS, look it up in the Medicare Clinical Laboratory Fee Schedule.

Pathology / laboratory codes have technical and professional components. When using the Medicare Clinical Laboratory Fee Schedule, reimbursement amounts are as follows:

Technical component = 125% of Medicare Clinical Laboratory Fee Schedule amount

- Medicare x 1.25 = Technical component MAR

Professional component = 45% of MAR for the technical component

- Technical component MAR x .45 = Professional component MAR

Whole procedure = Sum of Technical and Professional components

- Technical component MAR + Professional component MAR = Whole procedure MAR

## Reimbursement of Valid HCPCS (CPT) Codes Without an Assigned Value

Insurance carriers (carriers) are responsible for correctly reimbursing medically necessary workers' compensation treatments and services.

With the adoption of the 2002 Medical Fee Guideline (§134.202), the Texas workers' compensation system began using Medicare coding, billing, reporting, and reimbursement methodologies, models, and values or weights for reimbursement of professional medical services provided on or after August 1, 2003. This requirement remains the same for the new Medical Fee Guidelines, §134.203 and §134.204. Reimbursement values for most Healthcare Common Procedure Coding System (HCPCS) codes used in Texas workers' compensation may be found by using the Medicare Physician Fee Schedule Data Base or the fee calculator on the TrailBlazer Health Enterprises, LLC website at [www.trailblazerhealth.com](http://www.trailblazerhealth.com).

If a valid CPT code does not have a relative value assigned by CMS, or a reimbursement amount assigned by CMS or the Division, and there is no negotiated contract between an insurance carrier and a health care provider, reimbursement shall be the lesser of a health care provider's usual and customary charge or a fair and reasonable reimbursement amount.

Additionally, if payment for HCPCS codes for durable medical equipment, medical supplies and home health services are not specified by CMS, Texas Medicaid or the Division, and there is no negotiated contract between an insurance carrier and a health care provider, reimbursement shall be the lesser of a health care provider's usual and customary charge or a fair and reasonable reimbursement amount.

Division §134.1 provides that fair and reasonable reimbursement must be consistent with reimbursement for similar procedures provided in similar circumstances, and be based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.

## Health Professional Shortage Area (HPSA), and Designated Workers' Compensation Underserved Area Payments (New §134.2)

Medicare policies provide for an incentive payment for physicians who render and bill for medical services provided in a Health Professional Shortage Area (HPSA). Only doctors, as defined by the Texas Labor Code §401.011(17), are eligible to receive the HPSA incentive payment in the Texas workers' compensation system. Non-physician practitioners, such as certified registered nurse anesthetists or physical or occupational therapists, are not eligible for HPSA payments. Refer to Medicare payment policies for more information about HPSA incentive payment.

<http://www.trailblazerhealth.com/Payment/Health%20Professional%20Shortage%20Area/Default.aspx>

Health care providers who render and bill for medical services provided in a *designated workers' compensation underserved area* are entitled to a 10% incentive payment to be added to the maximum allowable reimbursement (MAR).

A workers' compensation underserved area incentive payment is based on the ZIP Code where the service is provided. The following 122 of the 4,254 Texas ZIP Codes are designated by the Division as workers' compensation underserved areas eligible for the 10% incentive payment.

75134	75135	75161	75181	75212	75410	75558	75603	75630	75650	75653	75654	75658
75660	75663	75666	75667	75672	75687	75692	75704	75750	75752	75763	75789	75849
75915	75933	75949	75964	75969	75973	75980	76023	76055	76060	76066	76088	76119
76226	76239	76247	76271	76380	76443	76534	76621	76640	76657	76682	76711	76932
76935	77033	77050	77053	77078	77336	77354	77363	77389	77396	77466	77496	77517
77561	77632	77808	77905	77968	78025	78123	78132	78140	78141	78210	78220	78239
78242	78333	78335	78343	78368	78370	78383	78407	78535	78574	78583	78590	78605
78640	78669	78802	78830	78836	78877	78884	78935	78960	79010	79107	79108	79114
79118	79311	79367	79408	79411	79511	79521	79536	79561	79563	79778	79782	79836
79838	79849	79901	79922	79934								

A modifier identifying services provided in one of the two types of shortage areas is not required.

## Medical Fee Guideline for Workers' Compensation Specific Services (New §134.204)

*The following information addresses medical services provided within the Texas workers' compensation system that are unique to the system or that require billing and reimbursement rules that are different than CMS policies.*

### Case Management

The function of case management in the Texas workers' compensation system is to effectively coordinate care and to facilitate the injured worker's timely and productive return to work. Case management consists of either team conferences or telephone calls with an interdisciplinary team, which may include the employer. Although the treating doctor is primarily responsible for case management, a referral provider may participate in and bill for these specified case management activities.

An interdisciplinary team may not include employees of the coordinating provider. A health care provider in a Return to Work (RTW) Rehabilitation Program may not initiate case management because reimbursement for the program includes coordination of care. However, a health care provider outside the RTW program may initiate case management with a health care provider in the RTW program. In this case, both the health care provider outside the RTW

program and the health care provider inside the RTW program can be reimbursed for reasonable and medically necessary case management activities.

Team conferences and telephone conversations should be triggered by a documented change in the condition of the injured worker. Documentation for case management activities must include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in the telephone conversation.

Team conferences may occur, and be billed for, more than once every 30 days if the conferences are for the purpose of 1) coordinating return to work options with the employer, employee, or an assigned medical or vocational case manager; 2) developing or revising a treatment plan; 3) altering or clarifying previous instructions; or 4) coordinating the care of employees with catastrophic or multiple injuries requiring multiple specialties.

Billing and reimbursement for case management services is as follows:

CPT Code	Description	Treating Doctor Modifier	Treating Doctor	Contributing HCP (No Modifier)
99361	Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 30 minutes	W1	\$113	\$28
99362	Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 60 minutes	W1	\$198	\$50
99371	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (e.g., nurses, therapists, social workers, nutritionists, physicians, pharmacists); simple or brief (e.g., to report on tests and/or laboratory results, to clarify or alter previous instructions, to integrate new information from other health professionals into the medical treatment plan, or to adjust therapy)	W1	\$18	\$5
99372	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (e.g., nurses, therapists, social workers, nutritionists, physicians, pharmacists); intermediate (e.g., to provide advice to an established patient on a new problem, to initiate therapy that can be handled by telephone, to discuss test results in detail, to coordinate medical management of a new problem in an established patient, to discuss and evaluate new information and	W1	\$46	\$12

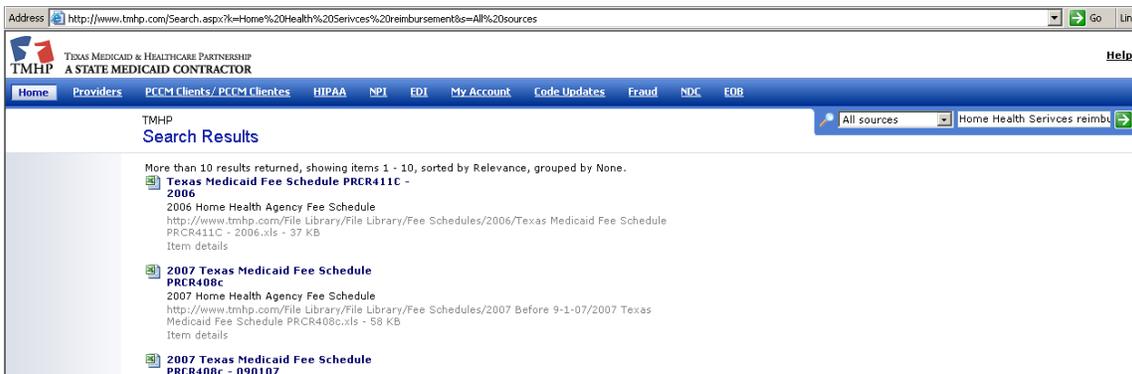
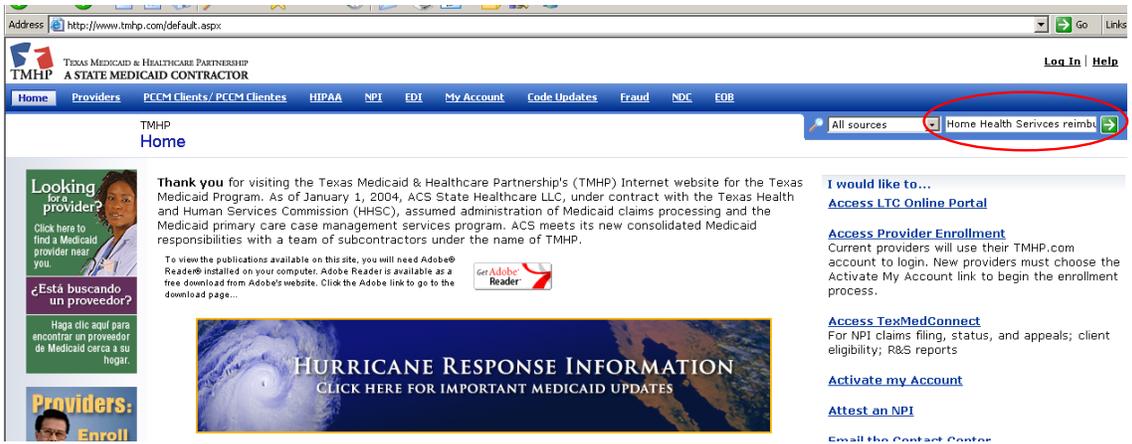
	details, or to initiate new plan of care)			
99373	Telephone call by a physician to patient or for consultation or medical management or for coordinating medical management with other health care professionals (e.g., nurses, therapists, social workers, nutritionists, physicians, pharmacists); complex or lengthy (e.g., lengthy counseling session with anxious or distraught patient, detailed or prolonged discussion with family members regarding seriously ill patient, lengthy communication necessary to coordinate complex services of several different health professionals working on different aspects of the total patient care plan)	W1	\$90	\$23

## Home Health Services

Home health services must be provided through a licensed home health agency and billed on the form required by CMS.

- Reimbursement for home health services is 125% of the published Texas Medicaid fee schedule for home health agencies.

<http://www.tmhp.com/Search.aspx>



## Functional Capacity Evaluations

Rule 134.204(g) details the required elements when conducting a functional capacity evaluation (FCE). Medicare payment policies using the Division CF as described in the “Calculating the MAR” section of this module, apply to billing and reimbursement for FCEs.

An FCE must include the following elements:

1. A physical examination and neurological evaluation:
  - Appearance (observational and palpation);
  - Flexibility of the extremity joint or spinal region (usually observational);
  - Posture and deformities;
  - Vascular integrity;
  - Neurological tests to detect sensory deficit;
  - Myotomal strength to detect gross motor deficit; and
  - Reflexes to detect neurological reflex symmetry.
  
2. A physical capacity evaluation of the injured area:
  - Range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and

- Strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative database. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes.

3. Functional abilities tests:

- Activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);
- Hand function tests that measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices;
- Submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and
- Static positional tolerance (observational determination of tolerance for sitting or standing).

A total of three FCEs for each compensable injury may be billed and reimbursed. Any FCE ordered by the Division does not count toward this total.

Use the “Physical performance test or measurement . . .” CPT code 97750 with the “FC” modifier. Documentation is required.

FCE reimbursement is limited to:

- Initial test: 4 hours,
- Interim test: 2 hours,
- Discharge test: 3 hours (unless it is the initial test), and
- Division-ordered FCE: 4 hours.

To calculate reimbursement for FCEs, use the methodology described for CPT codes valued by Medicare.

## Return to Work Rehabilitation Programs

The Division recognizes four Return to Work (RTW) Rehabilitation Programs:

- **Work Conditioning** – General Occupational Rehabilitation Program
- **Work Hardening** – Comprehensive Occupational Rehabilitation Program
- **Chronic Pain Management** – Interdisciplinary Pain Rehabilitation Program
- **Outpatient Medical Rehabilitation Program**

To qualify as a Division RTW Rehabilitation Program, a program must meet the specific program standards for the program listed in the most recent *Medical Rehabilitation Standards Manual* by the Commission on Accreditation of Rehabilitation Facilities (CARF), which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier.

Accreditation by the CARF is recommended, but not required, for participation in the Texas workers’ compensation system. CARF-accredited programs are reimbursed 100% of the MAR. Non-CARF accredited programs are reimbursed 80% of the MAR.

CARF is currently the only accrediting entity recognized by the Division for work conditioning &

work hardening exemption from preauthorization (\$134.600) and for 100% reimbursement purposes under these guidelines.

## Work Conditioning / General Occupational Rehabilitation Program

The following guidelines are for billing and reimbursing Work Conditioning:

- Bill the first two hours of work conditioning as one unit using the “work hardening /conditioning; initial 2 hours” CPT code with the “WC” modifier. Indicate one unit in the “units” field on the paper billing form or electronic format.
- Bill each additional hour using the “work hardening/conditioning; each additional hour” CPT code with the “WC” modifier. Indicate the number of hours in the “units” field on the paper billing form or electronic format. Reimbursement for less than one hour is prorated in 15-minute increments. A 15-minute increment may be billed and reimbursed if the time spent is greater than or equal to eight minutes and less than 23 minutes.
- CARF-accredited programs will add “CA” as a second modifier.
- Reimbursement is \$36.00 per hour for CARF-accredited programs or \$28.80 for programs that are not CARF-accredited—80 percent of the \$36.00 MAR.
- Individual providers in the program may not bill individually.

For Division purposes, General Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Conditioning.

For example, for one hour and thirty-five minutes, the entire time should be billed as one unit with supporting documentation to indicate the actual time spent in work conditioning. Reimbursement will be prorated as one hour and thirty minutes:

$\$36 + \$18 = \$54$  for a CARF-accredited program, or

$\$54 \times 80\% = \$43.20$  for a non-CARF-accredited program.

## Work Hardening / Comprehensive Occupational Rehabilitation Program

Follow these guidelines for billing and reimbursing Work Hardening:

- Bill the first two hours of work conditioning as one unit using the “work hardening conditioning; initial 2 hours” CPT code with the “WH” modifier. Indicate one unit in the “units” column on the bill (box 24g of the CMS-1500).
- Bill each additional hour using the “work hardening / conditioning; each additional hour” CPT code with the “WH” modifier. Indicate the number of hours in the “units” column on the bill (box 24g of the CMS-1500).
- CARF-accredited programs will add “CA” as a second modifier.
- Reimbursement is \$64.00 per hour for CARF-accredited programs or \$51.20 for programs that are not CARF-accredited—80 percent of the \$64.00 MAR.

- Reimbursement for less than one hour is prorated in 15-minute increments. A single 15-minute increment may be billed and reimbursed if the time spent is greater than or equal to eight minutes and less than 23 minutes.

For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.

For example, for two hours and forty minutes, the initial two hours should be billed as one unit. The remaining forty minutes should be billed as one unit on a separate line. Supporting documentation must indicate the actual time spent in work hardening. Reimbursement will be prorated as two hours and forty-five minutes:

$[(\$64 \times 2) + (\$64 \times 0.75)] = \$128 + \$48 = \$176$  for a CARF-accredited program, or

$\$176 \times 80\% = \$140.80$  for a non-CARF-accredited program.

## Outpatient Medical Rehabilitation Program (as defined by CARF)

Although many outpatient medical rehabilitation programs include physical therapy, stand-alone physical therapy services are not necessarily indicative of an outpatient medical rehabilitation program. (A program should meet the specific program standards as listed in the most recent *Medical Rehabilitation Standards Manual* by CARF, as mentioned above).

Following are the guidelines for billing and reimbursing Outpatient Medical Rehabilitation Programs:

- Bill this program using the “Unlisted physical medicine/rehabilitation service or procedure” CPT code with the “MR” modifier for each hour.
- Indicate the number of hours in the “units” column on the bill (box 24g of the CMS-1500).
- CARF-accredited programs will add “CA” as a second modifier.
- Reimbursement for CARF-accredited programs is \$90.00 per hour or \$72.00 for programs that are not CARF-accredited—80 percent of the \$90.00 MAR.
- Reimbursement for less than one hour is prorated in 15-minute increments. One 15-minute increment may be billed and reimbursed if the time spent is greater than or equal to 8 minutes and less than 23 minutes.

For example, six hours and five minutes should be billed as seven units with supporting documentation to indicate the actual time spent in outpatient medical rehabilitation. Reimbursement will be prorated as six hours:

$\$90 \times 6 = \$540$  for a CARF-accredited program, or

$\$540 \times 80\% = \$432.00$  for a non-CARF-accredited program.

## Chronic Pain Management / Interdisciplinary Pain Rehabilitation Programs

Following are the guidelines for billing and reimbursing Chronic Pain Management / Interdisciplinary Pain Rehabilitation Programs:

- Bill this program using the “Unlisted physical medicine/ rehabilitation service or procedure” CPT code with the “CP” modifier for each hour.
- Indicate the number of hours in the “units” column on the bill (box 24g of the CMS-1500).
- Programs that are CARF-accredited will add “CA” as a second modifier.
- Reimbursement is \$125.00 per hour for CARF-accredited programs or \$100.00 per hour if not CARF-accredited.
- Reimbursement for less than one hour is prorated in 15-minute increments. A single 15-minute increment may be billed and reimbursed if the time spent is greater than or equal to eight minutes and less than 23 minutes.

For example, three hours and twenty minutes should be billed as four units with supporting documentation to indicate the actual time spent in chronic pain management. Reimbursement will be prorated as three hours and fifteen minutes:

$$[(\$125 \times 3) + (\$125 \times 0.25)] = \$375 + \$31.25 = \$406.25 \text{ for a CARF-accredited program, or}$$

$$\$406.25 \times 80\% = \$325 \text{ for a non-CARF-accredited program.}$$

## Designated Doctor Examinations

Division ordered designated doctor examinations may be one, or any combination of the following examination types:

### MMI/IR Examinations

Attainment of maximum medical improvement  
Impairment caused by the compensable injury  
Multiple Impairment ratings

### Non-MM/IR Examinations

Extent of the employee’s compensable injury  
Whether the injured employee’s disability is a direct result of the work-related injury  
Employee’s ability to return to work  
Issues similar to those described above  
Multiple examinations under the same specific Division order are performed concurrently (other than MMI/IR)

Use the following methods for billing and reimbursement for designated doctor examinations:

MMI/IR Exam	Modifier	Billed and Reimbursed	Reimbursement
Attainment of maximum medical improvement	W5	As outlined in §134.204(j)	\$350
Impairment caused by the compensable injury	W5	As outlined in §134.204(j)	First body area \$300 (ROM) or \$150 (DRE) ----- \$150 per additional body area(s) (ROM or DRE)
Multiple Impairment ratings	MI	As outlined in §134.204(j)	\$50 per additional area

Non-MM/IR Examinations	Modifier	Billed and Reimbursed	Reimbursement
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Extent of the employee's compensable injury	W6	As outlined in §134.204(i)	\$500
Whether the injured employee's disability is a direct result of the work-related injury	W7	As outlined in §134.204(i)	\$500
Employee's ability to return to work	W8	As outlined in §134.204(i)	\$500
Issues similar to those described above	W9	As outlined in §134.204(i)	\$500
<b>Tiered reimbursement method for more than one non-MMI/IR examinations under the same order</b>			
Multiple examinations under the same specific Division order are performed concurrently (other than MMI/IR)		as outlined in §134.204(i)	1 <sup>st</sup> = 100% of fee 2 <sup>nd</sup> = 50% of fee subsequent = 25% of fee

When an MMI/IR examination and one or more non-MMI/IR examinations are required under the same Division order, the MMI/IR examination is calculated separately and is reimbursed in addition to the non-MMI/IR examinations.

For example:

MMI			\$350
IR	1st body area	ROM	\$300
	2nd body area	DRE	<u>\$150</u>
			\$800
Extent of injury			\$500
RTW			<u>\$250</u>
			\$750
Total Reimbursement			\$800
			<u>\$750</u>
			\$1550

## Maximum Medical Improvement and Impairment Rating Examinations

This section is organized into four main parts:

- General Information that Applies to All Doctors
- Information that Applies to Treating Doctors and Other Doctors Who Have Previously Treated the Injured Worker
- Information that Applies to Other Doctors Who Have Not Previously Treated the Injured Worker
- Billing and Reimbursement for Assignment of an Impairment Rating (applies to all doctors)

## General Information that Applies to All Doctors

The Maximum Allowable Reimbursement (MAR) for a Maximum Medical Improvement (MMI) / Impairment Rating (IR) exam is equal to the reimbursement for the MMI evaluation plus the reimbursement for the body area(s) evaluated for assignment of an IR.

Reimbursement for the MMI / IR exam includes the following components:

- The examination;
- Consultation with injured worker;
- Review of medical records and films;
- Reports, including the initial narrative report as well as any subsequent reports in response to the need for clarification, explanation, or reconsideration;
- Calculations, tables, figures, and worksheets; and
- Tests used to assign an IR, as outlined in the AMA's *Guides to the Evaluation of Permanent Impairment (AMA Guides)* [as stated in the Act and Chapter 130 rules].

When billing for an MMI / IR exam, provide the following information in the Procedures, Services, or Supplies field of the billing form (CMS-1500) or electronic format:

- MMI evaluation CPT code;
- Appropriate modifiers;
- Units (musculoskeletal body areas); and/or
- CPT code(s) that **best describe the test(s)** performed by the examining doctor for rating non-musculoskeletal areas. Reimbursement is based on the procedure codes (CPT) codes billed.

For dates of service on and after September 1, 2003, providers may bill and be reimbursed for an MMI / IR exam only if the examining doctor is an Impairment Rating doctor [§130.1].

## Information that Applies to Treating Doctors and Other Doctors Who Have Previously Treated the Injured Worker

Use the following billing and reimbursement guidelines:

- Report CPT code 99455;
- Use the "V1," "V2," "V3," "V4," or "V5" modifier to correspond with the last digit of the applicable established patient office visit code; and
- Reimbursement for the MMI Evaluation is the same amount as the corresponding office visit fees.

If the treating (examining) doctor determines that MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not required and only the MMI evaluation portion of the examination is billed and reimbursed.

The treating doctor is required to review the certification of MMI and assignment of IR performed by another doctor. The following billing and reimbursement guidelines will apply:

- Report the "Work related or medical disability examination by the treating physician . . ." CPT code;
- Use the "VR" modifier to indicate a review of the report only; and
- Reimbursement is \$50.

## Information that Applies to Other Doctors Who Have Not Previously Treated the Injured Worker

If the examining doctor (other than the treating doctor) determines that MMI has not been reached, the MMI evaluation portion of the exam is billed using the “Work related or medical disability examination by other than the treating physician . . .” CPT code 99456 with the appropriate modifier. In this instance, use the following billing and reimbursement guidelines:

- The referral doctor bills using 99456
- If the patient is not at MMI, then the provider uses the “NM” modifier;
- MMI Evaluation reimbursement is \$350, regardless of whether the injured worker is at MMI or not.

If the examining doctor determines that MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not required and only the MMI evaluation portion of the examination is billed and reimbursed.

## Billing and Reimbursement for Assignment of an Impairment Rating (Applies to all doctors)

### General

To bill for an IR evaluation, provide the following information in the HCPCS procedure, service or supply code field of the billing form (CMS-1500) or electronic format:

- MMI evaluation CPT code;
- Appropriate modifiers; and
- Units (number of body areas rated).

If additional testing that is not outlined in the *AMA Guides* is required, use the appropriate CPT code(s) for that service. Reimbursement for medically necessary testing is made in addition to the MMI/IR fees described in this section.

### Musculoskeletal Body Areas

The examining doctor may bill for a maximum of three musculoskeletal body areas, which are defined as follows:

- Spine and pelvis;
- Upper extremities and hands; and
- Lower extremities (including feet).

#### Component modifiers:

- WP = Whole Procedure (100% reimbursement)
- 26 = Professional Component (80% reimbursement)
- TC = Technical Component (20% reimbursement)

The MAR for musculoskeletal body areas is as follows:

- When the Diagnosis Related Estimates (DRE) method found in the *AMA Guides*, 4th edition is used:
  - Reimbursement is \$150 for each body area
- When a full physical evaluation with a range of motion test is performed:
  - Reimbursement is \$300 for the first musculoskeletal body area in which range of motion is measured
  - Reimbursement is \$150 for each additional musculoskeletal body area
- When the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the following guidelines apply:
  - Examining doctor bills using the appropriate MMI CPT code with the “WP” modifier
  - Reimbursement is 100 percent of the total MAR
- When the examining doctor performs the MMI examination and assigns the IR, but does not perform the testing of the musculoskeletal body area(s), the following guidelines apply:
  - Examining doctor bills using the appropriate MMI CPT code with the “26” modifier
  - Reimbursement is 80 percent of the total MAR
- When a health care provider other than the examining doctor performs the testing of the musculoskeletal body area(s), the following guidelines apply:
  - HCP bills using the appropriate MMI CPT code with the “TC” modifier, and
  - Reimbursement is 20 percent of the total MAR.

## Non-musculoskeletal Body Areas

Non-musculoskeletal body areas are billed and reimbursed using the appropriate CPT code(s) for the test(s) required for the assignment of IR. Non-musculoskeletal body areas are defined as:

- Body systems;
- Body structures (including skin); and
- Mental and behavioral disorders.

If the examining doctor refers testing for non-musculoskeletal body area(s) to a specialist and then incorporates the findings as part of the MMI/IR report, the following billing and reimbursement guidelines apply:

- The examining doctor (the referring doctor) bills using the appropriate MMI CPT code with the “SP” modifier
- Enter one unit in the “units” field of the billing form (CMS-1500) or the electronic format
- A \$50 reimbursement for incorporating one or more specialist’s report(s) information into the final assignment of IR is allowed only once per examination
- The referral specialist bills and is reimbursed for the appropriate CPT code(s) for the tests required for the assignment of an IR
  - Documentation is required

## Multiple Impairment Ratings by Designated Doctor

When multiple IRs are required as a component of a designated doctor examination [see Rule 130.6], the following guidelines apply:

- The designated doctor bills for the number of body areas rated

- Reimbursement is \$50 for each additional IR calculation
- Add the “MI” modifier to the MMI evaluation CPT code

For a complete list of body systems, body structures, and non-musculoskeletal body areas, refer to the appropriate *AMA Guides*.

## Return to Work (RTW) and Evaluation of Medical Care (EMC) Exams

When conducting a Division or insurance carrier requested RTW/EMC examination, the following billing and reimbursement guidelines apply:

- The examining doctor bills and is reimbursed using the “work related or medical disability examination by other than the treating physician . . .” CPT Code 99456 with the “RE” modifier.
- Required testing is billed using the appropriate CPT codes and is reimbursed in addition to the examination.
- Reimbursement for an individual RTW/EMC evaluation is \$500 and includes Division-required reports.
- When more than one RTW/EMC evaluation is conducted under the same request, the tiered reimbursement method described in §134.204(i) and shown in the table below, is applied.

RTW/EMC Examinations	Reimbursement
Extent of the employee’s compensable injury	\$500
Whether the injured employee’s disability is a direct result of the work-related injury	\$500
Employee’s ability to return to work	\$500
Issues similar to those described above	\$500
<b>Tiered reimbursement method for more than one RTW/EMC examinations under the same request</b>	
Multiple examinations under the same specific Division order are performed concurrently (other than MMI/IR).	1 <sup>st</sup> = 100% of fee 2 <sup>nd</sup> = 50% of fee subsequent = 25% of fee

# Work Status Report

Per §134.204(l), when billing for a Work Status Report (DWC-073) that is not conducted as part of the examinations outlined in subsection (i) and (k) of this section, refer to §129.5 (relating to Work Status Report).

As outlined in §129.5, only treating and referral doctors may bill and be reimbursed for a work status report. Billing and reimbursement for a Work Status Report is as follows:

Report	CPT Code	Modifier	Reimbursement
Required Work Status Report	99080	73	\$15.00
Additional report requested by or through the carrier	99080	73 and RR	\$15.00
Extra copy of a previously filed report requested by or through the carrier	99080	73 and EC	\$15.00

NOTE: When required by §129.5 to submit a DWC-073, an RME doctor or designated doctor is not reimbursed the \$15 for filing the report. Reimbursement to RME doctors and designated doctors for the report is included in the reimbursement for the examination, as outlined in subsections (i) and (k) of §134.204 and addressed above in the Return to Work and Evaluation of Medical Care Exams section of this training module.

# Treating Doctor Examination to Define the Compensable Injury

Per §134.204(m) billing for this type of examination is directed by §126.14 and is not included in the Medical Fee Guidelines.

As outlined in §126.14, reimbursement for the examination is \$350 and includes the required report. Necessary testing is reimbursed in addition to the examination fee.

Please refer to §126.14 for specific direction for this type of examination.

# Division Modifiers

For correct coding, reporting, billing, and reimbursement of the procedure codes, use the following modifiers when billing for professional medical services:

CA	Commission on Accreditation of Rehabilitation Facilities (CARF) Accredited programs	Use when a HCP bills for a Return To Work Rehabilitation Program that is CARF accredited.
CP	Chronic Pain Management Program	Add to CPT Code 97799 to indicate Chronic Pain Management Program services were performed.
FC	Functional Capacity	Add to CPT Code 97750 when a functional capacity evaluation is performed.
MR	Outpatient Medical Rehabilitation Program	Add to CPT Code 97799 to indicate Outpatient Medical Rehabilitation Program services were performed.
MI	Multiple Impairment Ratings	Add to CPT Code 99456 when the designated doctor is required to complete multiple impairment ratings calculations.

NM	Not at Maximum Medical Improvement (MMI)	Add 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.
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.
SP	Specialty Area	Add to the appropriate MMI CPT code when a specialty area is incorporated into the MMI report.
TC	Technical Component	Add to the CPT code when the technical component of a procedure is billed separately.
TX	Treating Doctor Examination to Define the Compensable Injury (§126.14)	Add to the HCPCS Level I code for work-related or medical disability evaluation services performed by a treating physician.
VR	Review report	Add to CPT Code 99455 to indicate that the service was the treating doctor's review of report(s) only.
V1	Level of MMI for Treating Doctor	Add to CPT Code 99455 when the office visit level of service is equal to a "minimal" level.
V2	Level of MMI for Treating Doctor	Add to CPT Code 99455 when the office visit level of service is equal to "self limited or minor" level.
V3	Level of MMI for Treating Doctor	Add to CPT Code 99455 when the office visit level of service is equal to "low to moderate" level.
V4	Level of MMI for Treating Doctor	Add to CPT Code 99455 when the office visit level of service is equal to "moderate to high severity" level and of at least 25 minutes duration.
V5	Level of MMI for Treating Doctor	Add to CPT Code 99455 when the office visit level of service is equal to "moderate to high severity" level and of at least 45 minutes duration.
WC	Work Conditioning	Add to CPT Code 97545 to indicate work conditioning was performed.
WH	Work Hardening	Add to CPT Code 97545 to indicate work hardening was performed.
WP	Whole Procedure	Add to the CPT code when both the professional and technical components of a procedure are performed by a single HCP.
W1	Case Management for Treating Doctor	Add to the appropriate case management billing code activities when performed by the treating doctor.
W5	Designated Doctor Examination for Impairment or Attainment of Maximum Medical Improvement	Add to the appropriate examination code performed by a designated doctor when determining impairment caused by the compensable injury and in attainment of maximum medical improvement.
W6	Designated Doctor Examination for Extent	Add to the appropriate examination code performed by a designated doctor when determining extent of the employee's compensable injury.
W7	Designated Doctor Examination for Disability	Add 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.
W8	Designated Doctor Examination for Return to Work	Add to the appropriate examination code performed by a designated doctor when determining the ability of employee to return to work.
W9	Designated Doctor Examination for Other Similar Issues	Add to the appropriate examination code performed by a designated doctor when determining other similar issues.

# Definitions

**Conversion factor (CF)** - A dollar amount by which the unit value of a medical service is multiplied to derive the fee for the medical service.

**Centers for Medicare and Medicaid Services (CMS)** - US federal agency which administers Medicare, Medicaid, and the State Children's Health Insurance Program.

**Geographic Practice Cost Index (GPCI)** - The area in which medical services are provided. The GPCI is one of the factors used to calculate a reimbursement amount.

**Malpractice expense (MP)** - Reflects the relative risk or professional liability associated with the service.

**Maximum allowable reimbursement (MAR)** - when used in this chapter, is defined as the maximum amount payable to a health care provider in the absence of a contractual fee arrangement that is consistent with §413.011 of the Labor Code, and Division rules.

**Medicare Payment Policies** - Reimbursement methodologies, models, and values or weights including coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

**Medicare Economic Index (MEI)** - The MEI is a measure of inflation faced by physicians with respect to their practice costs and general wage levels. It includes the components involved in furnishing physicians' services such as physician's own time, non-physician employees' compensation, rents, medical equipment, etc. The MEI measures year-to-year changes in prices for these various components based on appropriate price proxies. The adjusted MEI and Division CF based on the MEI, become effective January 1st of the new calendar year.

**Practice Expense (PE)** - Reflects the cost of physician's rent, staff, supplies, equipment, and other overhead associated with the service provided.

**Resource Based Relative Value Scale (RBRVS)** - RBRVS assigns procedures performed by a physician or other medical provider a *relative value* which is adjusted by geographic region (so a procedure performed in Manhattan is *worth* more than a procedure performed in El Paso). This value is then multiplied by a fixed *conversion factor*, which changes annually, to determine the amount of payment.

**Relative Value Unit (RVU)** - A unit value assigned to a medical service. Each service unit value is measured in relationship to the values of other services.

**Work Expense** - Reflects the cost of physician's time and skill required to provide the service.

**Workers' compensation shortage areas** - Areas of the state in which injured employees have little or no access to health care providers. Shortage areas are identified by ZIP Code.

## Medical Fee Guidelines Rules

§134.203

Medical Fee Guideline for Professional Services

§134.204

Medical Fee Guideline for Workers' Compensation Specific Services

Located at:

[http://info.sos.state.tx.us/pls/pub/readtac\\$ext.ViewTAC?tac\\_view=5&ti=28&pt=2&ch=134&sch=C&rl=Y](http://info.sos.state.tx.us/pls/pub/readtac$ext.ViewTAC?tac_view=5&ti=28&pt=2&ch=134&sch=C&rl=Y)

Texas Department of Insurance  
Division of Workers' Compensation

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