

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

3 **SUBCHAPTER C. MEDICAL FEE GUIDELINES**

4 **28 TAC §§134.209, 134.210, 134.235, 134.239, 134.240, 134.250, 134.260**  
5

6 **TEXT.**

7 **§134.209. Applicability**

8 (a) Sections 134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235,  
9 134.239, 134.240, 134.250 and 134.260 [~~134.250~~] of this title apply to workers'  
10 compensation specific codes, services, and programs provided in the Texas workers'  
11 compensation system, other than:

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

13 (2) prescription drugs or medicine;

14 (3) dental services;

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

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

19 (b) Sections 134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235,  
20 134.239, 134.240, 134.250, and 134.260 of this title apply to workers' compensation  
21 specific codes, services, and programs provided on or after January 1, 2024.

22 (c) If a court of competent jurisdiction holds that any provision of §§134.209,  
23 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, 134.250, and  
24 134.260 [~~134.250~~] of this title or its application to any person or circumstance is invalid  
25 for any reason, the invalidity does not affect other provisions or applications that can be  
26 given effect without the invalid provision or application and the provisions of §§134.209,  
27 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, 134.250, and  
28 134.260 [~~134.250~~] of this title are severable.

Fee amounts in this informal draft are estimates because the 2024 MEI is not yet available.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17                   (1) MAR amount;

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

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

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

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

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

4           (2) 52--This modifier must be added to CPT code 99456 when the division  
5 ordered the designated doctor to perform an examination of an injured employee, and  
6 the injured employee failed to attend the examination.

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

10           (4) [(2)] CP, chronic pain management program--This modifier must [~~shall~~]  
11 be added to CPT code 97799 to indicate chronic pain management program services  
12 were performed.

13           (5) [(3)] FC, functional capacity--This modifier must [~~shall~~] be added to CPT  
14 code 97750 when a functional capacity evaluation is performed.

15           (6) [(4)] MR, outpatient medical rehabilitation program--This modifier must  
16 [~~shall~~] be added to CPT code 97799 to indicate outpatient medical rehabilitation  
17 program services were performed.

18           (7) [(5)] MI, multiple impairment ratings--This modifier must [~~shall~~] be  
19 added to CPT code 99456 [~~99455~~] when the designated doctor is required to complete  
20 multiple impairment ratings calculations.

21           (8) [(6)] NM, not at maximum medical improvement (MMI)--This modifier  
22 must [~~shall~~] be added to the appropriate MMI CPT code to indicate that the injured  
23 employee has not reached MMI when the purpose of the examination was to determine  
24 MMI.

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

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

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

5           (9) ~~[(10)]~~ VR, review report--This modifier must ~~[shall]~~ be added to CPT  
6 code 99455 to indicate that the service was the treating doctor's review of reports  
7 ~~[report(s)]~~ only.

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

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

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

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

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

23           (13) ~~[(16)]~~ WC, work conditioning--This modifier must ~~[shall]~~ be added to  
24 CPT codes ~~[code]~~ 97545 and 97546 to indicate work conditioning was performed.

25           (14) ~~[(17)]~~ WH, work hardening--This modifier must ~~[shall]~~ be added to  
26 CPT codes ~~[code]~~ 97545 and 97546 to indicate work hardening was performed.

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

4           (15) [(19)] W1, case management for treating doctor--This modifier must  
5 ~~[shall]~~ be added to the appropriate case management billing code activities when  
6 performed by the treating doctor.

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

11           (17) [(21)] W6, designated doctor examination for extent--This modifier  
12 must ~~[shall]~~ be added to the appropriate examination code performed by a designated  
13 doctor when determining extent of the injured employee's compensable injury.

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

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

22           (20) [(24)] W9, designated doctor examination for other similar issues--This  
23 modifier must ~~[shall]~~ be added to the appropriate examination code performed by a  
24 designated doctor when determining other similar issues.

25

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

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

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

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

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

16 (A) the examination;

17 (B) consultation with the injured employee;

18 (C) review of the records and films;

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

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

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



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

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

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

14 (3) MMI. MMI examinations will be reimbursed at \$448 (est.) adjusted per  
15 §134.210(b)(4).

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

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

21 (i) Musculoskeletal body areas are:

22 (I) spine and pelvis;

23 (II) upper extremities and hands; and

24 (III) lower extremities (including feet).

25 (ii) For musculoskeletal body areas:

26 (I) the reimbursement for the first musculoskeletal  
27 body area is \$384 (est.) adjusted per §134.210(b)(4); and

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

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

6 (i) Non-musculoskeletal body areas are:

7 (I) body systems;

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

9 (III) mental and behavioral disorders.

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

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

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

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

25 (1) Extent of injury. The reimbursement rate for determining the extent of  
26 the injured employee's compensable injury is \$640 (est.) adjusted per §134.210(b)(4).

1           (2) Disability. The reimbursement rate for determining whether the injured  
2 employee's disability is a direct result of the work-related injury is \$640 (est.) adjusted  
3 per §134.210(b)(4).

4           (3) Return to work. The reimbursement rate for determining the ability of  
5 the injured employee to return to work is \$640 (est.) adjusted per §134.210(b)(4).

6           (4) Other similar issues. The reimbursement rate for determining other  
7 similar issues is \$640 (est.) adjusted per §134.210(b)(4).

8           (5) Appropriateness of health care. The reimbursement rate for  
9 appropriateness of health care as defined in §126.6 (concerning Required Medical  
10 Examination) and Labor Code §408.004 is \$640 (est.) adjusted per §134.210(b)(4).

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

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

23

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

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

1 **§134.240. Designated Doctor Examinations**

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

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

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

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

9 and

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

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

14 (3) Reimbursement for a missed appointment is \$100 adjusted per  
15 §134.210(b)(4).

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

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

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

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

27 (A) the examination;

1 (B) consultation with the injured employee;

2 (C) review of the records and films;

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

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

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

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

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

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

24 (3) MMI. MMI examinations will be reimbursed at \$448 (est.) adjusted per  
25 §134.210(b)(4), and the designated doctor must apply the additional modifier "W5."

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

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

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

5 (i) Musculoskeletal body areas are:

6 (I) spine and pelvis;

7 (II) upper extremities and hands; and

8 (III) lower extremities (including feet).

9 (ii) For musculoskeletal body areas:

10 (I) the reimbursement for the first musculoskeletal  
11 body area is \$384 (est.) adjusted per §134.210(b)(4); and

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

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

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

18 (I) body systems;

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

20 (III) mental and behavioral disorders.

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

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

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

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

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

8 (D) When multiple IRs are required as a component of a designated  
9 doctor examination under this title, the designated doctor must bill for the number of  
10 body areas rated, and the insurance carrier must reimburse, \$64 (est.) adjusted per  
11 §134.210(b)(4) for each additional IR calculation.

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

14 (5) Extent of injury. The reimbursement rate for determining the extent of  
15 the employee's compensable injury is \$640 (est.) adjusted per §134.210(b)(4), and the  
16 designated doctor must apply the additional modifier "W6."

17 (6) Disability. The reimbursement rate for determining whether the injured  
18 employee's disability is a direct result of the work-related injury is \$640 (est.) adjusted  
19 per §134.210(b)(4), and the designated doctor must apply the additional modifier "W7."

20 (7) Return to work. The reimbursement rate for determining the ability of  
21 the injured employee to return to work is \$640 (est.) adjusted per §134.210(b)(4), and  
22 the designated doctor must apply the additional modifier "W8."

23 (8) Other similar issues. The reimbursement rate for determining other  
24 similar issues is \$640 (est.) adjusted per §134.210(b)(4), and the designated doctor must  
25 apply the additional modifier "W9" when examining issues similar to those described in  
26 subsection (d)(1) - (6).



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

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

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

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

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

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

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

21                   (3) attaching the required documentation.

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

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

27

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

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

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

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

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

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

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

21                   ~~(D) Whether the injured employee's disability is a direct result of the~~  
22 ~~work-related injury shall be billed and reimbursed in accordance with §134.235 of this~~  
23 ~~title, with the use of the additional modifier "W7";~~

24                   ~~(E) Ability of the employee to return to work shall be billed and~~  
25 ~~reimbursed in accordance with §134.235 of this title, with the use of the additional~~  
26 ~~modifier "W8"; and~~

1                                   ~~(F) Issues similar to those described in subparagraphs (A) – (E) of~~  
2 ~~this paragraph shall be billed and reimbursed in accordance with §134.235 of this title,~~  
3 ~~with the use of the additional modifier "W9."~~

4                                   ~~(2) When multiple examinations under the same specific division order are~~  
5 ~~performed concurrently under paragraph (1)(C) – (F) of this section:~~

6   ~~(A) the first examination shall be reimbursed at 100 percent of the~~  
7 ~~set fee outlined in §134.235 of this title;~~

8   ~~(B) the second examination shall be reimbursed at 50 percent of the~~  
9 ~~set fee outlined in §134.235 of this title; and~~

10   ~~(C) subsequent examinations shall be reimbursed at 25 percent of~~  
11 ~~the set fee outlined in §134.235 of this title].~~

12

1 **§134.250. Maximum Medical Improvement Evaluations and Impairment Rating**

2 **Examinations by Treating Doctors**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9                           (I) spine and pelvis;

10                           (II) upper extremities and hands; and

11                           (III) lower extremities (including feet).

12                   (ii) For musculoskeletal body areas:

13                           (I) the reimbursement for the first musculoskeletal  
14 body area is \$384 (est.) adjusted per §134.210(b)(4); and

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

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

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

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

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

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

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

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

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

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

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

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

18 (I) body systems;

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

20 (III) mental and behavioral disorders.

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

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

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



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

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

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

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

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

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

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

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

1           (e) [(6)] The treating doctor is required to review the certification of MMI and  
2 assignment of IR performed by another doctor, as stated in the Labor Code and Chapter  
3 130 of this title. The treating doctor must [~~shall~~] bill using CPT code 99455 with modifier  
4 "VR" to indicate a review of the report only, and the insurance carrier must reimburse  
5 \$64 adjusted per §134.210(b)(4) [~~shall be reimbursed \$50~~].

6

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

2 **Examinations by Referral Doctors**

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

7 (1) the examination;

8 (2) consultation with the injured employee;

9 (3) review of the records and films;

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

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

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

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

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

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

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

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

9           (2) MMI. MMI examinations will be reimbursed at \$448 (est.) adjusted per  
10 §134.210(b)(4).

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

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

16                   (i) Musculoskeletal body areas are:

17                           (I) spine and pelvis;

18                           (II) upper extremities and hands; and

19                           (III) lower extremities (including feet).

20                   (ii) For musculoskeletal body areas:

21                           (I) the reimbursement for the first musculoskeletal  
22 body area is \$384 (est.) adjusted per §134.210(b)(4); and

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

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

1 (i) Non-musculoskeletal body areas are:

2 (I) body systems;

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

4 (III) mental and behavioral disorders.

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

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

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