CHAPTER 134. BENEFITS--GUIDELINES FOR MEDICAL SERVICES, CHARGES, AND PAYMENTS
SUBCHAPTER C. MEDICAL FEE GUIDELINES
28 TAC §§134.209, 134.210, 134.235, 134.239, 134.240, 134.250, AND 134.260

INTRODUCTION. The Texas Department of Insurance, Division of Workers' Compensation (DWC) adopts the repeal of 28 TAC §§134.235, 134.249, and 134.240; and new and amended 28 TAC §§134.209, 134.210, 134.235, 134.239, 134.240, 134.250, and 134.260, concerning medical fee guidelines for certain workers' compensation-specific services, including designated doctor examinations, required medical examinations, work status reports, and maximum medical improvement (MMI) evaluations and impairment rating (IR) examinations by treating and referred doctors. The sections implement Texas Labor Code Chapters 408 and 413, which govern workers' compensation benefits, including medical examinations required to establish benefit entitlements, and medical review to ensure compliance with DWC rules for health care, including medical policies and fee guidelines. The DWC medical advisor recommended the changes to the commissioner of workers' compensation under Labor Code §413.0511(b). The repealed, new and amended sections are adopted without changes to the proposed text published in the December 29, 2023, issue of the *Texas Register* (48 TexReg 8165). The rule will not be republished.

REASONED JUSTIFICATION. The changes in the new and amended sections adjust the billing methodology and reimbursement rates for certain workers' compensation-specific services, including designated doctor examinations, required medical examinations, work

status reports, and MMI evaluations and IR examinations by treating and referred doctors. They adjust the fees once by applying the Medicare Economic Index (MEI) percentage adjustment factor for the period 2009 - 2024, and then after the initial adjustment, adjust the fees annually on January 1 by applying the MEI percentage adjustment factor in §134.203(c)(2), which is how most other professional fees are adjusted annually in the system. They round the fees to whole dollars to simplify calculations and reduce errors. They eliminate unnecessary billing modifiers, eliminate a required sequence for modifiers, and replace the diagnosis-related estimate and range of motion billing methods with a single method of billing. They also create a $100 missed appointment fee and a $300 specialist fee. In addition, they eliminate tiering. For designated doctors and required medical examination doctors, all issues addressed within one examination will be paid at the established fee and not reduced.

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

authorized doctors as a result of a referral from a treating doctor under §130.1 of this title, concerning certification of MMI and evaluation of permanent impairment.

The changes are necessary to attract and retain doctors that perform certain workers' compensation-specific services, including designated doctor examinations, required medical examinations, work status reports, and MMI evaluations and IR examinations by treating and referred doctors, by addressing billing and reimbursement issues, reducing disputes, and by decreasing the administrative burden of participating in the program. Labor Code Chapter 408 entitles an employee that sustains a compensable injury to all health care reasonably required by the nature of the injury as and when needed. Specifically, the employee is entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment. To help determine the health care that meets those standards, the treating doctor manages and coordinates the injured employee's health care for the compensable injury, including referring the employee to a doctor authorized to determine MMI and to assign IRs when needed. The designated doctor program established under Chapter 408 provides for commissioner-ordered medical examinations to resolve any question about the impairment caused by the compensable injury, the attainment of MMI, the extent of the employee's compensable injury, whether the injured employee's disability is a direct result of the work-related injury, the ability of the employee to return to work, or other similar issues. Maintaining a viable program that ensures that injured employees can access examinations in a timely way is essential to meeting the statutory mandate of providing health care for injured employees.

Having too few doctors in the program has a negative impact on the doctors that remain in the system, injured employees, and insurance carriers. When there are too few doctors able to conduct the examinations needed to determine benefit levels, injured employees must often wait longer and travel farther to attend an examination, which can delay dispute resolution and other essential processes. DWC last adjusted reimbursement rates for workers' compensation-specific services in January 2008 (33 TexReg 364). Over the past 14 years, DWC has experienced a decline in the numbers of doctors providing workers' compensation-specific services. This decline has been particularly pronounced among designated doctors certified under Labor Code §408.1225 and providing designated doctor examinations as Labor Code §408.0041 requires, and especially among licensed medical doctors and doctors of osteopathy. In December 2022, for the entire state of Texas, there were only 63 available medical doctors, 10 doctors of osteopathic medicine, 177 doctors of chiropractic, and no doctors of podiatry, dental science, or optometry. Yet in that month, there were 1,259 designated doctor appointments for those 250 designated doctors to cover.

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

the proposal on January 23, 2024, as well as written comments it received by the January 29, 2024, deadline, when drafting this adoption order.

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

However, the common theme throughout the input-gathering process about how to improve the program was billing and reimbursement for certain workers' compensation-specific services, especially designated doctor examinations. Nearly every comment DWC received mentioned some combination of issues about the fees for designated doctor examinations--that they were insufficient, had not been adjusted for inflation or other economic factors in over a decade, did not take into account missed appointments or the time spent reviewing injured employees' medical records, and other similar issues. In adopting the amendments to Chapter 127 and §180.23, DWC stated that billing and reimbursement issues would be addressed in a separate rule project. As a

result, the changes in this rule proposal are another part of the project, and are necessary to account for past and future inflation, examination complexity, and other economic factors that affect participation in the designated doctor program.

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

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

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

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

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

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

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

- rounded to whole dollars; and

- effective on January 1 of each new calendar year.

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

In addition, the amendments simplify the modifiers that health care providers must use when billing professional medical services for correct coding, reporting, billing, and reimbursement based on procedure codes. The amendments add modifier 25 and specify

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

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

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

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

when the RME doctor refers testing to a specialist. It also requires documentation of the referral.

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

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

Section 134.240. New §134.240 specifies billing and reimbursement requirements for designated doctor examinations. It contains statutory references, provides for a $100 missed appointment fee, requires that each examination and its individual billable components be reimbursed separately, and describes the billing methods and reimbursement amounts for a designated doctor examination. In addition, new §134.240 sets the total MAR for an MMI or IR examination, describes what the MMI or IR examination must include and how it must be billed and reimbursed, specifies increased reimbursement rates for MMI evaluations and IR examinations for musculoskeletal and

non-musculoskeletal body areas, and, for testing that is not outlined in the AMA guides, requires billing and reimbursement for the appropriate testing CPT code or codes according to the applicable fee guideline in addition to the fees for the MMI and IR examinations. New §134.240 sets increased rates for examinations to determine extent of injury, disability, return to work, and other similar issues. New §134.240 also sets billing and reimbursement requirements for when the designated doctor refers testing to a specialist, and it requires documentation of the referral. It specifies that the 95-day period for timely submission of the designated doctor bill for the examination begins on the date of service of the additional testing or evaluation, and that the designated doctor and any referral health care providers must include the DWC-provided assignment number in the prior authorization field, per §133.10(f)(1)(N) of this title. In addition, for designated doctors, all issues addressed within one examination will be paid at the established fee and not reduced. Finally, new §134.240 sets a $300 specialist fee in addition to the examination fee for certain specialized diagnoses.

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

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

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

Section 134.250. The amendments to §134.250 rename the section "Maximum Medical Improvement Evaluations and Impairment Rating Examinations by Treating Doctors" to reflect the restructuring in this rule. The amendments move the requirements for required medical examinations into new §134.235, for designated doctors into new

§134.240, and for referred doctors into new §134.260. The amendments make §134.250 specific to treating doctors, so treating doctors will be able to find their billing requirements in one section. They specify the billing methods and reimbursement requirements for MMI and IR examinations, and they permit a treating doctor that is not authorized to assign an IR to refer the injured employee to an authorized doctor for the examination and certification of MMI and IR, specifying that the referred doctor must bill under §134.260. In addition, the amendments to §134.250 specify increased reimbursement rates for MMI evaluations and IR examinations for musculoskeletal and non-musculoskeletal body areas, and, for testing that is not outlined in the AMA guides, require billing and reimbursement for the appropriate testing CPT code or codes according to the applicable fee guideline in addition to the fees for examination by the treating doctor. Finally, the amendments increase the reimbursement rate for a treating doctor reviewing the certification of MMI and assignment of IR performed by another doctor (referred doctor). Amending §134.250 is necessary to consolidate treating doctors' billing and reimbursement requirements into one section to increase efficiency and ease of use and decrease the possibility of errors, to update the reimbursement rates in compliance with DWC's statutory obligations to maintain the workers' compensation benefit system and set reasonable reimbursement policies and guidelines, and to attract and retain doctors in the system.

Section 134.260. New §134.260 concerns MMI evaluations and IR examinations by referred doctors. It describes what the MMI or IR examination must include, specifies increased reimbursement rates for MMI evaluations and IR examinations for

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

SUMMARY OF COMMENTS AND AGENCY RESPONSE.

Commenters: DWC received 30 written comments by the January 29, 2024, deadline, and three oral comments at the January 23, 2024, hearing. Because DWC published the Chapter 133 proposal and the Chapter 134 proposal at the same time and discussed both proposals in the hearing, some commenters submitted comments specifically on both proposals, while others acknowledged both proposals but only commented specifically on one. Three acknowledged both proposals in their comments but did not specifically state a position on the Chapter 134 proposal. Commenters specifically in support of the Chapter 134 proposal were: the Office of Injured Employee Counsel and two individuals. Commenters specifically in support of the Chapter 134 proposal with changes were: Texas Mutual Insurance Company; the Insurance Council of Texas; the Texas Chiropractic Association; Texas Independent Evaluators, LLC; and 19 individuals. No commenters were against the Chapter 134 proposal. Some commenters included logistical or practical

questions or examples about how the rules will function once adopted. DWC will address those questions in the upcoming training sessions about how to comply with the updated rules.

Comment on Chapter 134 (notice of examination). A commenter stated that DWC should send an automated text and email in addition to a physical letter to claimants about the designated doctor examination, and that the days of snail mail are over.

Agency Response to Comment on Chapter 134 (notice of examination). DWC appreciates the comment but declines to make this change because it is out of scope for this rule project.

Comment on §134.240 (missed appointment fee). A commenter stated that the missed appointment fee should be recouped from the injured employee's temporary income benefits (TIBs), and that the insurance carrier should not be financially responsible for the claimant's choice to not attend.

Agency Response to Comment on §134.240 (missed appointment fee). DWC appreciates the comment. The missed appointment fee is necessary to compensate designated doctors for the work they are required to do in advance of an ordered examination, even if the injured employee does not attend the appointment. Section 127.25 of this title, Failure to Attend a Designated Doctor Examination, allows an insurance carrier to suspend TIBs if an injured employee fails, without good cause, to attend a designated doctor examination or a referral examination under §127.10(c) of this title, General Procedures for Designated Doctor Examinations.

Comments on §134.240 (missed appointment fee). Two commenters stated that they appreciated the new no-show fee.

Agency Response to Comments on §134.240 (missed appointment fee). DWC appreciates the comments.

Comments on §134.240 (missed appointment fee). Three commenters stated that the no-show fee should be higher. One stated that the minimum amount should be $200. Another stated that the minimum amount should be $250.

Agency Response to Comments on §134.240 (missed appointment fee). DWC appreciates the comments but declines to make the change at this time because of the significant one-time fee increases and annual inflation adjustments in this rule.

Comments on §134.240 (missed appointment fee). Fourteen commenters stated that DWC should provide a broken or missed appointment fee for all designated doctors, required medical examination doctors, treating doctors, and referral doctors. Three of those commenters also stated that DWC should include the same increase for MMI, IR, and other services.

Agency Response to Comments on §134.240 (missed appointment fee). DWC appreciates the comments but declines to make the change. DWC's rules do not require travel to appointments, missed or attended. In addition, designated doctors are the only ones that are required by rule to review medical records from the treating doctor and insurance carrier before conducting the examination. That is distinct from an MMI or IR

examination, where the examination itself includes a review of the records and films. The missed appointment fee is intended to compensate designated doctors for the work the rule requires them to perform before they go to perform the examination, only to find that they cannot perform the examination--and get paid for it--because the injured employee is not there.

Comment on §134.240 (missed appointment fee). One commenter stated that the $100 missed appointment fee proposed in §134.240 is consistent with the amount of the missed appointment fee proposed as part of House Bill (HB) 2702, 88th Legislature, Regular Session (2023), which failed to pass. The commenter stated that because the proposed rules include significant fee increases for all examinations, which will have a sizable cost impact on the workers' compensation system, the commenter did not support a fee amount greater than that which was proposed.

Agency Response to Comment on §134.240 (missed appointment fee). DWC appreciates the comment and agrees that the $100 missed appointment fee is appropriate.

Comments on Chapter 134 (record review fee). Three commenters stated that DWC needs to adopt a record review fee. One of those commenters stated that the fee should be $25 per 50 pages for records totaling more than 200 pages, and suggested that insurance carriers should have to pay extra for sending duplicated, useless, and out-of-order pages.

Agency Response to Comments on Chapter 134 (record review fee). DWC appreciates the comments but declines to make the change. DWC explored that option during the informal draft process, but found that a record review fee is not logistically feasible at this time. In addition, penalizing insurance carriers for sending duplicate pages is not in the scope of this rule. If an insurance carrier is not complying with the requirement to send records, or is abusing the system by sending voluminous, nonresponsive material, DWC encourages the doctor to file a complaint.

Comment on Chapter 134 (print fee). A commenter recommended that DWC allow a designated doctor to bill a print fee for medical records.

Agency Response to Comment on Chapter 134 (print fee). DWC appreciates the comment but declines to make the change, as it is not in scope for this rule. In addition, printing is not necessary to comply with the review requirement in the rule.

Comment on Chapter 134 (retroactive effect). A commenter asked DWC to consider making the fee schedule increase retroactive to January 1, 2024.

Agency Response to Comment on Chapter 134 (retroactive effect). DWC appreciates the comment but declines to make the change. System participants need to be able to program their systems and prepare for compliance in advance of the effective date. Making medical billing changes retroactive would increase medical fee disputes exponentially. In addition, the system does not have a practical way to process amended bills on that scale retroactively.

Comments on Chapter 134 (fee amounts). Two commenters stated that fee amounts should be higher.

Agency Response to Comments on Chapter 134 (fee amounts). DWC appreciates the comments but declines to make the change, as this rule has already increased fees significantly across the board to ensure fair compensation, and the fees will be adjusted annually to account for inflation.

Comments on Chapter 134 (fee amounts). Three commenters stated that the fee increases are fair as proposed. One of those commenters would not support a fee increase greater than what was proposed, and that going forward, the application of the annual adjustment factor will ensure that fees are adjusted as needed in the future. One commenter expressed support for increasing designated doctor compensation via the MEI, adjusting compensation annually to reflect changes in the MEI, and compensating multiple examinations performed concurrently without a discount.

Agency Response to Comments on Chapter 134 (fee amounts). DWC appreciates the comments and agrees.

Comments on Chapter 134 (extent of injury). Fifteen commenters stated that extent-of-injury examinations should be paid more. Thirteen of those commenters recommended reimbursing $50 for each condition after the initial fee when a designated doctor or a required medical examination doctor is required to answer extent-of-injury questions. One of those commenters recommended that for each disputed condition that has to be addressed after the initial condition, an additional $150 should be allowed.

Agency Response to Comments on Chapter 134 (extent of injury). DWC appreciates the comments but declines to make the changes at this time. As proposed, the rule already increased the fees for extent-of-injury examinations significantly, and the fees will be adjusted annually to account for inflation. In addition, the rule eliminates the tiering discount for designated doctors and required medical examination doctors, ensuring that all issues addressed within one examination will be paid at the established fee and not reduced. DWC believes that these changes will ensure that doctors are compensated fairly for extent-of-injury examinations.

Comments on §134.210 (MEI annual adjustment). Two commenters expressed uncertainty about how the MEI is calculated. One of those commenters was concerned about attaching fees to Medicare and wanted to be sure that, if the Medicare rate trended down in the future, the fees would not decrease.

Agency Response to Comments on §134.210 (MEI annual adjustment). DWC appreciates the comments, and offers the following explanation of the MEI, but declines to adjust the rule to remove the MEI factor. DWC sets its own fee schedule and modifies it based on the MEI to allow the fees to increase in relation to changes in the prices of goods and services, including physician-specific costs and compensation.

The MEI is a measure of practice cost inflation that was developed in 1975 and is updated quarterly to estimate annual changes in physicians' operating costs and establish appropriate Medicare physician payment updates. It consists of two categories: physician practice costs and physician compensation. The physician practice costs portion of the current MEI includes components for nonphysician compensation, such as fringe benefits;

medical supplies; professional liability insurance; and other expenses, including other professional services. Medicare assigns each component a weight and uses various proxy indices to estimate price changes. The physician compensation category of the MEI reflects increases in general earnings and is currently proxied by changes in the wages and benefits of professional occupations in the United States from the Bureau of Labor Statistics. Medicare then adjusts the change in the combined practice costs and physician compensation components by the 10-year average of multifactor productivity for the economy.

Comments on §134.210 (MEI annual adjustment). Fourteen commenters stated that DWC should retroactively include the MEI percentage adjustment factor for the years 2004 - 2008.

Agency Response to Comments on §134.210 (MEI annual adjustment). DWC appreciates the comments but declines to make the change. When DWC adopted amended medical reimbursement policies and medical fee guidelines in §§134.203 and 134.204 (proposed 32 TexReg 6966, October 5, 2007, with corrections at 32 TexReg 7329, October 12, 2007, and adopted 33 TexReg 364, January 11, 2008), the order stated that the commissioner adopted them to comply with Labor Code §413.012, which directs fee guidelines to be reviewed and revised to reflect fair and reasonable fees and to reflect medical treatment or ranges of treatment that are reasonable and necessary at the time the review and revision are conducted. DWC, in consultation with the medical advisor, considered the change in the MEI from 2002 to 2007 and found that, at the time of adoption, the fee for designated doctor activities was fair and reasonable, after

consideration of duties involved, including the additional duties HB 7, 79th Legislature, Regular Session (2005) added to Labor Code §408.0041.

Comment on §134.210 (MEI annual adjustment). One commenter stated, "While we understand the methodology for the one-time increase to account for the lack of fee increases since 2009, some members have expressed concern about the one-time large fee increase referenced in proposed 28 TAC 134.210(a)(1)(A). In addition to DDs, this increase would also apply to all RMEs under new rule 134.235. The purpose of this increase is because of a decline in DDs between 2009 - 2023. However, the proposed revisions in new rule 134.210(a)(1)(A) require an increase for current doctors using a MEI percentage adjustment for all years between 2009 - 2024. This is an average increase of 56% and seems to conflict with statutory provisions requiring DWC adjustment of fees every two years. See Labor Code 413.012."

Agency Response to Comment on §134.210 (MEI annual adjustment). DWC appreciates the comment but disagrees with the assertion that the one-time and annual adjustments are inappropriate or excessive and conflict with Labor Code §413.012.

For the affected programs, DWC estimates that based on calendar year (CY) 2022 activity, the total system impact from the changes will be about $9 million over CY 2022 reimbursement. That includes a one-time initial adjustment in rates based on the accrued changes in the MEI since the rates were last adopted, plus costs associated with removing tiering, adding the missed appointment fee, and adding the specialist fee. For the past five years, the annual change in the MEI has ranged from 1.4% to 4.6%, averaging 2.8%. Based on this estimated average future year over previous year percentage, DWC

estimates the increase in reimbursement to be a little more than $1 million per year. To help offset costs for teaching and training staff on the changes, DWC expects to provide free training presentations with specific billing examples after the rule is adopted but before it becomes effective.

The one-time adjustment is necessary to achieve fair and reasonable fees, and the annual inflation adjustment is necessary to ensure that future one-time large increases won't be needed. Labor Code §413.012 requires DWC to review medical policies and fee guidelines *at least* every two years to reflect fair and reasonable fees and medical treatment or ranges of treatment that are reasonable and necessary at the time the review and revision is conducted. DWC reviewed billing methodologies and reimbursement amounts to ensure that these medical policies and fee guidelines align with the need to attract and retain an adequate number of qualified designated doctors, RME doctors, and MMI and IR-certified doctors participating in the workers' compensation system.

Comment on §134.240 (specialist fee). Two commenters asked DWC to clarify what the $300 specialist fee is. Another commenter thought that DWC had confused "specialist" with "complex exam."

Agency Response to Comment on §134.240 (specialist fee). DWC appreciates the comment. The specialist fee is in §134.240(g)(3). It applies when DWC orders a designated doctor to perform an examination of an injured employee with one or more of the diagnoses listed in §127.130(b)(9)(B) - (I) of this title, Qualification Standards for Designated Doctor Examinations.

Comments on §134.240 (specialist fee). Three commenters recommended that DWC eliminate the additional $300 for specialists in §134.240(g)(3).

Agency Response to Comments on §134.240 (specialist fee). DWC disagrees with the recommendation. The specialist fee acknowledges designated doctors' time and effort spent in gaining specialty certifications and expertise. It reimburses board-certified physicians that participate in the designated doctor program and examine injured employees with certain complex injuries or diagnoses. The specialist fee is a necessary incentive for board-certified physicians to participate in the program, which reduces delays in examinations for employees with complex injuries or diagnoses and contributes to overall system health and efficiency.

Comments on §134.240 (specialist fee and tiering). One commenter stated that the extra costs incurred for specialist declaration should be compensated accordingly at an appropriate rate. With regard to eliminating tiering, the commenter stated that it is unfair to compensate differently for the same work product based on title (unless it is a specialist fee, as noted above). Another commenter expressed support for compensating multiple examinations performed concurrently without a discount.

Agency Response to Comments on §134.240 (specialist fee and tiering). DWC appreciates the comment and agrees that the specialist fee is necessary and appropriate. DWC also agrees that eliminating tiering is necessary so that, for designated doctors and required medical examination doctors, all issues addressed within one examination are paid at the established fee and not reduced.

Comment on Chapter 134 (tiering). One commenter recommended that DWC retain tiered reimbursement as set out in current rule §134.240, which provides that the first issue examined by a DD beyond MMI or IR will be paid at 100% of the fee guideline, the second issue will be paid at 50% of the fee guideline, and subsequent issues will be paid at 25% of the fee guideline.

Agency Response to Comment on Chapter 134 (tiering). DWC appreciates the comment but declines to make the change. Eliminating tiering is necessary so that, for designated doctors and required medical examination doctors, all issues addressed within one examination are paid at the established fee and not reduced. Compensating designated doctors and required medical examination doctors for the actual work performed, instead of imposing a discount for examining an issue just because the patient happens to have other issues as well, is fair and reasonable, in addition to being necessary to encourage participating providers to remain in the program and entice more providers to participate.

Comment on Chapter 134 (IR spine and MMI). One commenter stated that the fee for IR spine is too low. The commenter said that sometimes they have cases with multiple fusions that also fail back surgery, and that the fee should be higher because they have to use the diagnosis-related estimate model but still have to do all range of motion of the spine. The commenter also stated that the fee for "none MMI" evaluation should be much higher--more than just $350--since they have to do the examination, make a decision at the end, and review all the records.

Agency Response to Comment on Chapter 134 (IR spine and MMI). DWC appreciates the comment but declines to make the changes. The rule replaces the diagnosis-related estimate and range-of-motion billing methods with a single method of billing. In addition, the rules provide for a significant one-time increase in the fees established in §§134.235, 134.240, 134.250, and 134.260 by applying the MEI percentage adjustment factor for the period 2009 - 2024, as well as an annual MEI adjustment in those fees going forward. DWC made those adjustments to comply with DWC's statutory obligations to maintain the workers' compensation benefit system and set reasonable reimbursement policies and guidelines, and to attract and retain doctors in the system.

Comment on Chapter 134 (clarification letter). One commenter asked DWC to consider a small fee of $50 for a clarification letter. The commenter stated that in federal cases for any clarification letter they have a fee of $75 to resolve issues with any clarification response.

Agency Response to Comment on Chapter 134 (clarification letter). DWC appreciates the comment but declines to make the change, as it is out of scope for this rule project. In addition, clarification letters are not part of an examination, and DWC does not find it appropriate to charge for clarifying a report that should have been written clearly.

Comment on Chapter 134 (car accidents). One commenter asked whether there is a better system for payment in the case of patients in a car accident where workers' compensation applies. The commenter stated that those accidents always show multiple

body parts, such as shoulder, elbow, wrist, knee, hip, and spine, and today the system is only based on three body parts maximum.

Agency Response to Comment on Chapter 134 (car accidents). DWC appreciates the comment but declines to make the change, as it is out of scope for this rule project. In addition, changing the payment system for car accidents in workers' compensation would create many medical fee disputes and would be inconsistent with the way all other examinations are paid.

Comment on Testing. One commenter stated that DWC should continue to require doctors to test, instead of accepting all doctors who took the test some 10 years ago.

Agency Response to Comment on Testing. DWC appreciates the comment but declines to make the change, as it is out of scope for this rule project.

Comment on Chapter 134 (effective date). One commenter estimated that a minimum of 90 days after the rules become effective will be needed to implement the proposed changes.

Agency Response to Comment on Chapter 134 (effective date). DWC appreciates the comment and has attempted to ensure a minimum of 90 days' lead time between publication of the order and the date the rules become effective.

Comment on Chapter 134. One commenter expressed support and appreciation for DWC's efforts to provide free training for insurance carriers and health care providers on the new billing requirements and reimbursement rates.

Agency Response to Comment on Chapter 134. DWC appreciates the comment.

Comment on §134.210 (incentive payment). One commenter stated that they support the proposed amendments to §§134.210 and 134.240, which would exclude the proposed designated doctor missed appointment fee from the §134.2 incentive payment. The commenter requested that DWC clarify that the HPSA incentive payment, the physician scarcity bonus, and the §134.2 incentive payment be exempted from application to all designated doctor examination fees, including fees provided for in §134.240(g)(3) authorizing a $300 additional fee for examinations involving diagnoses listed in §127.130(b)(9)(B) - (I) and the missed appointment fees provided for in §134.240. The commenter stated that without this clarification, insurance carriers would be left to interpret the existing statute and rules without guidance, which could lead to unnecessary medical fee disputes.

Agency Response to Comment on §134.210 (incentive payment). DWC appreciates the comment but declines to make this change. Section 134.210(b)(3), as proposed and adopted, applies the 10% incentive payment to the maximum allowable reimbursement (MAR) for services that are performed in designated workers' compensation underserved areas and that are outlined in §§134.220 (case management services), 134.225 (functional capacity evaluations), 134.235 (required medical examinations), 134.240 (designated doctor examinations), 134.250 (MMI and IR examinations by treating doctors), 134.260 (MMI evaluations and IR examinations by referred doctors), and §134.210(d), which refers to services in §§134.215, 134.220, 134.225, and 134.230 where there is no negotiated or contracted amount that complies with Labor Code §413.011. It specifically exempts

reimbursement for a missed appointment under §134.240 from the 10% incentive payment.

Comment on §134.210 (annual adjustment factor). One commenter expressed support for the addition of an annual adjustment factor, but stated that the annual adjustment factor should not be applied to the missed appointment fee and the §127.130 expert exam fees. The commenter recommended that §134.210 be revised to exclude the application of the annual adjustment factor to reimbursements for expert examinations under §134.240(g)(3) and the missed appointment fees provided for in §134.240. The commenter also recommended that DWC publish the MEI-adjusted designated doctor, required medical examination doctor, treating doctor, and referral doctor examination fees each year in the same way it publishes the MEI adjuster professional fee conversion factors to ensure that all insurance carriers pay the correct reimbursement rates.

Agency Response to Comment on §134.210 (annual adjustment factor). DWC appreciates the comment but declines to exclude the specialist fee in §134.240(g)(3) from the annual adjustment based on the MEI, because it would increase the complexity of the bill and could lead to more errors. The missed appointment fee, unlike the specialist fee, is a one-time, one-line fee that would not apply to every examination and would not be billed as part of the examination. For example, if the designated doctor in the underserved area is also evaluating MMI and IR, and the injury is a traumatic brain injury, so the $300 specialist fee applies, excluding the 10% incentive payment from the specialist fee but not from other components of the examination would be confusing and time-consuming. In addition, the purpose of the annual adjustment is to ensure that payments keep pace with

inflation, preventing the need for another comprehensive update to the fees in the future, and excepting the $300 specialist fee does not accomplish this goal. To the commenter's other recommendation, which does not require a change in the rule text--DWC agrees and plans to publish the MEI-adjusted designated doctor, required medical examination doctor, treating doctor, and referral doctor examination fees each year in the same way it publishes the MEI adjuster professional fee conversion factors.

Comment on §134.235 (reference). One commenter suggested that §134.235(a) be revised to include a reference to Labor Code §408.0044.

Agency Response to Comment on §134.235 (reference). DWC appreciates the comment but declines to make the change because Labor Code §408.004 lists §§408.0043 and 408.0045, but does not list §408.0044.

Comment on Chapter 134 (modifiers). One commenter recommended that DWC create modifiers for various types of required medical examinations and retain the current modifier for appropriateness of health examinations.

Agency Response to Comment on Chapter 134 (modifiers). DWC appreciates the comment but declines to make those changes at this time. DWC understands that the suggested modifier, RE, exists, but is not used explicitly for required medical exams; and if it were required as the commenter suggests, it would not be used in billing, but instead only in an internal tracking system. One of DWC's goals in updating the billing and reimbursement rules in Chapters 133 and 134 has been to reduce administrative burdens

by simplifying the modifiers. Adding new modifier requirements would be counter to this goal.

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

STATUTORY AUTHORITY. The commissioner of workers' compensation adopts the repeal of §§134.235, 134.239, and 134.240 under Labor Code Chapter 408; Chapter 413, Subchapter B; and §§402.00111, 402.0016, and 402.061.

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

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

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

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

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

TEXT.

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

§134.239. Billing for Work Status Reports.

§134.240. Designated Doctor Examinations.

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

STATUTORY AUTHORITY. The commissioner of workers' compensation adopts amended §§134.209, 134.210, and 134.250; and new §§134.235, 134.239, 134.240, and 134.260 under Labor Code §§408.004, 408.0041, 408.021, 408.023, 408.0251, 408.0252, 408.1225, 413.007, 413.011, 413.012, 413.015, 413.0511, 413.053, 402.00111, 402.00116, and 402.061.

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

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

Labor Code §408.021 entitles an employee that sustains a compensable injury to all health care reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to health care that cures or relieves the effects naturally resulting from the compensable injury, promotes recovery, or enhances the ability of the employee to return to or retain employment.

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

the IR training and testing requirements in the rule if the doctor intends to provide MMI certifications or assign IRs.

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

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

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

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

treatment protocols, and must be able to be used in a meaningful way to allow DWC to control medical costs.

Labor Code §413.011 requires the commissioner to adopt health care reimbursement policies and guidelines that reflect the standardized reimbursement structures found in other health care delivery systems with minimal modifications to those reimbursement methodologies as needed to meet occupational injury requirements. It requires the commissioner to adopt the most current methodologies, models, and values or weights used by the federal Centers for Medicare and Medicaid Services (CMS), including applicable payment policies relating to coding, billing, and reporting; and allows the commissioner to modify documentation requirements as needed to meet the requirements of §413.053. It also requires the commissioner, in determining the appropriate fees, to develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of §413.011(d); and requires the commissioner to provide for reasonable fees for the evaluation and management of care as required by §408.025(c) and commissioner rules. The commissioner may not adopt the Medicare fee schedule or conversion factors or other payment adjustment factors based solely on those factors as developed by the federal CMS. Fee guidelines must be fair and reasonable, and designed to ensure the quality of medical care and achieve medical cost control. They may not provide for payment of a fee that exceeds the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. When establishing the fee guidelines, §413.011 requires the commissioner to consider the increased security of payment that Subtitle A, Title 5,

Labor Code affords. It allows network contracts under Insurance Code §1305.006. It specifically authorizes the commissioner and the commissioner of insurance to adopt rules as necessary to implement §413.011.

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

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

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

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

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

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

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

TEXT.

§134.209. Applicability.

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

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

(2) prescription drugs or medicine;

(3) dental services;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) MAR amount;

(2) health care provider's usual and customary charge; or

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

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

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

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

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

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

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

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

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

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

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

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

(10) V3, treating doctor evaluation of MMI--This modifier must be added to CPT code 99455 when the office visit level of service is equal to CPT code 99213.

(11) V4, treating doctor evaluation of MMI--This modifier must be added to CPT code 99455 when the office visit level of service is equal to CPT code 99214.

(12) V5, treating doctor evaluation of MMI--This modifier must be added to CPT code 99455 when the office visit level of service is equal to CPT code 99215.

(13) WC, work conditioning--This modifier must be added to CPT codes 97545 and 97546 to indicate work conditioning was performed.

(14) WH, work hardening--This modifier must be added to CPT codes 97545 and 97546 to indicate work hardening was performed.

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

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

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

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

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

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

§134.235. Required Medical Examinations.

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

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

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

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

(A) the examination;

(B) consultation with the injured employee;

(C) review of the records and films;

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

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

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

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

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

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

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

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

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

(i) Musculoskeletal body areas are:

(I) spine and pelvis;

(II) upper extremities and hands; and

(III) lower extremities (including feet).

(ii) For musculoskeletal body areas:

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

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

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

(i) Non-musculoskeletal body areas are:

(I) body systems;

(II) body structures (including skin); and

(III) mental and behavioral disorders.

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

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

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

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

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

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

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

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

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

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

§134.239. Billing for Work Status Reports.

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

§134.240. Designated Doctor Examinations.

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

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

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

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

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

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

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

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

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

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

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

(A) the examination;

(B) consultation with the injured employee;

(C) review of the records and films;

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

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

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

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

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

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

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

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

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

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

(i) Musculoskeletal body areas are:

(I) spine and pelvis;

(II) upper extremities and hands; and

(III) lower extremities (including feet).

(ii) For musculoskeletal body areas:

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

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

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

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

(I) body systems;

(II) body structures (including skin); and

(III) mental and behavioral disorders.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) attaching the required documentation.

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

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

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

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

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

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

(1) the examination;

(2) consultation with the injured employee;

(3) review of the records and films;

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

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

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

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

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

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

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

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

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

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

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

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

(i) Musculoskeletal body areas are:

(I) spine and pelvis;

(II) upper extremities and hands; and

(III) lower extremities (including feet).

(ii) For musculoskeletal body areas:

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

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

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

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

(I) body systems;

(II) body structures (including skin); and

(III) mental and behavioral disorders.

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

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

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

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

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

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

(1) the examination;

(2) consultation with the injured employee;

(3) review of the records and films;

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

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

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

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

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

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

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

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

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

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

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

(i) Musculoskeletal body areas are:

(I) spine and pelvis;

(II) upper extremities and hands; and

(III) lower extremities (including feet).

(ii) For musculoskeletal body areas:

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

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

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

(i) Non-musculoskeletal body areas are:

(I) body systems;

(II) body structures (including skin); and

(III) mental and behavioral disorders.

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

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

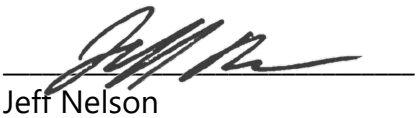
(d) If the examination for the determination of MMI or the assignment of IR requires testing that is not outlined in the AMA Guides, the referred doctor must bill, and the insurance carrier must reimburse, the appropriate testing CPT code or codes according to the applicable fee guideline in addition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

CERTIFICATION. The agency certifies that legal counsel has reviewed the adoption and found it to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on February 23, 2024.

Kara Mace
General Counsel
TDI, Division of Workers' Compensation

The commissioner adopts the repeal of 28 TAC §§134.235, 134.249, and 134.240; and new and amended 28 TAC §§134.209, 134.210, 134.235, 134.239, 134.240, 134.250, and 134.260.



Jeff Nelson
Commissioner
TDI, Division of Workers' Compensation

Commissioner's Order No. 2024-8541