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, 134.260

TEXT.

§134.209. Applicability

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

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

(2) prescription drugs or medicine;

(3) dental services;

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

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

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

(c) Sections 134.210, 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 DATE.

(d) If a court of competent jurisdiction holds that any provision of §§134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, 134.250, and 134.260[~~134.250~~] of this title or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications that can be

given effect without the invalid provision or application and the provisions of §§134.209, 134.210, 134.215, 134.220, 134.225, 134.230, 134.235, 134.239, 134.240, 134.250, and 134.260[~~134.250~~] of this title are severable.

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

(f) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants must apply Medicare payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

(1) "Medicare payment policies" mean reimbursement methodologies, models, and values or weights in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare. Medicare payment policies include:

(A) coding;

(B) billing;

(C) correct coding initiatives (CCI) edits;

(D) modifiers;

(E) bonus payments for health professional shortage areas (HPSAs);

(F) bonus payments for physician scarcity areas (PSAs);

(G) reporting; and

(H) other payment policies.

(2) Notwithstanding Medicare payment policies, chiropractors may be reimbursed for services provided within the scope of their practice act.

(3) Specific provisions in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (division) rules, including this chapter, take precedence over any conflicting provision adopted or used by CMS in administering the Medicare program.

(4) Independent review organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any division rules and Medicare payment policies.

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

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

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

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

(2) Modifying circumstance must[~~shall~~] be identified by use of the appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS codes. Where HCPCS modifiers apply, insurance carriers must[~~shall~~] treat them in accordance with Medicare and Texas Medicaid rules. In addition[~~Additionally~~], division-specific modifiers are identified in subsection (f)[~~(e)~~] of this section and in §§134.235, 134.240, 134.250, and 134.260. When two or more modifiers apply[~~are applicable~~] to a single HCPCS code, indicate each modifier on the bill.

(3) A 10% [~~percent~~] incentive payment must[~~shall~~] be added to the maximum allowable reimbursement (MAR) for services outlined in §§134.220, 134.225, 134.235, 134.240, 134.250, and 134.260[~~134.250~~] of this title and subsection (d) of this section that are performed in designated workers' compensation underserved areas in accordance with §134.2 of this title. However, reimbursement for medical record review 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 adjusted annually by applying the adjustment factor identified in §134.203(c)(2). The adjusted fees will be effective on January 1 of each new calendar year.

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

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

(1) MAR amount;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(15)[~~(20)~~] W5, designated doctor examination for impairment or attainment of MMI--This modifier must[~~shall~~] be added to the appropriate examination

code performed by a designated doctor when determining impairment caused by the compensable injury and in attainment of MMI.

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

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

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

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

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

(a) Required medical examination doctors (RME doctors) must perform examinations in accordance with Labor Code §§408.004, 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, the RME doctor will bill and be reimbursed 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 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 AMA 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 insurance carriers must only reimburse, for an MMI or IR examination if they are an authorized doctor in accordance with the Labor Code and Chapter 130 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 subsection (c)(1) 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 subsection (c)(1) 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 subsections (c)(1) and (d) of this section.

(3) MMI. MMI examinations will be reimbursed at NEW RATE.

(4) IR. For IR evaluations, 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 NEW RATE; and

(II) the reimbursement for each additional musculoskeletal body area is NEW RATE.

(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 NEW RATE.

(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 appropriate testing CPT code or codes must be billed and reimbursed according to the applicable fee guideline in addition to the fees outlined in subsections (a) and (b) 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 (c)(1)-(5).

(1) the reimbursement for extent of injury is NEW RATE;

(2) the reimbursement for disability is NEW RATE;

(3) the reimbursement for return to work is NEW RATE;

(4) the reimbursement for other similar issues as described in (c)(1) and (d)(1)-(4) of this section is NEW RATE; and

(5) the reimbursement for appropriateness of health care as defined in §126.6 (concerning Required Medical Examination) and Labor Code §408.004 is NEW RATE.

(e) When the RME doctor refers testing to a specialist, the referral specialist 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 is required.

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

§134.239. Billing for Work Status Reports

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

§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 maximum of two and a half hours of medical record review.

(1) For the first hour of medical record review, the CPT code is XXXXX, and the reimbursement is NEW RATE.

(2) For each additional half hour, the CPT code is XXXXX, and the reimbursement is NEW RATE, up to a maximum of three additional half hours and a corresponding maximum of NEW RATEx3.

(3) The designated doctor may bill for the review of medical records regardless of whether an examination is conducted.

(4) The designated doctor may bill for record review only once for each examination ordered.

(5) Reimbursement for medical record review 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) A designated doctor must only bill and be reimbursed for a maximum medical improvement (MMI) or impairment rating (IR) examination if they are an authorized doctor in accordance with the Labor Code and Chapter 130 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 (c)(1) 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 will be billed and reimbursed in accordance with subsection (c)(1) 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 subsections (c)(1) and (d) of this section.

(2) MMI. MMI examinations will be reimbursed at NEW RATE, and the designated doctor must apply the additional modifier "W5."

(3) IR. For IR evaluations, 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 NEW RATE; and

(II) the reimbursement for each additional musculoskeletal body area is NEW RATE.

(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 NEW RATE.

(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 (b) and (d)(1)-(3) 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, NEW RATE 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."

(4) Extent of injury. The reimbursement rate for determining the extent of the employee's compensable injury is NEW RATE, and the designated doctor must apply the additional modifier "W6."

(5) Disability. The reimbursement rate for determining whether the injured employee's disability is a direct result of the work-related injury is NEW RATE, and the designated doctor must apply the additional modifier "W7."

(6) Return to work. The reimbursement rate for determining the ability of the injured employee to return to work is NEW RATE, and the designated doctor must apply the additional modifier "W8."

(7) Other similar issues. The reimbursement rate for determining other similar issues is NEW RATE, 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 bill 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 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 specialist 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 when:

(A) determining IR or attainment of MMI;

(B) determining the extent of the employee's compensable injury;

(C) determining whether the injured employee's disability is a direct result of the compensable injury;

(D) determining the ability of the injured employee to return to work;

(E) determining other similar issues; or

(F) performing record review as described in 134.240(b).

(2) The designated doctor must add modifier "25" only one time for each examination conducted, 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, NEW RATE in addition to the examination fee.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Treating doctors must[~~(2) A health care provider shall~~] only bill and be reimbursed for an MMI or IR[~~MMI/IR~~] examination if they are[~~the doctor performing the evaluation (i.e., the examining doctor) is~~] an authorized doctor in accordance with the Labor Code and Chapter 130 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 subsection (c)(1) 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 subsection (c)(1) 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 subsections (c)(1) and (d) of this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) MMI. For MMI examinations, the treating doctor must bill using CPT code 99455 with the appropriate modifier.

(A) Reimbursement is the applicable established patient office visit level associated with the examination.

(B) Modifiers "V3," "V4," or "V5" must be added to the CPT code 99455 to correspond with the last digit of the applicable office visit.

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

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

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

(I) spine and pelvis;

(II) upper extremities and hands; and

(III) lower extremities (including feet).

(ii) For musculoskeletal body areas:

(I) the reimbursement for the first musculoskeletal body area is NEW RATE; and

(II) the reimbursement for each additional musculoskeletal body area is NEW RATE.

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

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

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

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

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

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

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

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

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

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

(I) body systems;

(II) body structures (including skin); and

(III) mental and behavioral disorders.

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

(iii) The reimbursement for the assignment of an IR in a non-musculoskeletal body area is NEW RATE.

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

~~(I) The examining doctor (e.g., the referring doctor) shall bill using the appropriate MMI CPT code with modifier "SP" and indicate one unit in the units column of the billing form. Reimbursement shall be $50 for incorporating~~

~~one or more specialists' report(s) information into the final assignment of IR. This reimbursement shall be allowed only once per examination.~~

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

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

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

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

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

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

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

(e)[~~(6)~~] The treating doctor is required to review the certification of MMI and assignment of IR performed by another doctor, as stated in the Labor Code and Chapter 130 of this title. The treating doctor must[~~shall~~] bill using CPT code 99455 with modifier

"VR" to indicate a review of the report only, and the insurance carrier must reimburse, NEW RATE[~~shall be reimbursed $50~~].

§134.260. Maximum Medical Improvement Evaluations and Impairment Rating Examinations by Referral 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) Referral doctors must only bill, and the insurance carrier must only reimburse, an MMI or IR examination if they are an authorized doctor in accordance with the Labor Code and Chapter 130 of this title.

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

(2) If the referral 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 referral doctor must bill, and the insurance carrier must reimburse, only the MMI evaluation portion of the examination in accordance with subsection (c)(1) of this section.

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

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

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

(2) MMI. MMI examinations will be reimbursed at NEW RATE.

(3) IR. For IR evaluations, the referral doctor must bill, and the insurance carrier must reimburse, 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 referral 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 NEW RATE; and

(II) the reimbursement for each additional musculoskeletal body area is NEW RATE.

(B) For non-musculoskeletal body areas, the referral 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 NEW RATE.

(C) The referral doctor must bill, and the insurance carrier must reimburse, for the appropriate CPT code or codes for the tests required for the assignment of IR, according to the applicable division fee guideline. Documentation is required.

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