RULES
TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE
DEVELOPMENT DIVISION OF WORKERS’ COMPENSATION

CHAPTER 0800-02-19
IN-PATIENT HOSPITAL FEE

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0800-02-19-.01 GENERAL RULES.

1. These In-patient Hospital Fee Schedule Rules shall become effective May 1, 2006 and are applicable to all in-patient services as defined herein. These include medical, surgical, rehabilitation, and/or psychiatric services rendered in a hospital to injured or ill workers claiming medical benefits pursuant to the Tennessee Workers’ Compensation Act. Maximum fees for outpatient hospital services are not addressed in these In-patient Hospital Fee Schedule Rules, but are addressed in Rule 0800-02-18-.07 of the Medical Fee Schedule Rules, Chapter 0800-02-18-.01 et seq. These In-patient Hospital Fee Schedule Rules are established pursuant to Tenn. Code Ann. § 50-6-204 (Repl. 2005). They must be used in conjunction with the Medical Cost Containment Program Rules for Medical Payments, Chapter 0800-02-17-.01 et seq., and the Medical Fee Schedule Rules, Chapter 0800-02-18-.01 et seq., as the definitions and provisions set forth in those rules are incorporated as if set forth fully herein. Providers rendering medically appropriate care outside of the state of Tennessee to an injured employee pursuant to the Tennessee Workers’ Compensation Act may be paid in accordance with the medical fee schedule, law, and rules governing in the jurisdiction where such medically appropriate care is provided.

2. General Information

(a) Reimbursements shall be determined for services rendered in accordance with these Fee Schedule Rules and shall be considered to be inclusive unless otherwise expressly noted in these Rules.

(b) The most recent current Medicare procedures and guidelines are hereby adopted and incorporated as part of these Rules as if fully set out herein and shall be effective upon adoption and implementation by the CMS. All such Medicare procedures and guidelines are applicable unless these Rules set forth a different procedure or guideline. Whenever there is no specific maximum fee or methodology for reimbursement set forth in these Rules for a service, diagnostic procedure, equipment, etc., then the maximum amount of reimbursement shall be 100% of the most recent current and effective CMS Medicare allowable amount and the most current effective Medicare guidelines and procedures shall be followed in arriving at the correct amount. Whenever there is no applicable Medicare code, the service, equipment, diagnostic procedure, etc. shall be reimbursed up to a maximum of the usual and customary amount, as defined in Rule 0800-02-17-.03(80) of the Medical Cost Containment Rules. All Medicare rules shall be applied that are effective on the date of service or the date of discharge in accordance with Medicare guidelines.

(c) Reimbursement for a compensable workers’ compensation claim shall be the lesser of the hospital’s usual and customary charges or the maximum amount allowed under this In-patient Hospital Fee Schedule.

(d) In-patient hospitals shall be grouped into the following separate peer groupings:
1. Peer Group 1 Hospitals
2. Peer Group 2 Rehabilitation Hospitals
3. Peer Group 3 Psychiatric Hospitals
4. Peer Group 4 Designated Level 1 Trauma Centers.

(e) For each inpatient claim submitted, the provider shall assign a Medicare Diagnosis Related Group ("MS-DRG") code which appropriately reflects the patient's primary cause of hospitalization.

This In-patient Hospital Fee Schedule shall become effective May 1, 2006, shall be reviewed annually, and may be updated annually.

Ongoing analysis will be conducted as to the projected savings of this schedule, as well as any impact on patient services.

(f) Prospective admission utilization review is required for non-emergent, non-urgent inpatient services, and emergency and urgent admissions require utilization review to begin within one (1) business day of the admission.


0800-02-19-.02 DEFINITIONS.

(1) "Administrator" means the chief administrative officer of the BureauDivision of Workers' Compensation of the Tennessee Department of Labor and Workforce Development or the Administrator's designee.

(2) "Allowed Charges" or "Allowable Charges" shall mean charges reviewed and approved under an appropriate audit and utilization review by the carrier as prescribed in the BureauDivision's Rules, or as determined by the Administrator or the Administrator's designee after consultation with the BureauDivision's Medical Director.

"Commissioner" means the Commissioner of the Tennessee Department of Labor and Workforce Development.

(3) "BureauDivision" means the Tennessee BureauDivision of Workers' Compensation of the Tennessee Department of Labor and Workforce Development.

(4) MS-DRG – Medicare classifications of diagnosis in which patients demonstrate similar resource consumption and length of stay patterns.

(4)(5) Hospital is as defined by Medicare.

(6) In-patient Services - Services rendered to a person who is formally admitted to a hospital and whose length of stay exceeds 23 hours as defined by Medicare.

(a) Is expected to include at least two midnights, or:

(b) The medical record supports the admitting physician's determination that the patient, requires inpatient care despite the lack of a two midnight length of stay, or:

(c) The procedure/treatment is included on the “in-patient only” list.
(5)(7) Institutional Services - All non-physician services rendered within the institution by an agent of
the institution.

(6)(8) Length of Stay ("LOS") - Number of days of admission where patient appears on midnight
census. Last day of stay shall count as an admission day if it is medically necessary for the
patient to remain in the hospital beyond 12:00 noon.

(9) Medical Admission - Any hospital admission where the primary services rendered are not
surgical, or in a psychiatric, or rehabilitation in nature, or in a specially designated
psychiatric or rehabilitation unit within an acute care hospital.

(7)(10) Stop-Loss Payment ("SLP") - An independent method of payment for an unusually costly
or lengthy stay.

(8)(11) Stop-Loss Reimbursement Factor ("SLRF") - A factor established by the Division to be used
as a multiplier to establish a reimbursement amount when total hospital charges have
exceeded specific stop-loss thresholds.

(9)(12) Stop-Loss Threshold ("SLT") - Threshold of total charges established by the Division, beyond
which reimbursement is calculated by multiplying the applicable Stop-Loss Reimbursement
Factor times the total charges identifying that particular threshold.

(10)(13) Surgical Admission - Any hospital admission where there is an operating room charge,
the patient has a surgical procedure or ICD-9 code, or the patient has an assigned surgical
MS-DRG as defined by the MedicareCMS.

(11)(14) Transfers Between Facilities - To move or remove a patient from one facility to another for
a purpose related to obtaining or continuing medical care. May or may not involve a change in
the admittance status of the patient, i.e. patient transported from one facility to another to
obtain specific care, diagnostic testing, or other medical services not available in facility in
which patient has been admitted. Includes costs related to transportation of patient to obtain
medical care.

(15) “Trauma Admission” - means any hospital admission in which the patient has a
diagnosis code of 800 to 959.99.

(a) Any level 1 trauma center hospital admission in which the patient has an ICD-9
diagnosis code of 800 to 959.99, or ICD-10 code that is (or includes) S00.00XA through
S99.99XX, T07, T14 to T32, T79 and the claim includes an ICU revenue code of 020x or
a CCU revenue code of 021x, or

(b) Any level 1 trauma center hospital admission for any diagnosis with a trauma response
revenue code of 068x and/or type of admission code, “5.”

Note: this includes all hospital days that qualify as an inpatient day as defined under inpatient services.

(12)(15)

(13)(16) “Usual and customary charge” means eighty percent (80%) of a specific provider’s average
charges to all payers for the same procedure.

(14)−(17) "Utilization Review" for workers’ compensation claims means evaluation of the necessity,
appropriateness, efficiency and quality of medical care services provided to an injured or
disabled employee based on medically accepted standards and an objective evaluation of
the medical care services provided; provided, that “utilization review” does not include the
establishment of approved payment levels or a review of medical charges or fees.

(18) Workers’ Compensation Standard Per Diem Amount ("SPDA") - A standardized per diem
amount established for the reimbursement of hospitals for services rendered.

0800-02-19-.03 SPECIAL GROUND RULES – INPATIENT HOSPITAL SERVICES.

(1) This section defines the reimbursement procedures and calculations for inpatient health care services by all hospitals. Hospital reimbursement is divided into four (42) groups based on type of admission (Peer Group 1: surgical or non-surgical (medical), Peer Group 2: rehabilitation, Peer Group 3: psychiatric, Peer Group 4: trauma) and length of stay (less than eight (8) days/over seven (7) days). Rehabilitation and Psychiatric hospitals are grouped separately.

(2) General Information

(a) For each inpatient claim submitted, the provider shall assign a Diagnosis Related Group (MS-DRG) code which appropriately reflects the patient’s primary cause for hospitalization to determine average length of stay and for tracking purposes. Hospitals within each peer group are subject to a maximum amount per inpatient day.

(b) The maximum per diem rates to be used in calculating the reimbursement rate is as follows:

1. Peer Group 1 (days; $1,800.2235.00 Surgical admission, Daily for the first seven (7) days; $1,500.1935.00 per day thereafter (surgical admission.) Includes Intensive Care (ICU) & Critical Care (CCU)

2. Peer Group 2 (Rehabilitation) $1,000.1090.00 fFor the first day and $900.890.00 per day thereafter

3. Peer Group 3 $700.790.00. Psychiatric Hospitals (applicable to chemical dependency as well.)

4. Peer Group 4 $3740 daily, see (c) below.

All trauma care at any licensed Level 1 Trauma Center only shall be reimbursed at a maximum rate of $3,000.00/$4,500.00 per day for each day of the patient’s admission as defined in 0800-02-18-.02 (16). $3,740.00 per day for each day of patient stay.

(c) Surgical implants shall be reimbursed separately and in addition to the per diem hospital charges.
1. Reimbursement for trauma inpatient hospital services shall be limited to the lesser of the maximum allowable as calculated by the appropriate per diem rate, or the hospital's billed charges minus any non-covered charges.

2. Non-covered charges are: convenience items, charges for services not related to the work injury/illness services—that were not certified by the payer or their representative as medically necessary.

3. Additional reimbursement may be made in addition to the per diem for implantables (i.e. rods, pins, plates and joint replacements, etc.). Maximum reimbursement for implantables for which charges are $100.00 or less per item shall be limited to eighty percent (80%) of billed charges. Maximum reimbursement for implantables for which charges are over $100.00 is limited to a maximum of the hospital's cost plus fifteen percent (15%) of the invoice amount, up to a maximum of invoice plus $1,000.00. This is applicable per item, and is not cumulative. Implantables shall be billed using the appropriate HCPCS codes, when available. Billing for implantables which have an invoice amount over $100.00 shall be accompanied by an invoice if requested by the payer.

4. The following items are not included in the per diem reimbursement to the facility and may be reimbursed separately. All of these items must be listed with the applicable CPT/HCPCS.
   (i) Durable Medical Equipment
   (ii) Orthotics and Prosthetics
   (iii) Implantables
   (iv) Ambulance Services
   (v) Take home medications and supplies
   (vi) Radiology Services
   (vii) Pathology Services
   (d) The items listed in subsection (d)(iv) shall be reimbursed according to the Medical Cost Containment Program Rules for Medical Payments (Chapter 0800-02-17) and Medical Fee Schedule Rules (Chapter 0800-02-18) payment limits. Refer to the maximum rates set forth in Rule 0800-02-18-02(4) for practitioner fees. Items not listed in the Rules shall be reimbursed at the usual and customary rate as defined in Rule 0800-02-17-03(80), unless otherwise indicated herein.
   (e) Per diem rates are all inclusive (with the exception of those items listed in subsection (d)(iv) above).
   (f) The In-patient Hospital Fee Schedule allows for independent reimbursement on a case-by-case basis if the particular care exceeds the Stop-Loss Threshold.
   (f)(g) Payments for implantables shall be made only to the facility and not to a supplier or distributor.

(3) Reimbursement Calculations
   (a) Explanation
      1. Each admission is assigned an appropriate MS-DRG.
2. The applicable Standard Per Diem Amount ("SPDA") is multiplied by the length of stay ("LOS") for that admission plus items paid under (c) (4) above.

3. The Workers’ Compensation Reimbursement Amount ("WCRA") is the total amount of reimbursement to be made for that particular admission.

(b) Formula: LOS X SPDA + (other items in (c) (4) above) = WCRA

(b) Example: DRG 222: Knee Procedures W/O CC

Hospital Peer Group: 1-Surgical admission:
Maximum rate per day: $1,800 first seven (7) days/$1,500 per day each day thereafter—
Number billed days: 9
Billed charges: $15,600

Maximum Allowable Payment: $15,600

(4) Stop-Loss Method

(a) Stop-loss is an independent reimbursement factor established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker.

(b) Explanation

1. To be eligible for stop loss payment, the total Allowed Charges for a hospital admission must exceed the hospital maximum payment, as determined by the hospital maximum payment rate per day, by at least $15,000 for Non-Trauma Admissions and $30,004.750 for Trauma Admissions. Amounts for items set forth in rule 0800-02-19-.03(d)(4.), such as implantables, radiology, pathology services, DME, etc., shall not be included in determining the total Allowed Charges for stop-loss calculations.

2. This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission.

3. Once the allowed charges reach the stop-loss threshold, reimbursement for all additional charges shall be made based on a stop-loss payment factor of 80%.

4. The additional charges are multiplied by the Stop-Loss Reimbursement Factor (SLRF) and added to the maximum allowable payment.

(c) Formula: (LOS) x (SPDA) + {Items listed under (d)} + (Additional Charges x SLRF) = WCRA Formula: (Additional Charges x SLRF) + Maximum Allowable Payment = WCRA

Example: DRG 222: Knee Procedures W/O CC

Hospital Peer Group: 1—Surgical admission
Maximum rate per day: $1,8002235 for first 7 days; $1,5001935 for 2 additional days. Number Billed Days: 9
Total Billed Charges: $120,000.00
(after subtracting amounts for implants, radiology, etc.): ................................................................. $53,65080,000.00

Maximum allowable per diem payment for Surgical Admission Normal DRG stay ................................................................. $15,60019,515.00

Total difference, charges over and above maximum payments:..........................
$38,0560,485.00 (if this amount is $20,750.00$15,000 or less, then stop-loss is not-applicable)

Difference over and above $15,000 $20,750.00 Stop-loss is ...........................................

$23,0539.735.00

Payable under Stop-loss (80% of $23,050,00039.735.00)...................................................

$18,440,00031.788.00

Amounts due hospital for implants, radiology, etc ......................................................

$10,000,0003,525.00

Maximum fee schedule amount: $15,600.00 $19,515.00 $31,788.00

3,525.00 $10,000 = $37,565,0061303.00

Proper reimbursement would be the lesser of billed charges, maximum fee schedule amount, or other contracted or negotiated rate

(20)(5) Billing for In-patient Admissions

(a) All bills for in-patient institutional services should be submitted on the standard billingUB-92 form or any revision to that form approved for use by the MedicareCMS.


0800-02-19-.04 PRE-ADMISSION UTILIZATION REVIEW.

Utilization review shall be performed when mandated by and in accordance with Chapter 0800-02-06.


0800-02-19-.05 OTHER SERVICES.

(1) Pharmacy Services

(a) Pharmaceutical services rendered as part of in-patient care are considered inclusive within the In-patient Fee Schedule and shall not be reimbursed separately.

(b) All retail pharmaceutical services rendered shall be reimbursed in accordance with the Pharmacy Schedule Guidelines, Rule 0800-02-18-.12.

(2) Professional Services

(a) All non-institutional professional and technical services will be reimbursed in accordance with the BureauDivision's Medical Cost Containment Program Rules for Medical Payments and Medical Fee Schedule Rules which must be used in conjunction with these Rules.

Authority: T.C.A. §§ 50-6-118, 50-6-125, 50-6-128, 50-6-204 and 50-6-205 (Repl. 2005).

0800-02-19-.06 PENALTIES FOR VIOLATIONS OF FEE SCHEDULES.

1. Providers shall not accept and employers or carriers shall not pay any amount for health care services provided for the treatment of a covered injury or illness or for any other services encompassed within the Medical Cost Containment Program Rules for Medical Payments, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules, when that amount exceeds the maximum allowable payment established by these Rules. Any provider accepting and any employer or carrier paying an amount in excess of the BureauDivision's Medical Cost Containment Program Rules for Medical Payments, Medical Fee Schedule Rules or the In-patient Hospital Fee Schedule Rules shall be in violation of these Rules and may, at the Administrator's discretion, be subject to civil penalties of fifty ($50) to five thousand ($5000) dollars up to ten thousand dollars ($10,000.00) per violation for each violation, which may be assessed severally against the provider accepting such fee and the carrier or employer paying the excessive fee, whenever a pattern or practice of such activity is found. Any provider reimbursed or employer or carrier paying an amount which is in excess of these Rules shall have a period of one hundred eighty (180) calendar days from the time of receipt/payment of such excessive payment in which to refund/recover the overpayment amount. Overpayments refunded/recovered within this time period shall not constitute a violation under these Rules. At the discretion of the Administrator, the Administrator's Designee, or an agency member appointed by the Administrator, such provider may also be reported to the appropriate certifying board and may be subject to exclusion from participating in providing care under the Act. Any other violation of the Medical Cost Containment Program Rules for Medical Payments, Medical Fee Schedule Rules, or the In-patient Hospital Fee Schedule Rules shall subject the alleged violator(s) to a civil penalty of not less than one hundred dollars ($100.00) nor more than one thousand dollars ($1,000.00) per violation, at the discretion of the Administrator, Administrator's Designee, or an agency member appointed by the Administrator.

2. Any provider reimbursed or carrier paying an amount which is in excess of these Rules shall have a period of one hundred eighty (180) calendar days from the time of receipt/payment of such excessive payment in which to refund/recover the overpayment amount. Overpayments refunded/recovered within this time period shall not constitute a violation under these Rules.

3. A provider, employer or carrier found to be in violation of these Rules, whether a civil penalty is assessed or not, may request a contested case hearing by requesting such hearing in writing within fifteen (15) calendar days of issuance of a Notice of Violation and, if applicable, the notice of assessment of civil penalties. All rights, duties, obligations, and procedures applicable under the Uniform Administrative Procedures Act, Tenn. Code Ann. § 4-5-101 et seq., are applicable under these Rules, including, but not limited to, the right to judicial review of any final departmental decision.

4. The request for a hearing shall be made to the Division in writing by an employer, carrier or provider which has been notified of its violation of these Rules, and if applicable, assessed a civil penalty.

5. Any request for a hearing shall be filed with the Division within fifteen (15) calendar days of the date of issuance of the Notice of Violation and, if applicable, of civil penalty. Failure to file a request for a hearing within fifteen (15) calendar days of the date of issuance of a Notice of Violation shall result in the decision of the Administrator, Administrator's Designee, or an agency member appointed by the Administrator becoming a final order and not subject to further review.

6. The Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner shall have the authority to hear the matter as a contested case and determine
if any civil penalty assessed should have been assessed. All procedural aspects set forth in
the Division's Penalty Program Rules, Chapter 0800-02-13, shall apply and be followed in any
such contested case hearing.

(7) Upon receipt of a timely filed request for a hearing, the Commissioner shall issue a Notice of
Hearing to all interested parties.

Authority: T.C.A. §§ 50-6-102, 50-6-125, 50-6-128, 50-6-204, 50-6-205, 50-6-233 (Repl. 2005), and
effective through November 27, 2005. Public necessity rule filed November 16, 2005; effective through
April 30, 2006. Original rule filed February 3, 2006; effective April 19, 2006. Amendment filed June 12,