TMA Executive Summary of the
Proposed Workers' Compensation Medical Fee Schedule Rules

This summary provides TMA members with an overview of the major changes proposed in the Bureau's rulemaking notice. It is organized section by section for reference. The proposed rules can be accessed via these links:

Chapter 17: https://publications.tnsosfiles.com/rules_filings/09-06-22.pdf
Chapter 18: https://publications.tnsosfiles.com/rules_filings/09-07-22.pdf

Chapter 17 – Rules for Medical Payments

0800-02-17-.01

- The proposed rules revise the medical fee schedule. There is a fee schedule setting forth maximum rates just as there is now in current rules in Rule 0800-02-18-.02(3)(c). The proposed rules add that codes that are not valued by CMS are gap-filled using FAIR Health data. Whenever there is no specific fee or methodology for reimbursement set forth in the rules and rate tables, then the maximum amount of reimbursement shall be at 100% of the Medicare allowable amount in effect.
- RBRVS changes from that effective on the date of service to that in effect on the date of publication of the fee schedule.

0800-02-17-.03

- Adds a definition of "gap filled codes".
- Adds a definition of "implantables" or "surgical implants".
- Makes changes to the definition of "medicare conversion factor". Under the current definition, "medicare conversion factor" is the amount in dollars assigned to an RVU that may be modified by Medicare that is in effect on the date of service. The proposed new definition is "the amount in dollars that Medicare multiplies by the relative values units (RVUs) assigned to the procedure code to determine the fee. The RVUs are first multiplied by the Geographic Practice Cost Indices ("GPCI") for Tennessee. Conversion factors are modified on a regular basis."
- Adds a definition of "rate table" which is the established fees for services provided by the Bureau and updated in accordance with the Rules.

0800-02-17-.05

- Medically Unlikely Edits are recognized.
- Adopts the Medicare procedures and guidelines in effect on the date of service.
- Whenever there is no specific fee or methodology for reimbursement set forth in the rules and rate tables, then the maximum amount of reimbursement shall be at 100% of the Medicare allowable amount in effect.
- Whenever there is no Medicare allowable amount, the service is reimbursed at the usual and customary amount as defined in Rule 0800-02-17-.03.
- The maximum reimbursement for services provided via telehealth is the lesser of billed charges or the amounts listed in this fee schedule. Services that are eligible to be provided via

telehealth are identified with a star (★) in the rate tables.

0800-02-17-.07

- Establishes Tennessee specific modifier codes which may be added to procedure codes.
- Repeals the rule that states when Modifier 21, 22, or 25 is used, and requires that a report explaining the medical necessity of the situation must be submitted to the employer when those codes are used.

0800-02-17-.09

- Revamps how to bill for an independent medical exam. It requires the use of state-specific codes and shall include the practitioner's time only. Time spent shall include the office visit (face-to-face time with the patient), time spent reviewing records, reports and studies, and time spent preparing reports. State-specific code Z0610 shall be used to bill the first hour (shall not exceed $500). State-specific code Z0611 shall be used to bill each additional half hour (shall not exceed $250 per half hour) State-specific code Z0310-Impairment Rating (Form Completion) shall not be billed for IME services or in combination with codes Z0610 and Z0611, see 0800-02-17-.25.
- Deletes the rule on payment to physicians who perform consultant services and/or records review in order to determine whether to accept a new patient. Instead of reimbursement at $200 for the first hour and $100 each hour thereafter, under the proposed rules, the physician cannot bill for such review.

0800-02-17-.10

- Deletes the current rule regarding the edition of Medicare RBRVS. Whenever a guideline or procedure is not set forth in the rules, the Medicare guidelines and procedures in effect on the date of service shall be followed.
- Deletes the use of modifier 21 for extraordinary services; modifier 22 must be used.

0800-02-17-.14

- Caps payment for a missed appointment at $200 and dictates to use code Z0110 for new patients and $100 with Z0111 for an established patient. This replaces the current rule which allows billing a 99199 and sets reimbursement at the maximum allowable fee schedule.

0800-02-17-.15

- Changes the code for payment for copies of narrative medical reports required by 0800-02-17-.15(1) and (2). Currently, providers bill using 99080; the new rules require using Z0710.
- Changes the code from 99358 and 99359 to Z0210 and Z0211 in the situation where after an initial opinion on causation has been issued by the physician, a request for a subsequent review is made based upon new information not available to the physician initially.
- Changes the code from 99354-52 and 99354 to Z0410 and Z0411 for extra time spent in explanation or discussion with an injured worker or the case manager (that is separate from the discussion with the injured worker) It may be charged on the same day as an office visit charge provided the extra time is equal to or greater than fifteen minutes.

- Changes the code from 99408 to Z0510 for if a provider assesses, counsels or provides behavioral intervention to a Workers' Compensation patient for substance and/or alcohol use, or for substance and/or alcohol use disorder.

0800-02-17-.24

- Establishes code Z0710 to use for billing by health care providers and facilities are entitled to recover an amount in accordance with Tenn. Code Ann. § 50-6-204 to cover the cost of copying documents requested by the employer, employee, attorneys, etc.
- Establishes code Z0710 to use for billing for copying X-rays, microfilm or other non- paper records.

0800-02-17-.25

- Changes the coding for providing the impairment rating, fully completing the report on a form prescribed by the Administrator, and submitting the report to the employer, as required by these Rules from 99455 to Z0310 and adds that the analysis shall include documentation of the section, page, or table as applicable as well as a description of the reasoning and methodology based upon the medical records. The fee is payable even if the analysis results in a Zero impairment rating. The physician may bill for an office visit, in addition to Z0310, using the appropriate CPT code for services provided on the same day.

Chapter 18

0800-02-18-.01

- Establishes CMS base units are used for anesthesia services in the medical fee schedule.
- Establishes that services that are not valued by Medicare are gap filled, when possible, based on FAIR Health data.
- Deletes rule that fees shall be calculated using the edition of the CPT® and RBRVS effective on the date of service, including rules concerning “families” of procedures, add-on codes, status indicators, and multiple procedure discounts in all places of service, except where exceptions are specified in these rules. Adopts the fee schedule rate tables after applying any applicable modifiers, methodologies of exceptions set out in the rules.
- Provides for annual updating of fees every April 1st.

0800-02-18-.02

- Changes reimbursement calculation for medical fees. Deletes the calculation based on the Medical Fee Schedule Rules (includes 100% of Medicare if no other specific fee or methodology is set forth in these Rules).
- Deletes penalty rule for receiving payment in excess of fee schedule.
- Re-writes fee schedule calculation rule to specify that maximum reimbursement amount for professional services is listed in the accompanying rate tables by CPT® category (i.e., evaluation and management, anesthesia, surgery). If the fee for a current service or procedure is not listed in the rate tables or included in the Rules, the maximum allowable reimbursement amount is

100% of the Tennessee-specific Medicare allowable amount calculated in accordance with Medicare guidelines and methodology effective on the date of service, except where a waiver has been granted by the Bureau.

- FAIR Health data will be used for codes not valued by CMS.
- Provides for additional payment to certain board-certified specialties. Board certified orthopedic and neurosurgeons receive 275%. See proposed rule 0800-02-18-.02(4).
- Deletes rule basing medical fees based on the Medicare's Physician Fee Schedule Conversion Factor in effect on the date of service, which shall be used in conjunction with the effective Medicare RVUs on the date of service, as adjusted.
- Reduces pathology fees from 200% to 180%.
- Sets emergency care at 200% (CPT 99281-99292).
- Board certified or board eligible Orthopedists and Neurosurgeons may use the modifier "ON" on the appropriate billing form for reimbursement up to 137.5% of the fees listed in the rate tables (275% of CMS) on surgical codes only. (CPT 10004-69999). Physicians board certified or board eligible in the following specialties and by the following organizations may use the modifier "OP" on the appropriate billing form for reimbursement up to 112.5% of the fees listed in the rate tables (180% of CMS) on Evaluation & Management and General Medicine codes only: American Board of Preventive Medicine, Specialty of Occupational Medicine; American Board of Physical Medicine and Rehabilitation (ABPMR); Pulmonologists board certified in pulmonary disease by the American Board of Internal Medicine (ABIM); Psychiatrists board certified by the American Board of Psychiatry and Neurology (ABPN); Neurologists board certified by the American Board of Psychiatry and Neurology (ABPN); Cardiologists board certified in cardiovascular disease by the American Board of Internal Medicine (ABIM).
- Non-Physician Practitioners properly licensed or certified to perform services shall be reimbursed at 85% of the fees listed in the rate tables except when providing anesthesia during surgery.
- Disallows "incident to" billing by PAs or APRNs.
- Modifiers 22 and 25 - When Modifier 22 or 25 is used, a report explaining the medical necessity of the situation shall be submitted to the employer. It is not appropriate to use Modifier 22 or 25 for routine billing. The maximum allowable additional amount under these Rules for Modifier 22 is 50%, not to exceed billed charges of the primary procedure.

0800-02-18-.03

- Changes coding for urine drug screens.

0800-02-18-.04

- APRNs and PAs as surgical assistants. Payment not to exceed 85% of the maximum allowable reimbursement listed on the rate table for an assistant surgeon billed with modifier 80.
- Second surgeons. Reimbursement to each surgeon shall be the lesser of billed charges or 62.5% of the maximum allowable reimbursement listed in the rate tables.

0800-02-18-.05

- CRNA reimbursement shall be 100% of the maximum allowable fee based on Time Values and the Base Units included in the fee schedule rate tables.
- Allows for an additional time unit to be billed when an additional 1 – 15 minutes of anesthesia time has elapsed.

·02-18-.07

Ambulatory Payment Classification groups and maximum allowable reimbursement amounts for facility services performed in an outpatient hospital or ASC setting are included in the rate tables on the same line as the professional fees. Deletes rule for payment of 150% of most current Medicare APC rates.

- The maximum allowable facility reimbursement is the usual & customary amount, which is 80% of the billed charges, as defined in the Bureau's Rulesfor Medical Payments.

0800-02-18-.09

- Changes OT and Speech payment to time-based schedule and defines how it should be coded.

0800-02-18-.10

- Changes DME reimbursement. Includes DME reimbursement in rate tables.
- If no amount is listed in the rate tables and the billed charge is $100.00 orless, reimbursement shall be 80% of billed charges.
- If no amount is listed in the rate tables, and the billed charge is greater than $100.00, reimbursement shall be the original supplier's or manufacturer's invoice amount, plus the lesser of 15% of invoice or $1,000.00, and coded using the HCPCS codes. These calculations are per item and are not cumulative.
- Rule now applies to home DMEs, infusion and oxygen services.

0800-02-18-.11

- Changes orthotics and prosthetics reimbursement. Includes reimbursement in rate tables and sets out how to code them.

0800-02-18-.14

- Sets psychological service payment for anyone but a licensed psychiatrist at 85% of fees in rate table. This is down from 130%.
- Psychiatrists reimbursed per the rate tables.