WORKERS' COMPENSATION FEE SCHEDULE

RULE 40.000

INTERPRETATIVE MEMORANDUM

TO: All interested parties

FROM: Mary S. Hooper, Commissioner

DATE: May 10, 1996

SUBJECT: Interpretative Memorandum Number 3: Rule 40.000

This memorandum is issued, per 3 V.S.A. ? 831 (b), to describe appropriate practices in the application of Rule 40.000, Workers' Compensation Fee Schedule. Additional questions that relate to the fee schedule should be directed to Julie Heath of the Workers' Compensation Division at 828-2991.

Q: What Current Procedure Terminology (CPT) codes, descriptive terms, guidelines, and maximum allowable payments should be used for reimbursement and claims processing if CPT 96 contains new codes, updated codes or deletes codes?

A: It is the intent of Rule 40.000 to conform to the most recent CPT manual for reimbursement policy, per section 40.012 (B) and section 40.021 (G). The descriptive terms, guidelines, new codes, updated codes and deletes codes in CPT 96 should be followed for care provided on or after May 15, 1996.

The Department of Labor and Industry has developed Addendum B (attached) to Appendix I of Rule 40.000, that should be used to determine the maximum allowable payments for new or updated CPT codes contained in CPT 96, effective May 15, 1996.

Q: Are health care providers required to use 1996 CPT or HCPCS level II and III procedure codes and ICD-9-CM diagnosis codes when billing for care provided on or after May 15, 1996?

A: Per section 40.021 (G), health care providers are required to submit bills on form HCFA 1500, form HCFA 1450 (UB-92), or the ADA claim form. For care provided on or after May 15, 1996, health care providers shall use the appropriate 1996 CPT or HCPCS level II and III procedure codes and ICD-9-CM diagnosis codes in filling out these forms.

Q: What is the appropriate reimbursement policy for CPT codes 90801 through 90889 when used for billing purposes by M.D. level Psychiatrists, Clinical Psychologists, and Clinical Social Workers under Rule 40.000?

A: CTP codes 90801 through 90889 may be used for psychotherapy by M.D. level Psychiatrists, Clinical Psychologists and Clinical Social Workers, with the exception of codes 90820, 90862, 90870, and 90871, which may be billed by M.D. level Psychiatrists only.

The reimbursement policy for each of these categories of health care providers is as follows:

- M.D. level Psychiatrists shall receive the maximum fee for a procedure, listed in Appendix I of Rule 40.000, or the health care provider's charge, whichever is less;
- Clinical Psychologists shall receive 80 percent of the maximum fee for a procedure, listed in Appendix I of Rule 40.000, or the health care provider's charge, whichever is less;
- Clinical Social Workers shall receive 60 percent of the maximum fee for a procedure, listed in Appendix I of Rule 40.000, or the health care provider's charge, whichever is less.

The level of licensure of the treating health care provider shall indicated on the billing form.

Q: Is code A2000, which is to be used by Chiropractic physicians for all manipulations of the spine, to be included when calculating the declining reimbursement percentages for physical medicine and rehabilitation codes under section 40.100?

A: Section 40.100 provides for declining percentages of the maximum allowable payment, for CPT codes 97010 through 97750, when multiple health care procedures or modalities that fall within this range are provided to the same patent on the same day. Further, it is the department's intent, when the procedure is based on time units, that multiple time units of the same procedure be counted as a single procedure for the purposes of Section 40.100. Code A2000 should not be included in the calculation of declining percentages for CPT codes 97010 through 97750 (note: the use of A2000 precludes the billing of any other manipulation procedure code for care provided to a patient on the same day).