WORKERS' COMPENSATION FEE SCHEDULE

RULE 40.000

INTERPRETATIVE MEMORANDUM

TO: All interested parties

FROM: Mary S. Hooper, Commissioner

DATE: July 28, 1995

SUBJECT: Interpretative Memorandum Number 1: Rule 40.000

This memorandum is issued to provide uniformity and clarification relating to a number of issues in the application of Rule 40.000, Workers' Compensation Fee Schedule, effective April 1, 1995. Additional questions that relate to the fee schedule should be directed to Julie Heath of the workers' compensation division at 828-2991.

Q: Some CPT codes appear more than once in Appendix I, with different maximum allowable payments shown and no modifier is indicated. Which one of the codes is intended for the global payment of the procedure, which one is intended for the reimbursement of professional services, with modifier -26, and which code is intended for the reimbursement of technical services, with modifier -27 or -TC?

A: For those CPT codes that appear more than once in Appendix I, and no modifier is shown, the first amount is intended for the global payment of the procedure, the second amount is intended for the reimbursement of professional services, with modifier -26, and the last amount, when there are three listed, is intended for the reimbursement of technical services, with modifier -27 or -TC.

Q: What is the global surgical reimbursement policy for codes 10000-69999 in Appendix I of the fee schedule?

A: For all surgical procedure codes in Appendix I, with **30** follow-up days indicated in the right column under FUD, any medically necessary care may be allowed during the 30-day period following the procedure.

Surgical procedure codes in Appendix I that are followed by the letter **S or I**, allow for reimbursement for a medical service by the surgeon on the same day as the procedure. The letter S indicates that any visit (new patient or established patient) may be allowed. The letter I indicates that only a new patient visit is reimbursable in addition to the procedure.

For those surgical procedure codes, in Appendix I, **that do not have a 30, S or I** in the right-hand column under FUD, all professional routine pre-operative care and post-operative care, for 30 days following the surgical procedure, are included as a part of the global fee for that surgery, and medical follow-up visits for the same or a related condition within 30 days of the procedure should be denied.

Q: Is reimbursement that is less than the maximum allowable payment provided for in the fee schedule allowed?

A: Reimbursement for an amount less than the maximum allowable payment in Rule 40.000 is allowed, but only in those instances where there is a contract that provides for a lower amount, between the employer or insurer and the health care provider.

Q: What option is available to an employee when a health care provider refuses to provide a deposition based on the maximum allowable payment set forth in Section 40.111?

A: Section 40.080, Good Cause Exception, allows the Commissioner to authorize reimbursement at a rate higher than permitted in the fee schedule if an employee demonstrates to the satisfaction of the Commissioner that the service is not reasonably available at a rate consistent with the fee schedule.

Q: What are the guidelines for hospital reimbursement?

A: The maximum allowable payments for professional services, that are appropriately billed by hospitals on the HCFA 1500 form, shall not exceed the amount found in Appendix I of the fee schedule. Hospital reimbursement for medically necessary procedures, articles and supplies, that are appropriately billed on the HCFA 1450 (UB-92) form, shall not exceed 90 percent of the charge. Hospitals and all other health care providers are required to bill for professional services on the HCFA 1500 form.

Physical medicine and rehabilitation services, identified by procedure codes 97010 through 97750, that are provided in a hospital setting, are considered to be technical services and are appropriately billed on the HCFA 1450 (UB-92) form. Reimbursement for these technical services, provided in a hospital setting, shall not exceed 90 percent of the charge.

Q: Are physical medicine procedures that are reimbursed based on time units, subject to the provisions of Section 40.100 relating to fee adjustments for physician medicine and rehabilitation modalities?

A: Physical medicine procedures that are reimbursed based on time units, are not subject to the provisions of Section 40.100, unless the physical medicine procedures are combined with physical medicine and rehabilitation modalities for health care services provided to the same patient on the same day. In the event that physical medicine procedures are combined with physical medicine and rehabilitation modalities for health care services provided to the same patient on the same day, the fee adjustment provisions of Section 40.100 would apply.