

# MEDICAL FEE SCHEDULE

Rule 40 establishes a medical fee schedule that sets the maximum allowable payments to health care providers for workers' compensation medical services. A "health care provider" as defined in [18 VSA § 9432\(11\)](#) "means a person, partnership, corporation, facility or institution, licensed or certified or authorized by law to provide professional health care service in this state to an individual during that individual's medical care, treatment or confinement."

The fee schedule reimburses approximately 9,000 medical procedures by amounts that are comparable to private insurance reimbursement. In addition, it sets reimbursement for hospital revenue codes at 83 percent of the charge and establishes prescription drug payments. Rule 40 requires insurers to pay allowed bills within 30 days of receipt when submitted with appropriate documentation. It also provides for an annual review of the fee schedule and prohibits billing of fees to an injured worker. The licensed adjuster is responsible for the proper handling and processing of medical bills in accordance with Vermont statute and rules, even if the insurer is using a medical bill review company for bill processing.

The changes that have been brought about by Rule 40 and the goals that have been achieved are:

1. Prior to September 1, 1993 the insurer was responsible for the full payment of the medical provider's fees.
2. From September 1, 1993 to February 6, 1994 the insurer was responsible for the usual and customary reimbursement for the same or similar services in Vermont.
3. Prior to February 7, 1994 fees for health care services to injured workers were limited by rule according to the maximum charge allowed by Blue Cross/Blue Shield of Vermont.
4. On February 7, 1994 the Department adopted Rule 12(b), an RBRVS fee schedule for workers' compensation with a

conversion factor of \$38.00 for medical procedures and \$48.00 for surgical procedures. The fee schedule was designed to reimburse health care providers at approximately the same rate as Blue Cross/Blue Shield's Community Fee Schedule.

5. Under the current Rule 40, medical procedures are reimbursed based upon the amounts shown in Appendix I. The amounts were established by a melded rate of private insurance reimbursements to establish a single combined fee schedule.

Rule 40.024 sets a prescription drug reimbursement level at the average wholesale price plus a \$3.15 dispensing fee. This rule also deals with intravenous drugs and infusion therapy. For certain of these services preauthorization by the insurer is required. The insurer may be required to establish a pharmacy account for injured workers with certain chronic conditions. See [21 VSA §640\(d\)](#) and Rule 26.0000.

An insurer shall, within 30 days of receipt of a bill for medical services, together with the supporting documentation, make payment to the provider pursuant to Rule 40.021(C). Reimbursement must be made in accordance with the fee schedule in effect at the time of service. If the bill is held with documentation past the 30 days, the insurer shall provide a status report to the medical provider. Under no circumstances shall an injured worker whose claim has been accepted as compensable pay for medical services provided. There is no balance billing allowed pursuant to Rule 40.021(B).

A provider may not charge for narrative reports pursuant to Rule 40.021(E) and **must** provide documentation that is sufficiently detailed to allow for review of the medical necessity of the service and the appropriateness of the fee charged. If a specific report is requested in addition to the documentation required under Rule 40.021(E), the provider is limited to \$10 per page with the total not to exceed \$70. If a physician provides an office note that includes an impairment rating but does not specify how the physician arrived at the percentage of impairment, the adjuster should request a detailed explanation of how the physician arrived at the rating using the 5<sup>th</sup> edition of the A.M.A. Guides.

The insurer must provide an “Explanation of Benefits” to the provider within 30 days if the service is denied or the payment is reduced. A procedure code may not be changed by the insurer without the agreement of the provider. Disputes may be adjudicated by the Department.

For a complete description of services for codes listed, refer to the A.M.A. CPT Manual in effect at the time of service. **NOTE: The A.M.A. updates the manual on January 1 of each year. Updates, if any, of the Workers’ Compensation Fee Schedule do not take effect until April 1 of each year when it is determined appropriate.** The A.M.A. CPT Manual can be purchased from the A.M.A. by calling 1-800-621-8335. (The fee schedule is not available on disk as the CPT Codes are copyrighted information belonging to the American Medical Association.)

Clarification of some of the most commonly asked questions:

1. Providers **must** use the HCFA 1500 form and/or UB-92 form or the ADA (dental) form for billing and must identify the service provided by using the proper CPT or revenue codes. These forms can be purchased from the AMA by calling 1-800-621-8335.
2. For those procedures not listed in Appendix 1 of Rule 40, reimbursement shall not exceed 83 percent of a provider’s charge or if there is a long-term contract with the provider (PPO), the lesser amount.
3. Rule 40.090 is applicable to codes 97010 through 97039 only.
4. The fee schedule is based upon 15-minute units for codes allowing time units. For example, 30 minutes of treatment for code 97032 = 2 units. Utilizing the fee schedule amount of \$22.18 and multiplying by two, the base reimbursable amount is \$44.36. Further reduction in accordance with Rule 40.100 shall apply, if appropriate. Rule 40.100 states that maximum fees for physical medicine and rehabilitation **modalities** are determined according to the following schedule when one or more modalities are provided to the same patient on the same

day: 100 percent of the fee for the most expensive modality, 75 percent of the fee for the second most expensive, 50 percent of the fee for the third most expensive and 10 percent of the fee for all other modalities.

5. If there is no code for ambulatory services, payment shall be 83 percent of the provider's charge.
6. If a medical service is specifically addressed by a written rule within the fee schedule, the reimbursement shall be paid in accordance with that rule. An example would be reimbursement for surgical procedures. See Rule 40.060.
7. Dental services are to be reimbursed at 83 percent of the provider's charge. The dental codes are not listed in Appendix 1 of Rule 40.
8. To determine prescription drug reimbursement in accordance with Rule 40.024, refer to the "Redbook" manual or its equivalent to determine the Average Wholesale Price. The amount of reimbursement is the lower of the prescription charged or the average wholesale price plus a \$3.15 dispensing fee.
9. To determine the correct anesthesia conversion rate in accordance with Appendix 1 of Rule 40, refer to Pages 1-5. The following example is used to determine the correct reimbursable amount:

Code billed:	00100
Time billed:	30 minutes
RVU's listed for Code 00100:	5.00

To determine the compensable amount, the time billed needs to be broken down to 15 minute units (30 minutes = 2 units), add the number of RVU's to the number of units ( $5.00 + 2 = 7$ ), multiply the total units by the conversion factor outlined at the

top of the chart in Rule 40.040 (7 x \$34.25) to get the reimbursable amount of \$239.75.

10. The medical fee schedule does not apply to vocational rehabilitation services. The vocational rehabilitation fee schedule can be found in Rule 58.0000.