

SUBCHAPTER A. Medical Reimbursement Policies
28 TAC §134.1 and §134.2

SUBCHAPTER C. Medical Fee Guidelines
28 TAC §134.203 and §134.204

1. INTRODUCTION. The Commissioner of Workers' Compensation (Commissioner), Texas Department of Insurance (Department), Division of Workers' Compensation (Division), adopts amended §134.1 and new §§134.2, 134.203, and 134.204 concerning the Medical Fee Guideline (MFG) with changes to the proposed text published in the October 5, 2007 issue of the *Texas Register* (32 TexReg 6966) and error corrections published in the October 12, 2007 issue of the *Texas Register* (32 TexReg 7329).

In accordance with Government Code §2001.033, the preamble contains a summary of the factual basis of the rules, a summary of comments received from interested parties, names of those groups and associations who commented and whether they were in support of or in opposition to adoption of the rules, and the reasons why the Division made changes based on the comments or disagreed with the comments and proposals.

2. REASONED JUSTIFICATION.

BACKGROUND INFORMATION

The Texas workers' compensation law was enacted in 1913, and revised in 1917 to include state regulation of medical fees. In July 1987, the Legislature

created the Joint Select Committee on Workers' Compensation Insurance. The Committee Report issued in December 1988, concluded that workers' compensation medical costs were high in relation to those in other states and that they had increased faster than medical costs outside the system and faster than indemnity costs. In other words, the Committee Report concluded that workers' compensation had been subsidizing the provision of non-workers' compensation medical care.

The overhaul of the workers' compensation law with the enactment of the "new law" in 1989 resulted in the addition of a statutory mandate that the medical fee guidelines enacted by the Industrial Accident Board (IAB) (the precursor of the Texas Workers' Compensation Commission (Commission)) be designed to also achieve effective medical cost control. This was the first time that Texas workers' compensation law specifically mandated that a state agency work to control medical costs within the workers' compensation system, and sent a strong message that the steps taken by the Commission in this area must differ markedly from those of the IAB in the past.

As noted by the Texas Supreme Court in *Texas Workers' Compensation Comm'n v. Garcia*, 893 S.W.2d 504, 512 (Tex. 1994), "In 1989, the Legislature enacted a new Workers' Compensation Act (hereinafter the "Act") restructuring the workers' compensation law in Texas. The new Act replaced the old system that had become increasingly expensive and was suffering from a loss of public

confidence. Medical costs for injured workers within the workers' compensation system began increasing at a much higher rate than similar costs outside the system. These increases, in part, caused workers' compensation insurance premiums to more than double between 1984 and 1988."

In response to these mounting costs, the Legislature gave the newly created Commission sweeping new powers. One of these powers was in the area of medical costs and reimbursement. See Labor Code §413.011. Pursuant to that section, the Legislature directed the Commission to set new guidelines for reimbursements to healthcare providers treating injured workers. Labor Code §413.011(a)(1). In so doing, the Legislature assigned the Commission the daunting task of designing a guideline that provides fair and reasonable reimbursements, ensures the quality of medical care, and simultaneously achieves effective medical cost control. Labor Code §413.011(b).

An extensive research program and review of the relevant literature and §134.200 (concerning Medical Fee Guideline) (1991 MFG) was undertaken by the Commission to assist in evaluating the strengths and deficiencies of the 1991 MFG, prior to the development of §134.201 (concerning Medical Fee Guideline for Medical Treatment and Services Provided Under the Texas Workers' Compensation Act) (1996 MFG).

The objectives for the 1996 MFG were to move Texas MFG reimbursements toward a median position in comparison with other states, away

from a charge-based reimbursement structure, and more toward a market-based system. Consequently, to accomplish these objectives, and because no reference point or benchmarking against market based charges was done during the development of the 1991 MFG, in developing the 1996 MFG, the Commission determined that it was appropriate to obtain data from outside sources to use in evaluating what changes in reimbursements were necessary. The Commission also elected to switch from the California Relative Value System, to the more widely used and recognized McGraw-Hill Relative Values for Physicians. Commercial market data was supplied from an outside source and included conversion factors based on charges for every 10th percentile starting at the 20th percentile and ending at the 90th percentile. This revealed that the lack of benchmarking in 1991 resulted in some medical services groups being reimbursed around the 10th percentile when compared to the commercial market data, while other groups were reimbursed above the 90th percentile. In addition, some of the individual codes within each group were reimbursed far above or far below the median of the data. As noted in Congressional Budget Office testimony: a charge-based reimbursement system gives physicians the incentive to increase their charges from year to year to boost their revenues; this leads to spiraling expenditures. (Statement of Dan L. Crippen, Director, Congressional Budget Office, Testimony Before the Subcommittee on Health of the House

Committee on Ways and Means, Hearing on Physician Payments, February 28, 2002.)

The conversion factors for the 1996 MFG were derived by dividing the sum of all charges for each American Medical Association (AMA) Current Procedural Terminology (CPT) category group by the sum of the relative value units for each charge in the same group. At this point in developing the 1996 MFG the Commission was concerned that a full shift away from the 1991 MFG could destabilize the system. Therefore, the goal of establishing a 1996 MFG that produced the same level of total expenditures as the 1991 MFG was identified as an alternative to a fully market based system. Thus, the move to a fully market based system was restricted by Commission goals to maintain the same level of expenditure overall, and as much as possible in each individual service category. Adjustment restrictions per procedure were also established to avoid extreme changes. Conversion factors for service categories ranged from the 20th to the 60th percentiles. In essence, this methodology retained the reimbursement relationships established in the 1991 MFG so that the 1996 MFG still did not reflect median or average commercial reimbursements.

In developing the 1996 MFG, the Commission's expenditure goals included keeping reimbursements for medical services in Texas relatively stable so that over time the effects of inflation and changes in other states' medical fee guidelines would help move Texas towards a median position. The 1996 MFG

was thus a transitional step to the Commission's stated intent to review and revise the MFG on a regular basis in developing a market-based system. These assumptions were not fully realized because medical inflation during the late 1990's was much less intense than in the previous decade, there was significant realignment in reimbursement structures in both the commercial and Medicare systems, and other states' compensation systems began to adjust their fee schedules accordingly.

These factors, in addition to the transitional implementation of the McGraw-Hill relative value system and the overall restriction in total system reimbursement, would result in a significant realignment and significant reduction of reimbursements for some services in the 2002 MFG.

After the adoption of the 1996 MFG, several research reports showed that Texas workers' compensation medical costs continued to exceed those in other states and other health care delivery systems.

* Policy year 1995 data show that the average medical cost per claim in Texas exceeded the national average by almost 80 percent. (Texas Research and Oversight Council (ROC) on Workers' Compensation and Med-FX, LLC., *Striking the Balance: An Analysis of the Cost and Quality of Medical Care in the Texas Workers' Compensation System*, A Report to the 77th Texas Legislature, January 2001, citing National Council on Compensation Insurance (NCCI), *Annual Statistical Bulletin*, 1999.)

* The average medical payment (paid and incurred) per claim with more than seven days' lost-time in Texas was the highest of the eight states analyzed (California, Connecticut, Florida, Georgia, Massachusetts, Minnesota, Pennsylvania, and Texas). Together these states account for at least 40 percent of the nation's workers' compensation benefits. (Workers' Compensation Research Institute (WCRI), Benchmarking the Performance of Workers' Compensation Systems: CompScope Multistate Comparisons, July 2000.)

* When similar types of injuries were compared in the group health and workers' compensation systems, Texas had higher than average medical costs for the top five types of injuries. (ROC, January 2001.)

* When compared with group health (a State of Texas employee Preferred Provider Organization (PPO) group health plan), average workers' compensation medical costs for State of Texas injured employees were approximately six times higher per worker (\$578 per worker in this group health system compared to \$3,463 per worker in the Texas workers' compensation system, 18 months post-injury). (ROC, January 2001.)

* In general, the amount of medical treatment (often called treatment utilization) and the length of medical treatment (often called treatment duration) provided to Texas injured workers accounted for the majority of these cost differences between other state workers' compensation systems and other health care delivery systems. Additional differences between Texas workers'

compensation and Texas group health systems also widened the cost gap. These differences included the lower cost of many individual medical treatments in group health (due to the PPO or other negotiated discounts), the existence of pharmaceutical formularies in the group health system, and in the case of workers' compensation, the inclusion of costly and questionable medical services (e.g., work hardening/conditioning). (ROC, January 2001).

The January 2001 ROC report concluded that Texas policymakers and system regulators should consider developing a comprehensive plan to address:

- * the amount of medical care provided to injured employees;
- * the price of individual treatments and services in workers' compensation;
- * the method by which the system resolves disputes; and
- * the method by which the system regulates doctors and insurance carrier utilization review agents.

With this background of information and reports, the 77th Texas Legislature enacted House Bill 2600 which amended §413.011 of the Labor Code to address reimbursement policies.

Prior to the revisions of House Bill 2600, §413.011 required that guidelines for medical services fees be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.

Section 413.011 also stated that the guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured

individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission was to consider the increased security of payment afforded by the Texas Workers' Compensation Act (the Act) in establishing the fee guidelines.

In addition to the previous requirements, the revised statute also required that the commission:

- * use health care reimbursement policies and guidelines that reflect the standardized reimbursement structures found in other health care delivery systems with minimal modifications to those reimbursement methodologies as necessary to meet occupational injury requirements;
- * adopt the most current reimbursement methodologies, models, and values or weights used by the federal Health Care Financing Administration (HCFA) to achieve standardization, including applicable payment policies relating to coding, billing, and reporting, and may modify documentation requirements as necessary to meet the requirements of §413.053 of the Act (relating to Standards of Reporting and Billing);
- * develop conversion factors or other payment adjustment factors in determining appropriate fees, taking into account economic indicators in health care; and
- * provide for reasonable fees for the evaluation and management of care as required by §408.025(c) and commission rules.

Section 413.011(b) stated that this section of the law does not adopt the Medicare fee schedule, and the commission shall not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the HCFA.

On April 25, 2002, the Texas Workers' Compensation Commission adopted §134.202, (concerning Medical Fee Guideline) (2002 MFG), to be effective for professional medical services provided on or after September 1, 2002.

On July 10, 2002, the Texas Medical Association and Texas AFL-CIO filed a lawsuit against the Commission. Texas Medical Assoc., et al. v. Texas Workers' Compensation Commission, Cause No. GN 202203 (126th Judicial Dist., Travis County, Texas) (TMA v. TWCC I), which challenged the 2002 MFG on various statutory authority grounds and also alleged that it was adopted without substantial compliance with the reasoned justification requirements of notice-and-comment rulemaking under Government Code §2001, subchapter B. After a temporary injunction hearing, the district court judge issued a Temporary Injunction and Remand Order, pending trial on the merits.

The temporary injunction order included a remand to the Commission, under amendments added to the Government Code's provisions for challenges to agency rules in 1999. These amendments make a court's decision after trial on the merits that a rule's adoption was not in substantial compliance with reasoned

justification requirements voidable, rather than void, and confirm that a trial court may allow a rule to go into effect pending efforts to revise the preamble to satisfy reasoned justification standards. The Court in this case made a number of statements from the bench identifying the Commission's decision to adopt a multiplier as the focus of its concerns and shedding further light on the nature and extent of the Court's concerns with the reasoned justification for the 125 percent multiplier as stated in the preamble for the 2002 MFG, published in the May 10, 2002 issue of the *Texas Register* (27 TexReg 4048).

The Commission clarified the reasons for the 125 percent multiplier issue with particular focus on TMA's challenges and the Court's concerns. In addition to the parties' briefs, testimony and exhibits in the temporary injunction hearing, the Commission's Executive Director invited stakeholders to a September 16, 2002 meeting and requested further input, in particular on the extra administrative burdens of the workers' compensation system, the appropriate conversion factor, and the access to care issue. On September 19, 2002, the Commissioners directed the Executive Director and staff to review any additional stakeholder input and all other relevant information and to make reports and recommendations to the Commission at the October or another future meeting. The Commission's staff reviewed the input received in that process, and relevant new publications. Staff also reviewed the Commission's previous statement of factual and legal analyses as reflected in the existing preamble in light of

additional staff analysis. Based on its review, the staff prepared and the Executive Director submitted for the Commission's consideration a supplemental order/preamble.

The Commission adopted the "Supplemental Preamble" on December 12, 2002 and readopted the 2002 MFG with no textual changes to the rule. The 2002 MFG was republished in the December 27, 2002 issue of the Texas Register (27 TexReg 12304).

In April 2003, the district court held another hearing, this time on the appellants' request for a permanent injunction and on the merits of the rule's validity. After hearing evidence and argument, the court determined that the Commission's Supplemental Preamble substantially complied with the reasoned-justification requirement and issued an order declaring the 2002 MFG valid in all respects, effective August 1, 2003. The appellants filed a motion for rehearing, which the district court denied. The appellants then brought an appeal, reasserting their arguments urged to the district court and the Third Court of Appeals upheld the district court's findings in *Texas Medical Assoc. v. Texas Workers' Compensation Commission*, 137 S.W.3d 342 (Tex. App. – Austin 2004, no pet.). (*TMA v. TWCC II*).

The new sections and the amendments to the 2002 MFG build on the prior history and prior court decisions, and address statutory changes that have come into effect subsequent to the 2002 MFG.

ADOPTED RULES

The Commissioner adopts amended §134.1 and new §§134.2, 134.203, and 134.204 to comply with Labor Code §413.012, which directs fee guidelines to be reviewed and revised to reflect fair and reasonable fees and to reflect medical treatment or ranges of treatment that are reasonable and necessary at the time the review and revision are conducted. In response to written comments received from interested parties and testimony at a public hearing held on November 5, 2007, the Division has changed some of the language in the text of the proposed rules as adopted. These changes, however, do not introduce new subject matter or affect persons in addition to those subject to the proposal as published. Other changes are made for consistency.

The amendments to §134.1 are necessary to address rule name changes and the addition of the new §§134.2, 134.203 and §134.204, to clarify when fair and reasonable reimbursement applies, to correct grammatical inconsistencies in the section, to add a definition of maximum allowable reimbursement (MAR) as requested by one commenter, and to renumber the subsections to accommodate the added definition.

Adopted §134.2 is added pursuant to Labor Code §408.0252, which allows the Commissioner to identify areas of the state in which access to health care providers is less available and to adopt appropriate standards, guidelines, and rules regarding the delivery of health care in those areas. The text in the

adopted section provides an incentive reimbursement of 10 percent over the regular reimbursement amount to encourage health care providers to provide services to injured employees in areas identified by the Division as being underserved. In specifying workers' compensation underserved areas, the Division utilized three criteria simultaneously: a ZIP Code that was not in a designated Medicare Health Professional Shortage Area (HPSA), a ZIP Code that had at least one Division approved request for a case-by-case exception to the appointment of a provider who was not on the Division's Approved Doctor List (ADL), and a ZIP Code that had no ADL provider listed. Using those three criteria, the Division has designated 122 of the 4,254 Texas ZIP Codes as eligible for the 10 percent incentive payment. The Division determined that 10 percent is a fair and reasonable incentive because it is consistent with the percentage factor currently used as the physician bonus payment provided by the Centers for Medicare and Medicaid Services (CMS) for its 2007 Primary Care HPSA. The 10 percent incentive payment is anticipated to improve participation because it is a reasonable financial bonus in a physician scarcity geographic area and it is a measure that has been used historically by the federal Medicare system. Because the ADL was abolished effective September 1, 2007, the Division anticipates revision of the selection criteria when §134.2 is next revised. A more detailed explanation of the methodology used for selecting the 122 ZIP

Codes is set forth in the Division's responses to comments received as part of the rule proposal.

New §134.203 and §134.204 are based on and address the same subject matter as the current §134.202 medical fee guideline; however, the new sections apply to medical services provided on or after March 1, 2008, and contain changes that provide for fair and reasonable reimbursement in the current health care market. Section 134.202 will remain in effect for reimbursements related to professional medical services provided between August 1, 2003 and March 1, 2008. Rather than modifying §134.202, two new sections (§134.203 and §134.204) are adopted to create a separation of the conversion factors for Medicare-based fee schedules from workers' compensation specific services and reimbursements that are currently combined in §134.202. With two separate sections, any future amendments will be easier for the Division to manage and for system participants to implement. New §134.203 relates to medical fees for reimbursements predominantly based on conversion factors and Medicare. New §134.204 relates to medical fees for reimbursement of workers' compensation specific codes, services, and programs that, for the most part, are needed in the Texas workers' compensation system but are not as dependant on the RBRVS system and the Medicare methodologies.

HB 7, enacted by the 79th Texas Legislature, Regular Session, effective September 1, 2005, added new duties for designated doctors to Labor Code §408.0041. The adopted rules, specifically §134.204(i) and (k), are required in order to reflect the new duties, provide appropriate modifiers to be used in billing for the new duties, and to structure reimbursement to take into account the new duties.

At the time the 2002 MFG rules were adopted, there was no statutory provision for more than one conversion factor. With the passage of HB 7, the Labor Code was amended at §413.011(b) to direct the Commissioner to develop one or more conversion factors taking into account economic indicators in health care and the requirements of subsection (d), which requires that reimbursement be fair and reasonable and designed to ensure the quality of medical care. In place of the single conversion factor provided by §134.202, new §134.203 adopts two conversion factors. The two conversion factors are established in consultation with the Medical Advisor pursuant to Labor Code §413.0511(b)(1) and in consideration of the amendments made by HB 7.

The conversion factor of \$52.83 for calendar year 2008 is to be used for all professional service categories, with the exception of surgical procedures when performed in a facility setting, such as a hospital or an ambulatory surgical center (ASC). This "non-facility" conversion factor is based on the Medicare Economic Index (MEI) used by CMS to develop its adopted 2008 conversion

factor. Labor Code §413.011 requires that reimbursement be fair and reasonable. In 2003, the Texas court of appeals validated the conversion factor of 125 percent of Medicare in the 2002 MFG. In reaching that decision, the court said, “the Commission was not required to demonstrate that 125% is the only reasonable or factually defensible policy alternative. Rather, it needed only to demonstrate that there is a rational connection between its conversion factor and the factual material it has received or otherwise considered, and that 125% is a legitimate and factually defensible choice that complies with the multiple statutory requirements of the labor code.” TMA v. TWCC II at 355. That conversion factor was adopted and has been used for setting reimbursement since the 2002 MFG became effective on August 1, 2003. A review by the Division shows that erosion of the value of reimbursement over the past four years due to yearly practice expense increases has caused the 125 percent conversion factor to not fully recognize changes in the economic indicators of health. This reimbursement is no longer fully consistent with the requirements of Labor Code §413.011. Rather than continue using 125 percent of the most current Medicare conversion factor, the adopted §134.203 establishes a conversion factor that reflects the aggregate changes in the MEI since the baseline year of 2002. The MEI is a weighted average of price changes for goods and services used to deliver physician services. The goods and services include physician time and effort as well as practice expenses. The MEI is a portion of Medicare's

Sustainable Growth Rate (SGR). The other components of the SGR serve as major price restraints necessary to comply with Medicare's budget neutrality requirements, and do not directly relate to workers' compensation reimbursements. This change updates the 125 percent conversion factor to essentially reflect the changes in the cost of providing the covered goods, services, and practice expenses that have occurred over the prior four years. The adopted conversion factor of \$52.83 for calendar year 2008 begins with the 125 percent multiplier developed for §134.202, and applying the annual MEI adjustment year-to-year beginning with the baseline year of 2002. In 2002, the reimbursement amount was \$45.25. The MEI increased 3.0 percent for 2003, 2.9 percent for 2004, 3.1 percent for 2005, 2.8 percent for 2006, 2.1 percent for 2007, and 1.8 percent for 2008. In order to minimize the need for rulemaking activity and to provide predictability to system participants, the Division adopts, as part of §134.203, a provision that will automatically update the conversion factor each year based on the MEI. The Division will monitor the resulting change to ensure that the conversion factor is reflective of the mandatory statutory factors. This approach is analogous to the approach that was upheld in the 2002 MFG suit where the plaintiffs complained that use of the Medicare conversion factor to develop a conversion factor was an improper delegation of agency duty; however, the court found that there was no delegation. *TMA v. TWCC II*, 137 S.W.3d at 348. The section that was challenged stated, "The 2002

fee guidelines provide that fees for certain services are to be calculated by using the 'effective conversion factor adopted by CMS multiplied by 125%.' TMA v. TWCC II, 137 S.W.3d at 348. In finding that there was no delegation, the court stated, "Changes to the Medicare conversion factor are historically announced several months before they become effective. See, e.g., 42 C.F.R. § 414.4 (2003) (CMS announces proposed changes in Federal Register and provides opportunity for public comments prior to publication of final changes); 67 Fed. Reg. 79,966 (Dec. 31, 2002) (2003 conversion factor published on December 31, 2002, to be effective on March 1, 2003). Thus, the Commission will have an opportunity to make any necessary changes to the Texas multiplier prior to the date the Medicare conversion factor becomes effective. Indeed, the Commission has already adjusted the Texas conversion factor to 125%, up from 120%, after the Medicare conversion factor for 2002 was reduced. Supp. Preamble 12,335; see also 66 Fed. Reg. 55,320 (Nov. 1, 2001). Even without the Commission's statement in the Supplemental Preamble, the Commission has the ongoing statutory duty to review and revise the fee guidelines to ensure they are in compliance with the statutory factors. See Tex. Lab. Code Ann. § 413.012 (Commission is to review and revise guidelines at least every two years). Appellants' contention that the adjustment to the Texas conversion factor is "automatic" is thus overstated. The Commission will have the ultimate authority, and the ongoing duty, to make adjustments to the Texas conversion factor to

keep it reflective of the mandatory statutory factors.” TMA v. TWCC II, 137 S.W.3d at 349.

As with the Medicare conversion factor, the annual MEI is published in the Federal Register each November for the following year. Estimates of the MEI are available throughout the year prior to November. The Commissioner, exercising his ultimate authority and his statutory duty to review and revise, has the opportunity to implement any necessary changes to the reimbursement rate prior to its effective date.

Using the estimates and the final annual MEI also provides an element of stability and predictability to the system. Insurance carriers can anticipate changes in the conversion factor well in advance of their implementation. Also, in the past, there have been situations where Medicare has lowered the Medicare conversion factor below the then current year and Congress has stepped in to maintain the conversion factor at the prior rate. On at least one occasion, the congressional action occurred well after January 1 effective date of the change, which meant that the congressional action was retroactive and caused reimbursement and billing problems for both carriers and health care providers (HCPs). With the adoption of the rule, this will no longer be a problem since the change is tied to the MEI rather than to the Medicare conversion factor.

The adopted section establishes a second conversion factor of \$66.32 for calendar year 2008 to be used for surgical procedures when performed in a

facility setting, such as a hospital or ASC. This conversion factor is based on the average reimbursement differential between reimbursement rates for surgical services and overall services of those state workers' compensation systems using the Resource Based Relative Value Scale (RBRVS) as listed in Benchmarks for Designing Workers' Compensation Medical Fee Schedules: 2006 (Workers' Compensation Research Institute, 2006). This WCRI Report also states that for surgical services, 23 of the states that use RBRVS, set their workers' compensation fee schedule more than double the state's Medicare fee schedule; about half of the states have fee schedules that range from 30-65 percent above the state's Medicare rates; and the interstate differences are greatest for surgical and specialty care, and smallest for primary care and physical medicine services. This Division conversion factor also takes into consideration the limited availability of HCPs with the specialized expertise necessary to provide those services. As reported by the Texas Medical Association in their 2006 Survey of Texas Physicians Research Findings, there has been a dramatic loss of access to surgical specialties by injured employees since the adoption of §134.202. As a result of stakeholder input received in response to the posting of the informal working draft sections and in consultation with the Medical Advisor, the \$66.32 conversion factor applies only to surgical services when performed in a facility setting, rather than the earlier suggestion of specialty surgical procedures distinguished by CPT codes. Use of specific CPT

codes would result in an increased administrative burden due to the changing nature of the CPT codes. Current billing practices allow the designation of the setting where the surgical procedure was performed (i.e., office versus facility). Medicare now allows site of service preference deemed by the physician as long as the procedure may be performed safely in that setting. Under the adopted conversion factors, the HCP will generally be paid at a higher rate for services when performed in a facility than a comparable service when performed in the HCP's office. The relative value units (RVUs) for professional services provided in the facility are generally less than RVUs for comparable services provided in an office, because the doctor does not encumber the overhead costs of the facility.

In order to clarify and improve billing procedures, new billing modifiers are added. The new modifiers are for coding the examinations performed by designated doctors and for the identification of treating doctors performing their case management functions. Those new modifiers are set out in §§134.204(e), 134.204(i), and 134.204(n). Proper use of the modifiers in conjunction with eBilling will decrease the administrative burden on both the HCP and the carrier in submitting, processing, and paying bills.

Case management fees have previously been a part of §134.202, but the reimbursement was left to the carriers to determine a fair and reasonable amount since Medicare does not place a value on the relevant CPT codes. In §134.204,

the Division has set the case management fees to eliminate the multiple fair and reasonable determinations and to provide for uniform reimbursement for HCPs performing case management activities. The established fees are derived from the 2007 Ingenix publication of The Essential RBRVS for determining the gap-filled, non-facility value, and then multiplied by the Division's 2007 conversion factor used during the early 2007 calendar year rule adoption stage. In developing these fees, the Division considered Labor Code §413.011(b) that indicates that the Commissioner may also provide for reasonable fees for the evaluation and management of care as required by § 408.025(c) and Division rules. Adopted §134.204(e) also establishes set fees, which are 25 percent of the total provided to treating doctors, when a referral health care provider contributes to the case management activity.

In developing these rules concerning the MFG, the Division has carefully and fully analyzed all of the statutory and policy mandates and objectives and all the facts and evidence gathered and submitted, as well as all informal and formal system participants' input and comments received throughout the development process. The Division has utilized the information gathered and submitted, along with its expertise and experience, to develop these guidelines in a way that best balances the statutory mandates, including the mandate to ensure that injured employees receive the quality health care reasonably required by the nature of

their injury, the mandate to ensure that fee guidelines are fair and reasonable, and the mandate to achieve effective medical cost control.

The Division considered all the factors put forth by the Legislature over the past decade. These rules take into consideration not only the specific provisions of §413.011 but the overall intent of the Legislature to bring about reform to the workers' compensation system in Texas.

The following summary provides a few examples of how these adopted new and amended MFG rules, as well as other Division rules and policy, address and implement some of these key factors as well as the statutory requirements of §413.011:

* For effective medical treatment utilization: The Disability Management Concepts of Chapter 137 are anticipated to reduce costs in the Texas workers' compensation systems, as they have resulted in reduced system cost when implemented in other settings, such as group health and other states' workers' compensation systems. Reduced costs benefit all system participants through the potential for reduced premiums and an option for reallocation of savings to other system needs.

* For fair and reasonable reimbursements: Reimbursement modifications in these adopted MFG rules, including conversion factor increases, which are reflective of the increased costs as identified through the MEI for the provision of medical services, more accurately reflect the increases in costs of providing

health care than the previous index to Medicare. Licensed home health agencies, as providers, will benefit from clarification as to reimbursement for home health services provided to injured employees; and designated doctors will benefit from a more streamlined and tiered reimbursement structure for non-Maximum Medical Improvement (MMI) and Impairment Rating (IR) designated doctor examinations.

* For standardized reimbursement structures, as found in other health care delivery systems with minimal modifications to meet occupational injury requirements: The continued use of standardized and current Medicare methodologies, models, and value units, and use of standardized reporting, billing, and coding requirements, in addition to considering economic indicators in health care, will benefit all system participants. Additional benefits to all system participants include the specification of the tiered reimbursement structure for the non-MMI and IR designated doctor examinations, as well as guidance on the coding and billing for licensed home health services, and the new modifiers, all of which lend certainty and stability to the system.

* For reasonable and timely access to medical care: Injured employees in underserved areas will benefit from the inducement to providers created by the provisions for an additional 10 percent reimbursement to health care providers who provide services in designated shortage areas represented by specific ZIP

Codes. Increased reimbursement rates may encourage additional providers to participate in the Texas workers' compensation system.

* For reasonable fees for the evaluation and management of care: Treating doctors that perform the majority of evaluation and management codes and functions, will benefit from the set reimbursement amounts for case management as these activities become increasingly important in the Texas workers' compensation disability management model. The Division acknowledged during the adoption process of the Chapter 137 Disability Management Rules that the treating doctor will assume an essential role in the coordination of care on behalf of the injured employee. In accordance with Labor Code §408.023(l) and §408.025(c), the responsibility of a treating doctor to effectively medically case manage and maintain efficient utilization of health care is fulfilled through the process of treatment planning. Medical case management fosters a framework for the treating doctor to facilitate and improve communications among injured employees, health care providers, employers, insurance carriers, and the Division. The Division expects case management, including the treatment planning process, to lead to consensus between the treating doctor and insurance carrier regarding health care to be provided. Additionally, clarifications and specificities associated with this change in reimbursement methodology will allow providers to be more consistently reimbursed for case management responsibilities, and this change further supports the responsibilities of the

treating doctor and contributing health care providers to fulfill the disability management objectives of the Division.

3. HOW THE SECTIONS WILL FUNCTION. The amendments to §134.1 address rule name changes and the addition of the new §§134.2, 134.203 and 134.204, clarify when fair and reasonable reimbursement applies, correct grammatical inconsistencies in the section, and define MAR.

The new §134.2 provides a listing of the ZIP Codes that are designated as workers' compensation underserved areas, which are determined by the ZIP Code where the service is provided. The section provides that when required by Division rule, an incentive payment shall be added to the MAR for services performed in a designated workers' compensation underserved area.

New §134.203 and §134.204 are based on and address the same subject matter as the current §134.202 medical fee guidelines; however, the new sections apply to medical services provided on or after March 1, 2008, and contain changes that provide for fair and reasonable reimbursement in the current health care market.

New §134.203 is applicable to professional services provided on or after March 1, 2008. It does not apply to facility, pharmaceutical, dental, and other services and it is not applicable to services provided through a workers'

compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapter 1305.

In place of the single conversion factor currently provided by §134.202, new §134.203 adopts two conversion factors. The conversion factor of \$52.83 for calendar year 2008 is to be used for all professional service categories, with the exception of surgical procedures performed in a facility setting, such as a hospital or ambulatory surgical center (ASC). The conversion factor of \$66.32 for calendar year 2008 is to be used for surgical procedures performed in a facility setting. Both adopted conversion factors are to be updated each subsequent calendar year to reflect the annualized MEI percentage adjustment published in the Federal Register each November.

Adopted §134.203 maintains reimbursement of Healthcare Common Procedure Coding System (HCPCS) Level II codes at the level specified in §134.202, 125 percent of fees listed in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule, or 125 percent of the published Texas Medicaid fee schedule for durable medical equipment if the code has no published Medicare DMEPOS rate. The reimbursement for these services was not developed as part of the Medicare Physicians Fee Schedule and has not been subject to the SGR provisions that are required by the Medicare budget neutrality provisions. In addition, Medicare updates the DMEPOS fee schedule on a quarterly basis and the Division adopts those updates as they

occur. For those reasons, the reimbursement for these items will not be subject to the MEI adjustment.

Adopted §134.203(a) describes the applicability of the section. Section 134.203(a)(1) states that the section does not apply to workers' compensation specific codes, services, and programs described in §134.204; prescription drugs or medicine; dental services; facility services of a hospital or other health care facility; or medical services provided through a workers compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapter 1305. Section 134.203(a)(2) notes that the section only applies to professional medical services provided on or after March 1, 2008, the applicability date of adopted new §134.203. Section 134.203(a)(3) provides that §134.202 is to be applied to professional medical services provided between August 1, 2003 and March 1, 2008.

Adopted §134.203(a)(4) states that for professional medical services provided before August 1, 2003, §134.201 (relating to Medical Fee Guideline for Medical Treatments and Services Provided under the Texas Workers' Compensation Act) and §134.302 (relating to Dental Fee Guideline) apply. Adopted §134.203(a)(5) defines the term "Medicare payment policies" to mean reimbursement methodologies, models, and values or weights, including its coding, billing, and reporting payment policies as set forth in the CMS payment policies specific to Medicare, when used in this section. As with current

§134.202, this section allows for the basic Medicare program provisions to be applied with any additions or exceptions necessary for adaptation to the Texas workers' compensation system. The Medicare program is not a static system. Medicare policies change frequently. To achieve standardization it is necessary to use the Medicare billing and reimbursement policies as they are modified by CMS.

As in §134.202(a)(3), adopted §134.203(a)(6) clarifies that, notwithstanding Medicare payment policies, chiropractors may be reimbursed for services provided within the scope of their practice act, since, in accordance with the Labor Code §401.011(17), they are included in the definition of “doctor” in the Texas workers' compensation system.

Adopted §134.203(a)(7) states that specific provisions contained in the Labor Code or the Division rules, including Chapter 134, take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program and that Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies. Adopted §134.203(a)(8) establishes that whenever a component of the Medicare program is revised, use of the revised component shall be required for compliance with Division rules,

decisions, and orders for professional services rendered on or after the effective date, or after the effective date or the adoption date of the revised component, whichever is later.

Adopted §134.203(b)(1) requires that for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for HPSAs, and physician scarcity areas (PSAs); and other applicable payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

Adopted §134.203(b)(2) provides that a 10 percent incentive payment shall be added to the MAR for services outlined in subsections (c) - (f) and (h) of the section that are performed in designated workers' compensation underserved areas in accordance with §134.2.

Adopted §134.203(c) requires system participants to apply the Medicare payment policies with minimal modifications to determine the MAR. Adopted §134.203(c)(1) provides the annual conversion factors for use in various service categories beginning in calendar year 2008. Adopted §134.203(c)(2) indicates that the conversion factors in paragraph (1) of that subsection are for calendar year 2008 and that the subsequent year's conversion factors will be determined by applying the annual percentage adjustment of the MEI to the previous year's

conversion factors and the new conversion factors shall be effective January 1 of the new calendar year. Paragraph (2) also provides an example of the calculation methodology used early in rule development in calendar year 2007 to describe the 2007 workers' compensation conversion factor based on the Medicare 2006 conversion factor with the annual increase of 2.1 percent of the MEI. This calculation methodology is to be applied each subsequent calendar year based on the annualized MEI percentage adjustment published each November in the Federal Register for the following calendar year.

As in §134.202(c)(2), adopted §134.203(d) provides that the MAR for HCPCS Level II codes A, E, J, K, and L shall be 125 percent of the Medicare DMEPOS fee schedule, or 125 percent of the published Medicaid fee schedule, or, if neither applies, according to subsection (f) of this section.

As in §134.202(c)(3), adopted §134.203(e) provides that the MAR for pathology and laboratory services not addressed in (c)(1) of this section or in other Division rules shall be 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component, and 45 percent of the Division established MAR for the technical component shall be the professional component.

Adopted §134.203(f) contains a clarification change from proposal and establishes that where no relative value unit or payment has been assigned by

Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f), or the Division, reimbursement shall be provided in accordance with §134.1.

Adopted §134.203(g) establishes that where there is a negotiated or contracted amount that complies with Labor Code §413.011, that amount shall be the reimbursement amount that applies to the billed services.

Adopted §134.203(h) establishes that where there is no negotiated or contracted amount that complies with Labor Code §413.011, the reimbursement shall be the lesser of the MAR amount; the HCP's usual and customary charge, unless a Division rule specifies a specific bill amount; or the fair and reasonable amount consistent with the standards of §134.1.

Adopted §134.203(i) requires HCPs to bill their usual and customary charges using the most current HCPCS Level I and Level II codes and to submit medical bills in accordance with the Labor Code and Division rules.

Adopted §134.203(j) describes that appropriate modifiers, including more than one modifier if necessary, shall follow the appropriate Level I and Level II HCPCS codes on the bill to identify modifying circumstances. Division-specific modifiers are identified in proposed new §134.204(n) along with instructions for application.

Adopted new §134.204 provides for reimbursement of workers' compensation specific services, and provision of a separate section from new proposed §134.203 is required for ease in future amendments by the Division

and for ease of implementation by system participants. Section 134.204 applies to workers' compensation specific codes, services, and programs provided on or after March 1, 2008. The adopted section is not applicable to professional medical services described in adopted new §134.203; prescription drugs or medicines; dental services; facility services of a hospital or other health care facility; or medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in §134.1 of this title and Insurance Code Chapter 1305.

Adopted §134.204(a)(3) provides that §134.202 (relating to Medical Fee Guideline) applies to workers' compensation specific codes, services and programs provided between August 1, 2003 and March 1, 2008, the applicability date of adopted §134.204. Adopted §134.204(a)(4) provides that for workers' compensation specific codes, services, and programs provided before August 1, 2003, §134.201 (relating to Medical Fee Guideline for Medical Treatments and Services Provided under the Texas Workers' Compensation Act) and §134.302 (relating to Dental Fee Guideline) apply. Adopted §134.204(a)(5) sets forth that specific provisions contained in the Labor Code or the Division rules, including this chapter, take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program and that IRO decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 (relating to MDR by Independent Review Organizations), which are made on a

case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.

Adopted §134.204(b)(1) requires HCPs to bill their usual and customary charges using the most current HCPCS Level I and Level II codes and to submit medical bills in accordance with the Labor Code and Division rules.

Adopted §134.204(b)(2) states that appropriate modifiers, including more than one modifier if necessary, shall follow the appropriate Level I and Level II HCPCS codes on the bill to identify modifying circumstances. Division-specific modifiers are identified in subsection (n) of this section along with instructions for their application.

Adopted §134.204(b)(3) provides that a 10 percent incentive payment shall be added to the MAR for services outlined in subsections (d), (e), (g), (i), (j), and (k) of the section that are performed in designated workers' compensation underserved areas in accordance with §134.2.

Adopted §134.204(c) establishes that when there is a negotiated or contracted amount that complies with Labor Code §413.011, that amount shall be the reimbursement amount for the billed services.

Adopted §134.204(d) establishes that when there is no negotiated or contracted amount that complies with Labor Code §413.011, the reimbursement shall be the least of the MAR amount; the HCP's usual and customary charge,

unless Division rule specifies a specific bill amount; or the fair and reasonable amount consistent with the standards of §134.1.

Adopted §134.204(e) sets forth the case management responsibilities for the treating doctor, establishes set fees for treating doctor case management services, directs the treating doctor to use a specific modifier when billing for these services that will distinguish treating doctors from other health care providers, and allows treating doctors a payment commensurate with case management responsibilities and workers' compensation administrative tasks. Adopted §134.204(e) also establishes set fees, which are 25 percent of the total provided to treating doctors, when a referral health care provider contributes to the case management activity. These established fees are derived from the 2007 Ingenix publication of The Essential RBRVS for determining the gap-filled, non-facility value, and then multiplied by the Division's 2007 conversion factor used during the early 2007 calendar year rule development stage. In developing these rules, the Division considered Labor Code §413.011(b) that indicates the Commissioner may also provide for reasonable fees for the evaluation and management of care as required by Section 408.025(c) and Division rules.

Adopted §134.204(f) is changed from the proposed rule text as a result of a comment. It establishes that to determine the MAR for home health services provided by a licensed home health agency, the MAR shall be 125 percent of the published Texas Medicaid fee schedule for home health agencies.

As in §134.202(e)(4), adopted §134.204(g) sets forth the requirements and limitations on functional capacity evaluations (FCEs), including limits on the number of FCEs allowed, the maximum number of hours to be reimbursed, the required billing code and modifier, and the required elements of a physical examination and neurological evaluation.

As in §134.202(e)(5), adopted §134.204(h) sets forth the billing and reimbursement requirements for Return to Work Rehabilitation Programs including appropriate coding, modifiers, and reimbursement rates. The section includes details of comparable Commission on Accreditation of Rehabilitation Facilities (CARF) accredited programs.

Adopted §134.204(i) addresses the examinations and reimbursements with new modifiers that are associated with the expanded duties of designated doctors. This subsection is established for whichever examination is appropriate, and sets forth an established cap with a prorated payment method for the four examinations not associated with MMI and IR.

As in §134.202(e)(6), adopted §134.204(j) sets forth the billing, coding, and reimbursement requirements, including modifiers, for MMI and IR examinations. The subsection specifies what shall be included in the examinations; any limitations on the number of examinations allowed; billing and reimbursement for testing not outlined in the AMA Guides; and that the doctor performing the examinations be an authorized doctor under the Act, Division

rules, and Chapter 130 relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment. The subsection further sets out different billing, coding, including modifiers and reimbursement rates, depending on whether the examining HCP is the treating doctor, a referral doctor, or a referral specialist. A new clarifying provision has been added for the billing and reimbursement of an IR evaluation in circumstances when there is no test to determine an IR for a non-musculoskeletal condition.

Adopted §134.204(k) sets forth the billing, coding, including modifiers, and reimbursements rates for Return to Work and Evaluation of Medicare Care examinations (RTW/EMC), that are not done for the purpose of certifying MMI or assigning IR. As proposed, the adopted subsection addresses the newer designated doctor responsibilities and raises the overall reimbursement rate from \$350 to \$500 for whichever examination is appropriate as outlined in subsection (i) of this section. Additionally, any required testing is to be billed using appropriate codes and modifiers in addition to the examination fee.

Adopted §134.204(l) refers a HCP to §129.5 (relating to Work Status Reports) when billing for a Work Status Report that is not conducted as part of the examination outlined in subsections (i) and (j) of this section.

Adopted §134.204(m) refers a treating doctor to §126.14 (relating to Treating Doctor Examination to Define Compensable Injury) when billing for an examination to define the compensable injury.

Adopted §134.204(n) sets forth Division modifiers to be used by HCPs in conjunction with procedure codes to ensure correct coding, reporting, billing, and reimbursement. The adopted subsection includes six new modifiers associated with treating doctor case management functions and requested designated doctor examinations.

4. SUMMARY OF COMMENTS AND AGENCY'S RESPONSE.

General

Comment: Commenters support and endorse the proposed fee schedule rules with expressions that it is long over-due, it is an improvement from the current fee schedule, and that it hopefully will attract more doctors to the system, thus improving treatment and access to quality medical care of employees sustaining on the job injuries.

Agency Response: The Division appreciates the supportive comments.

Comment: Commenter opposes adoption of these rules as it will result in drastic increase in cost of medical care in the Government Employees Workers' Compensation Program. While it appears the goal is to improve access, there is no substantive fiscal analysis on the actual impact of the rules on the system.

Agency Response: The Division disagrees that analysis of impact of the proposed rules on the system has not been conducted or shared. Fiscal impacts

were developed and provided in the “Public Benefit/Cost Note” portion of the proposal preamble that states for proposed reimbursements for professional services other than surgical procedures performed in a facility setting, the estimated approximate increase is \$51 million, or 9.8 percent. Additionally, the proposal preamble reflects reimbursement for surgical services performed in a facility setting to increase approximately \$20.6 million, or 39.5 percent. Overall, this is an approximate increase of \$71.6 million in system costs with a net change of approximately 7.2 percent of total system medical payments. These estimates for overall impact are consistent with the estimated impact developed by the NCCI, which calculates an increase in medical costs in Texas of 7.1 percent, and also includes the 10 percent incentive payment for workers' compensation underserved areas, and the increase in payments to designated doctors.

Comment: Commenter requests further definition of what encompasses professional services (e.g., §134.203) and workers' compensation specific codes, services, and programs (e.g., §134.204) as it is not clear which is to be referenced in a particular circumstance.

Agency Response: The Division clarifies that adopted §134.203 is the appropriate rule reference that provides guidance for reimbursement of CPT code service categories; HCPCS level II codes A, E, J, K, and L; and the

Medicare Clinical Fee Schedule for laboratory and pathology services, with appropriate instruction of workers' compensation conversion factors to be applied. Adopted §134.204 is the appropriate rule reference that provides guidance for reimbursement of provider case management services; home health services; functional capacity evaluations (FCEs); return to work rehabilitation programs; designated doctor examinations; MMI and IR examinations; return to work and/or evaluation of medical care examinations; references to work status reports and treating doctor examinations to define the compensable injury; and Division modifiers. Depending on the circumstance of the medical care being provided to the injured employee, both adopted rules, and other Division rules, may be applicable.

Comment: Commenter requests a definition for the term "maximum allowable reimbursement," and states it should clarify whether or not the medical fee guidelines (MFG) are a ceiling or not, thus making it clear if physicians can negotiate through a contract for reimbursement above the MFG.

Agency Response: The Division agrees that the term "maximum allowable reimbursement" requires a definition, as the statute does not reference the term, yet it is frequently used in Division rules. The Division has defined the term in adopted §134.1(a) as "the maximum amount payable to a health care provider in the absence of a contractual fee arrangement that is consistent with §413.011

and Division rules.” The Division clarifies that the medical fee guideline is not to be considered either a floor or a ceiling on reimbursement. HCPs are free to contract for different reimbursement when done pursuant to the requirements of statute and Division rules.

Comment: Commenters assert that increase in fees to health care providers will not hurt and might help in bringing doctors back into the workers' compensation system; however, they note, it is the system's "hassle factors" that need to be addressed as the most significant system problem. A commenter reminds the Division that physicians have continually adjusted their practices to the shifting and increasing administrative requirements and have absorbed most of the costs while doing so.

Agency Response: The Division agrees that the reimbursement rates are an important factor, and also agrees that there are administrative burdens that are unique to a workers' compensation system. The Division notes, however, that numerous steps have been implemented to minimize these burdens within the parameters of the Labor Code. For example, the Division has taken steps to implement new eBilling rule requirements to offset the more burdensome paper billing process. Additionally, adopted fee guidelines by the Division lend certainty to the system with consistency in payments, thereby reducing the number of medical fee dispute resolution requests. Two additional examples include the

agency's goal and commitment to limit the creation of new forms, and the abolishment of the Approved Doctors List (ADL), the ADL application, training, and certification processes.

Comment: Commenters recommend a \$500 "no show" reimbursement amount to compensate for a patient who does not keep an RME appointment that is blocked by the busy doctor's practice.

Agency Response: The Division declines to make the change. The reimbursement for broken appointments was removed from the MFG by adopted §134.202 in 2002, in part, because the reimbursement structure for MMI examinations changed, which resulted in an overall increase in reimbursement for MMI examinations from the previous §134.201 of 1996. The overall increase in MMI and IR reimbursement in the 2002 update factored in the no-show rate and was intended to compensate for possible costs a health care provider may incur due to broken appointments. More recently, a Division survey conducted from August to October, 2006 demonstrated that of 14,283 designated doctor appointments, injured employees missed approximately 656 (4.7 percent) of these visits, while designated doctors missed approximately (510) 3.7 percent of these appointments. Based on those factors, the Division has determined that the current policy adequately addresses the issue.

§§134.1 and 134.203(g)

Comment: Commenter supports the decision to reimburse products without a Medicare or Medicaid code under "usual and customary" approach of the proposed rules. The commenter suggests that such a policy is consistent with workers' compensation legislation in other states, as well as the commercial market. The commenter asserts that such a system of using usual and customary charges will work more effectively, be applied more fairly and implemented easier.

Agency Response: The Division appreciates the commenter's support. However, the Division would clarify that when §134.203(g) is applied, reimbursement should be the lesser of the MAR, the usual and customary charge, or the fair and reasonable amount consistent with the standards of §134.1. Additionally, §134.1 requires that reimbursement be made in accordance with the Divisions' fee guidelines, a negotiated contract, or be a fair and reasonable amount.

§134.1(a), (b), and (d)

Comment: Commenter recommends added language to ensure that the intent of the MFG stays intact and that rental networks do not erode the protections and safeguards that the MFG provides patients. The commenter asserts that all reimbursements for Chapter 408 Labor Code (non-network) services provided to

patients according to a negotiated contract must be based on a contract apart and separate from Insurance Code Chapter 1305 Network (certified network) patients. In the new managed care networks (informal or voluntary networks), many of the contracts contain provisions that allow discounts to be sold and repriced. These "silent brokering" transactions could circumvent the protections provided by the MFG.

Agency Response: The Division disagrees that §134.1 is an appropriate place to address what provisions may or may not be included in a private contract between a provider and a network certified pursuant to Insurance Code Chapter 1305 (certified network) or an informal or voluntary network arranged pursuant to Labor Code §§413.011(d-1) – (d-5) and 413.0115. Certified networks are regulated pursuant to Insurance Code Chapter 1305 and 28 TAC Chapter 10. The informal working draft rules implementing Labor Code §§413.011(d-1) – (d-5) and 413.0115, to be located at 28 TAC §§ 133.2, 133.4, and 132.5, were posted on the Division's website in November, and will be formally proposed and open for public comment on a future date.

§134.1(d) and §134.203(g)

Comment: Commenter recommends language be re-written in proposed §134.1(d) as follows: "(3) In conforming with §134.203(f) of this chapter, in the absence of an applicable fee guideline or a negotiated contract, separate from a

Chapter 1305 network contract, a fair and reasonable reimbursement amount as specified in subsection (e) of this section.”

Agency Response: The Division disagrees with commenter’s recommendation. It would be unsuitable to limit §134.1(d) applicability to §134.203, because §134.1 is applicable to all medical reimbursement made pursuant to Title 5 of the Labor Code, not just that which falls under §134.203. Additionally, it would not be correct to make a distinction concerning a contract between a certified network and a provider. In most instances such reimbursement is regulated by Insurance Code Chapter 1305 and 28 TAC Chapter 10. However, some provisions in Insurance Code chapter 1305 do contemplate carrier liability for out-of-network services. In such instances, §134.1 might be applicable.

§134.1(d)(1) and §134.2(a)

Comment: Commenter states that fee "guidelines" is an ambiguous term as it implies "guidance," and not the set fees actually established by a MAR or a fee "schedule." The commenter asks whether, due to the ambiguity of the terminology, there is a difference between fee guidelines, fee schedules, and MARs.

Agency Response: The Division clarifies that there is a difference between “fee guidelines,” “fee schedules,” and “MAR.” “Fee guidelines” is a term used by the Legislature in Labor Code §413.011, where the Division is directed to develop a

system for reimbursement, using the most current reimbursement methodologies, models, and values or weights used by the Centers for Medicaid and Medicare Services (CMS). “Fee schedule” is also a term used by the Legislature in Labor Code §413.011, as well as a term frequently used by CMS in describing its reimbursement methodologies – the adopted sections use the term “fee schedule” when necessary for clear references to CMS. “MAR” is a term used by the Division that means “The maximum amount payable to a health care provider in the absence of a contractual fee arrangement that is consistent with Labor Code §413.011 and Division rules.” To clarify the meaning of “MAR,” this definition has been added to §134.1.

§§134.1(d)(2), 134.2(a), and 134.2(b)

Comment: Commenter recommends that HCPs in markets where their services are in limited supply be allowed to negotiate above the "guidelines," which in turn, would negate the need for a MAR. Commenter questions if, on the other hand, the MAR is intended to apply to those instances where there has been no negotiated contract. Commenter recommends deletion of the term "MAR" in subsection (a) of §134.2, and to make rule language clear in §134.2(b) that providers may enter into a negotiated contract that is either above or below the fee set by the "guidelines."

Agency Response: The Division declines to make the change that deletes the provisions concerning MAR. The Division notes that Labor Code §413.011(d) allows providers and carriers to contract for fees that differ from the Division's fee guidelines, and the sections as proposed contemplate this provision and the existence of contractual arrangements. Specifically, §134.203(g) and §134.204(c) only require payment at MAR if there is not a negotiated or contracted amount that complies with the requirements of Labor Code §413.011. It would be inappropriate to delete the provisions addressing MAR, because Labor Code §413.011 requires the Commissioner to adopt health care reimbursement policies, and merely providing for contractual arrangements would not satisfy this legislative mandate. Language changes to make it clear a provider may enter into a negotiated contract that is either above or below the fee set by the fee guidelines are unnecessary, because the rules as adopted sufficiently state this.

§134.1(e)(3)

Comment: Commenters recommend deleting §134.1(e)(3). One commenter states that the paragraph would negate "fair and reasonable" used in disputes, asserting that "fair and reasonable" should not be defined by inconsistent medical dispute decisions, which could ultimately be overturned. Another commenter states that it is unclear which nationally recognized studies are meant

by the reference or the manner in which a study would qualify as a "nationally recognized published study."

Agency Response: The Division disagrees with commenters' suggestion and declines to make the suggested change. The provisions in §134.1(e)(3) are not new language, and are thus currently applicable in the determination of "fair and reasonable" as it occurs in disputes. The language in §134.1(e)(3) has not resulted in difficulty in application in the past, and the Division anticipates that parties will continue to apply §134.1(e)(3) without difficulty. The Division clarifies that the rule is not referencing any specific nationally recognized published studies. Rather, this provision is included due to the Division's awareness that workers' compensation is an area with ongoing research. As new studies are published, parties may take them into consideration.

§134.1(f)

Comment: Commenter recommends rule language addition to last sentence of this paragraph to read, "Upon request of the Division or a HCP, an insurance carrier... ." Commenter states that health care providers will have data on reimbursement amounts from various insurance carriers and will be able to readily determine if the fee by one specific carrier is outside the norm.

Agency Response: The Division disagrees with the suggestion and declines to make the requested provision, because the requested change is unnecessary.

The section referenced by the commenter anticipates that monitoring of carrier fees and reimbursements will be carried out as part of the Division's medical bill review and audit procedures. The Division also clarifies that the section referenced by the commenter as §134.1(f) has been renumbered as §134.1(g) due to the addition of the definition of MAR in §134.1(a).

§134.2 - General

Comment: Commenters express support for incentive payments for the critical access shortage areas.

Agency Response: The Division appreciates the supportive comments.

Comment: Commenter supports the 10 percent incentive payment by ZIP Code, but recommends the language be tightened to clarify that a provider's facility must be established in that ZIP Code and it cannot have a mailing address for the purpose of qualifying for the 10 percent pay incentive. Commenter also recommends the Division address providers with multiple offices in multiple ZIP Codes. If a provider has one office in an underserved area and another office in an area that does not qualify, the Division should ensure that providers not be eligible to receive the incentive pay when a patient is seen in an office in a qualifying area because of the provider's schedule rather than geographical location.

Agency Response: The Division appreciates the supportive comment. The Division believes that all references to the proposed 10 percent incentive payment by ZIP Code under §§134.2, 134.203(b)(2), and 134.204(b)(3) clearly state that the services must be performed in one of the 122 designated ZIP Codes qualifying as a workers' compensation underserved areas, therefore, further clarification is unnecessary. Using a mailing address to qualify for the incentive payment would be fraud, and is outside the scope of this rule. The Division declines to address multiple offices and multiple ZIP Codes, because choices of office locations and practice schedules are business decisions providers make and are beyond the Division's control.

Comment: Commenter supports the concept of providing an incentive payment to increase participation in the underserved areas, and suggests the additional criteria of access within a reasonable distance of the ZIP Code. The methodology should consider the availability of care in nearby areas, rather than just within the ZIP Code itself.

Agency Response: The Division appreciates the support. At this time, the Division declines to add the additional criterion of access to care within a reasonable distance of the ZIP Code to its methodology. The Division considers its current methodology appropriate and allowable under Labor Code §408.0252.

The Division will consider whether additional criteria and changes in methodology are necessary during future reviews.

Comment: Commenter asks if these rule provisions are applicable to pharmacies, since the observation is made that the rule provisions appear to be applicable to durable medical equipment (DME).

Agency Response: The Division clarifies that the adopted rules do not apply to prescription drugs or medicine as provided by pharmacies, as stated in §134.203(a)(1)(B) and §134.204(a)(1)(B). The commenter may refer to Division rules at 28 TAC, Subchapter F, §§134.500-134.504 and §134.506 to view the rules concerning pharmaceutical benefits and reimbursements.

Comment: Commenter asserts that one DWC Form-75 request is not proof of a reasonable amount of demand to justify the 10 percent incentive.

Agency Response: The Division clarifies that one approved DWC Form-75 request is not the sole criterion used in the Division methodology. Providers must also meet two other Division criteria simultaneously to qualify for the incentive payments: a ZIP Code that is non-HPSA designated and a ZIP Code where there was no provider on the ADL.

Comment: Commenter asserts that the determination to pay an incentive to physical therapists based on the three part test for determining the 122 underserved ZIP Codes is flawed. A physical therapist is not a doctor or eligible to fill out a DWC Form-75; however, a physical therapist shall receive a 10 percent incentive payment for performing an FCE under §134.204(g).

Agency Response: The Division clarifies that a physical therapist is a recognized ancillary provider under Labor Code §401.011(21)(A) and a treating doctor's approval is needed before a physical therapist can initiate care.

Comment: Commenter asserts that the 122 underserved ZIP Code areas that are based, in part, on PSAs are flawed, since Medicare PSA ZIP Code maps do not consider chiropractors, optometrists or podiatrists and they do not qualify for the PSA payment, nor do they qualify for any HPSA payment as a primary care, dental or mental health physician.

Agency Response: The Division clarifies that chiropractors, optometrists and podiatrists are included in the definition of "Doctor" under Labor Code §401.011(17). Therefore they would be eligible to receive the 10 percent incentive payment under proposed §§134.2, 134.203(b)(2) and 134.204(b)(3).

§134.2(a)

Comment: Commenter recommends a designated modifier for the 10 percent incentive payments for workers' compensation underserved areas.

Agency Response: The Division declines to use a designated modifier for the 10 percent incentive payments for workers' compensation underserved areas. The ZIP Codes that comprise the designated workers' compensation underserved areas designate where the workers' compensation services were performed. Further, the Division points out that under Medicare's current automated Primary Care HPSA bonus payment, health care providers automatically receive the 10 percent incentive if the health care provider's ZIP Code is on the HPSA list of ZIP Codes where the services were rendered, without the use of a modifier.

§134.2(b)

Comment: Commenter asks if the ZIP Codes listed are the only ones that qualify for the 10 percent HPSA incentive.

Agency Response: The Division clarifies that if a provider qualifies for a HPSA payment as established by Medicare, then the provider does not meet the criteria for the incentive payment of providing services in a designated workers' compensation underserved area. In specifying workers' compensation underserved areas, the Division utilized three criteria simultaneously: a ZIP Code that was not in a designated Medicare HPSA, a ZIP Code that had at least one approved case-by-case exception of Division-approved request to the

appointment of a provider who was not on the Division's ADL, and a ZIP Code where there was no provider on the ADL. Using those three criteria, the Division designates 122 of the 4,254 Texas ZIP Codes as eligible for the 10 percent incentive payment. The Texas ZIP Codes that qualify for the 10 percent HPSA incentive payment as established by Medicare will continue to receive the incentive payment from Medicare.

Comment: Commenter recommends a different mechanism, other than by rule, for identifying those applicable ZIP Codes as it seems a continuous list update adjustment, and the ADL is already obsolete. The commenter asserts that not doing this will eventually lead to distortions in the market for what constitutes underserved areas.

Agency Response: The Division declines to use a different mechanism, other than by rule, in identifying and updating workers' compensation underserved areas at this time. The Division notes that Labor Code §408.0252 requires the Commissioner to use a rule to identify areas of the state in which access to HCPs is less available. The Department will utilize alternatives to the ADL to determine applicable ZIP Codes in the future, after it has performed sufficient research in identifying viable alternatives.

Comment: Commenter recommends the Division's Medical Advisor office administer a survey similar to the case-by-case exception from the ADL, in order to encourage an improved and re-defined methodology for determining underserved areas.

Agency Response: The Division declines to administer such a survey at this time. Development and use of a survey of the type the commenter requests would impose a significant administrative burden on both the Division and the stakeholders required to respond with no guarantee of benefits greater than those received through analysis of data currently collected by the Division. The Division will, however, be open to revisiting that issue during future rule reviews.

§§134.2, 134.203(b)(2) and 134.204(b)(3)

Comment: Commenter supports a 10 percent incentive payment to be added to the MAR for areas underserved by health care providers. However, the commenter also recommends that HPSA designated areas should be included, as most physicians in HPSA areas are not servicing or are not the type of physicians that would service workers' compensation patients. The entire purpose of offering the incentive is to encourage physicians in these areas to start participating and treating workers' compensation patients; if most physicians in the HPSA ZIP Codes will not participate in the workers' compensation system, then the cost of offering the incentive in a larger geographical area would be

minimal. The commenter recommends using more current and reliable data to establish underserved areas, and suggests that workers' compensation underserved areas be based on whether an injured employee has access to a health care provider and not on the number of available health care providers in that specific geographical region.

Agency Response: The Division appreciates the supportive comment, but at this time declines to include the 452 ZIP Codes designated as 2007 Primary Care HPSAs as workers' compensation underserved areas. Increasing the workers' compensation underserved areas by 330 ZIP Codes without independently researched and verified Division support is premature. Further, Medicare already provides a 10 percent incentive payment to those shortage areas. The Division does not believe that an additional 10 percent over Medicare for a total incentive of 20 percent is a fair and reasonable amount at this time. Additionally, those shortage areas are already federally identified areas for the delivery of primary medical care which overlap with services that injured employees in Texas will need. The Division clarifies that it used the most reasonably current and reliable data it had available when it undertook the methodology of establishing the workers' compensation underserved areas given the constraints of limited resources and timelines.

Comment: Commenter states that it is unclear on what basis the 10 percent incentive payment is justified, because the ZIP Codes do not consistently reflect a shortage of providers within a given mileage radius or geographic area. The commenter asserts that ignoring travel reimbursement provisions and using ZIP Codes as criteria for determining provider shortages is flawed, noting that in large cities ZIP Codes tend to be geographically small but densely populated areas. In addition, the commenter notes that medical facilities often concentrate themselves geographically to serve population clusters, so absence of a provider or specialty in a ZIP Code does not equate to underserved.

Agency Response: The Division clarifies that 10 percent is a measure used by Medicare which the Division considers fair and reasonable. The Division's criteria for establishing underserved areas are: a non-HPSA designated ZIP Code, a ZIP Code with at least one approved case-by-case exception and a ZIP Code where there was no ADL provider. The points regarding mileage radius and travel reimbursements are well taken, and the Division thanks the commenter for this insight. The Division will consider this suggestion in future rulemaking.

Comment: Commenter recommends deletion of the provisions regarding workers' compensation underserved areas, because the methodology set forth in the proposed rule captures areas that are not truly underserved. Since the

rationale is based on the ADL, now deleted, the commenter says that it is not clear how the Division will update the list in the future.

Agency Response: The Division declines the recommendation to delete the subsections and disagrees that the methodology does not capture areas that are underserved. Each of the 122 ZIP Codes has at least one injured employee requesting and getting approval for an exception to get treated by a non-ADL provider. Simultaneously, each ZIP Code also has no approved doctor on the ADL. To avoid double reimbursement, none of the ZIP Codes is on the HPSA list. The Division clarifies that a “point in time” methodology, partially based on the ADL when it was formulated, may be reviewed and revised under Labor Code §413.012. Comments regarding underserved areas will be considered in the Division’s review process.

§§134.2(a), 134.2 (b), 134.203(b)(2), and 134.204(b)(3)

Comment: Commenters recommend that §134.2 and any associated references to a workers' compensation underserved area incentive payment be deleted from the rules until there is solid research and information on which to base this payment adjustment. The commenters criticize the methodology used for establishing the ZIP Code inclusion, stating that it does not adequately demonstrate health care provider shortage in all ZIP Codes, no apparent indication is given to access for reasonable travel distances, and is not an

accurate representation of an underserved area. Carriers have provided mileage reimbursement and travel expenses for injured employees for decades to help alleviate the problem of underserved areas. Commenter notes ZIP Code 79411 is adjacent to 79410 in the city limits of Lubbock, and further objects to the listing of 79411 when there is ample availability of 127 ADL doctor in ZIP Code 79410. One commenter recommends further analysis be done to address these concerns, as there is no need to add unnecessary medical costs to areas of the state when there is adequate access to health care services.

Agency Response: The Division declines to make the deletions. Carriers have historically provided mileage reimbursement and travel expenses for injured employees, yet the 79th Legislature considered the issue of underserved areas and deemed it of enough importance to pass Labor Code §408.0252 as part of HB 7. This section, effective September 1, 2005, allows the Commissioner to identify the areas of the state in which access to health care providers is less available and adopt appropriate standards, guidelines, and rules regarding the delivery of health care in those areas. In early 2007, Division staff began conducting an extensive analysis of Division data and ZIP Code records to identify underserved areas of the state. Data reviewed were: HPSA ZIP Code designation, provider specialty groups, and injuries per ZIP Code. First, Division staff reviewed the 4,254 Texas ZIP Codes and set aside those ZIP Codes that contained one or more of the following information: a HPSA designation, an

approved DWC Form-75, a provider on the ADL by specialty group, a Texas Medical Board provider by specialty group and at least one record of injury. There were 3,527 records in the data analysis. After deleting ZIP Codes that were included more than once, the result was a count of 2,198 ZIP Codes. The next step was the separation of the 2,198 ZIP Codes into non-HPSA and HPSA designated ZIP Codes. The Division determined the HPSA designation from the 2007 list of Texas HPSA primary care ZIP Codes available from the CMS. There are currently 452 HPSA primary care ZIP Codes. Starting from the 2,198 ZIP Codes, the Division subtracted the 452 HPSA ZIP Codes resulting in 1,746 non-HPSA ZIP Codes. Next, the analysis identified non-HPSA ZIP Codes from the 1,746 that had at least one approved request for a case-by-case exception for a non-ADL doctor, using DWC Form-75. The Division selected approved requests for case-by-case exception that included only one claim number, and excluded any invalid or missing claim identification. The Division used the time period between September 2006 and February 15, 2007. Out of the 1,726 non-HPSA ZIP Codes, 536 ZIP Codes also had at least one approved DWC Form -75. The next step was to drill down the 536 ZIP Codes into ZIP Codes that had no ADL providers practicing in those 536 ZIP Codes where there was an approved exception. The Division looked at current "Active" license status providers approved to provide treatment that had a Texas practice address or indicated a primary address in Texas in the particular ZIP Code that was not a mailing or

correspondence address. ZIP Codes from the ADL practice addresses were used first, limiting the count of ADL providers to one per ZIP Code where there were multiple office locations within the same ZIP Code. 122 ZIP Codes qualified.

The Division points out that Labor Code §408.0252 is stated in terms of “appropriate” standards. Even in the strictest of statutory construction, it is improbable that “appropriate” would be interpreted that the Commissioner must have an optimal methodology in setting the criteria when designating the workers’ compensation underserved areas. Further, the 122 ZIP Codes constitute only 2.8 percent of the total ZIP Codes in Texas and a spike in unnecessary medical costs is unlikely compared with the possible benefit of health care provider access for injured employees.

§134.203(a)(5)

Comment: Commenter recommends the deletion of Medicare Local Carrier Determination (LCD) policies due to payers distortion of proper application, such as using the LCDs to deny reimbursement for services that are properly covered under workers' compensation. Local Carrier Determinations are designed for traditional Medicare-aged population and not the working-age patients with return to work concerns. The commenter asserts this will still retain the policy goal of

achieving standardization by using the Medicare billing and reimbursement policies as modified by the CMS.

Agency Response: The Division declines to make the change. The rule language is consistent with the requirements of the Labor Code and §137.1 (relating to Disability Management Concept). The Labor Code requires the use of evidence-based medicine and CMS and its fiscal intermediaries follow these concepts in establishing payment policies. However, any rules specifically adopted by the Division take precedence over the Medicare policies. The Division believes a potential misapplication of a policy is a poor reason to delete the policy, and sets a poor precedent in evaluating system requirements.

§§134.203(a)(2), 134.204(a)(2), and 134.204(a)(3)

Comment: Commenters recommend the implementation date of these rules be changed to six months after the rules are adopted, in order to give insurance carriers an appropriate amount of time to make programming changes to their claims management/payment computer systems. The commenters express concerns with similar implementation deadlines for eBilling processes and preparation for hospital inpatient and outpatient fee guidelines.

Agency Response: The Division declines to extend the implementation date. The activities necessary to implement these rule changes are consistent with the changes insurance carriers have made on an annual basis since the adoption

and implementation of the 2002 MFG, and the applicable date of these sections has been the Division's recommendation to system participants since the May 2007 posting of the informal working draft rules on the Division's website.

§134.203(a)(5) and §134.203(a)(7)

Comment: Commenter supports the provisions added to the rule by §134.203(a)(5) and (7).

Agency Response: The Division appreciates the supportive comment.

§134.203(a)(6)

Comment: Commenter recommends this paragraph be deleted as it is bad public policy and inconsistent with the provisions of the Labor Code. The commenter notes that Medicare reimbursement methodology appropriately does not permit chiropractors to be reimbursed for evaluating and directing care that is outside their scope of practice, and it is essential that the Division not open the door to allow chiropractors to be reimbursed for evaluating and directing care of all medical conditions.

Agency Response: The Division declines to delete §134.203(a)(6). In accordance with Labor Code §413.011(c), reimbursement policies may not restrict the ability of chiropractors to serve as treating doctors, and they have the same rights and responsibilities as any other treating doctor in the workers'

compensation system working within the scope of their practice act. This paragraph is necessary to modify the Medicare system to adapt to features unique to the Texas workers' compensation system, such as the ability of chiropractors to serve as treating doctors. Thus, chiropractors are an exception to the CMS payment policies, and may be reimbursed for services provided within the scope of their practice act. Specific provisions contained in the workers' compensation Act, or commission rules, shall take precedence over any conflicting provision adopted or utilized by CMS in administering the Medicare program. Finally, the statute states that it is not to be interpreted in a manner that would discriminate in the amount or method of payment or reimbursement for services in a manner prohibited by Section 1451.104, Insurance Code, or as restricting the ability of chiropractors to serve as treating doctors as authorized by this subtitle. Chiropractors have been reimbursed as treating doctors since the effective date of §134.202, and will continue to be reimbursed as treating doctors according to statute.

§134.203(a)(7) and §134.204(a)(5)

Comment: Commenter recommends the provisions in §134.203(a)(7) and §134.204(a)(5) be deleted, as they are confusing and unnecessary. The commenter further references the rule language "including timed procedures and other limitations."

Agency Response: The Division declines to make the change and clarifies that these comments were written based on input to the informal draft rules. The referenced language was deleted in the proposed rules.

§134.203(b)

Comment: Commenter recommends that, any Federal policies related to budget adjustments be specifically excluded, as Georgia and Maryland workers' compensation systems have done in their fee schedules, because this additional adjustment in the calculation of the Medicare physician fee schedule was intended solely as a Federal adjustment and should not impact the state of Texas workers' compensation system. Commenter states such ongoing action at the federal level, if applied in workers' compensation, will drag down the overall work RVUs by 11.94 percent in the coming year.

Agency Response: The Division declines to make the change. In order to achieve standardization with the most current reimbursement methodologies, models, and values or weights used by the CMS, as statutorily required in §413.011 of the Labor Code, the Division retains the budget neutrality factors included in the Medicare reimbursement calculations. Modifying the formula would negate standardization and create a more complex calculation in the workers' compensation system. This complexity might increase the volume of fee disputes, making it more time consuming for the Division's Medical Fee

Dispute Resolution to resolve such disputes. In addition, excluding a factor of the Medicare reimbursement formula might set a precedent for further expectations to alter Medicare's formulas.

§134.203(b)(2)

Comment: Commenter states it is unclear whether a payment that is to be added for a workers' compensation underserved area is to be made in addition to any "bonus" payment that is to be made for HPSA and PSAs.

Agency Response: The Division clarifies that the incentive payment applied to the reimbursement for workers' compensation services provided by doctors in underserved areas is not intended to apply to services that are provided in Medicare designated HPSAs and/or PSAs. In accordance with Medicare policies, incentive payments are already automatically applied to reimbursements for workers' compensation services provided in areas of Texas that are designated as either a HPSA and/or a PSA by Medicare. These areas were intended to be eliminated from the criteria of the designated workers' compensation underserved areas to prevent a double incentive bonus payment for providing the services in these areas. While the Division strives to address the issue of underserved areas as authorized in §408.0252 of the Labor Code, the Division, at the same time must balance the requirement in §413.011 to

achieve effective cost containment measures. Allowing for a double incentive bonus does not achieve the goal of effective cost containment.

§134.203(c)(1)

Comment: Commenters support the proposed conversion factors, noting that the fee increase will attract orthopedists and orthopedic surgeons into the system. The commenters also state that the proposed conversion factor will cover the administrative costs associated with workers' compensation. A commenter noted that Medicare reduced reimbursement for mental and behavioral services by nine percent in 2007. The increased reimbursement, as well as the annual increases, will offset overhead costs and attract and keep quality providers in the workers' compensation system. The commenters stated improving access to medical care will result in better, earlier and more cost-effective medical care.

Agency Response: The Division appreciates the supportive comments.

Comment: Commenters support an increase in reimbursement amount, but do not believe the adopted conversion factors are adequate. The commenters expressed various opinions for the inadequacy of the rates. The commenters state that the proposed conversion factors will not attract physicians back into the system and will not attract a robust physician network to workers' compensation

in the daily treatment injured workers. The commenters state the result is that patients cannot find needed health care, which is supposed to be guaranteed.

The commenters state the proposed conversion factors will not cover the administrative costs in dealing with the system as a whole, including preauthorization requirements, treatment planning, treatment guidelines, and return to work guidelines, along with new electronic billing requirements.

The commenters recommend an increase in fees to 155 percent for evaluation and management codes and 190 percent for surgical codes to cover the administrative requirements and costs associated with workers' compensation claims. To attract doctors back into the system, a commenter recommends the conversion factor for evaluation and management should be set at 200 percent of Medicare's 2007 conversion factor and the conversion factor for surgery should be set at 300 percent of Medicare.

Agency Response: The Division disagrees that the adopted conversion factors are inadequate. In determining "fair and reasonable" reimbursement levels, the Division must look at several factors. The Division is tasked with several rigorous statutory requirements that must be balanced. Labor Code §413.011(d) requires that a fair and reasonable standard must be met and fees must be "designed to ensure the quality of medical care and to achieve effective medical cost control." In addition, the statute provides that, "The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured

individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The Commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines.”

In addition to the medical practice expenses, the Division examines the administrative requirements of the Texas workers' compensation system. HB 7 realigned many of the administrative requirements. Doctors no longer have a requirement to apply for inclusion on the ADL, but must continue with requirements related to types of injured employee examinations (e.g., maximum medical improvement, impairment ratings, and functional restoration). Doctors now must comply with the Division's adopted disability management rules, which include treatment and return to work guidelines. Treatment within the parameters of the treatment guidelines is presumed medically necessary. Treatment outside or in excess of the guidelines must be preauthorized. Beginning January 1, 2008 providers and carriers are required to be able to exchange billing information electronically unless granted a waiver by the Division.

Comment: Commenter generally supports the proposed reimbursement rates, but states orthopedic surgeons will not sign up with networks unless the adopted

reimbursement conversion factor is at least 155 percent of Medicare and 165 percent of Medicare for surgeries.

Agency Response: The Division clarifies that these adopted rules relate to workers' compensation fee guidelines and do not apply to the rates established by certified networks or political subdivisions contracting directly with health care providers. Subsections (a) in both sections 134.203 and 134.204 state that medical services provided through workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapters 1305, are not applicable.

Comment: Commenter states the proposed rates will strengthen the certified workers' compensation networks by giving them a margin to create a cost efficient system that will allow creation of high quality panels, which will lower total workers' compensation costs.

Agency Response: The Division agrees and appreciates the supportive comment.

Comment: Commenters are supportive of increased fees but are concerned that they will only apply to non-network patients. A commenter states that no "discounts" should be allowed by the insurers who "buy" their way into other

networks silently, and then take 20-30 percent discounts off the top. Another commenter questioned what will happen to existing network contracts.

Agency Response: The Division clarifies that rule §134.203 will not apply to certified networks or political subdivisions contracting directly with health care providers. The Division suggests, however, that carriers and providers review existing contracts to determine the relationship between contract fees and the Division's MFG.

HB 473, adopted during the 80th legislative session, amends Labor Code §413.011(d-2) to require informal and voluntary networks or the carrier or the carrier's authorized agent, to notify each health care provider of any person that is given access to the network's fee arrangements with that health care provider within the time and according to the manner provided by Division rule. Rules implementing this bill are to be located at 28 TAC §§ 133.2, 133.4, and 132.5.

Comment: Commenter states the introduction of managed care networks in workers' compensation has a significant effect on prices for physician services in-network, but should not affect non-network medical fee guidelines. The commenter states workers' compensation insurers have adequate means for negotiating lower fees with physicians. Networks allow market forces to be applied to workers' compensation fees so that the standard fee schedule is not needed to micromanage the marketplace, but can be used to provide a cap that

prevents price-gouging. The fee schedule should be set as a higher cap on prices, thereby allowing a wider range of acceptable fee amount to be governed by market forces and giving freedom of negotiation to managed care networks.

Commenters assert that the proposed rates will result in unnecessary increases in system medical costs that will undermine the viability of networks and their ability to negotiate reimbursement rates that are not impacted or tied to the fee guideline. A commenter recommends that the Division understand the direct viable impact the proposed reimbursement rates will have on political subdivisions that choose to directly contract with health care providers.

Commenters state this will cause employers to leave the system, which could harm the economy of Texas. Another commenter states the proposed reimbursement rates will undermine certified network expansion by reducing the costs savings that the certified networks were created to promote. The commenters assert that the proposed increases will result in a floor for re-negotiating fees with network providers. One commenter says many providers have already begun renegotiating their contracts to the proposed rates.

Commenter references TDI's Research and Evaluation Group network rate study and recommends that the market should continue to play a significant role in price determination. The commenter states that more than 85 percent of orthopedic surgeons are being reimbursed at or below 150 percent of Medicare, and in general, 60 percent of physicians, including specialists, are being paid at

150 percent of Medicare or less. The commenter states neurosurgeons are the only providers being paid above 175 percent of Medicare, although the surgical reimbursement range for neurosurgeons is anywhere from 96 to 205 percent of Medicare.

Agency Response: The Division clarifies that these rules do not apply to certified networks or political subdivisions contracting directly with health care providers. The Division disagrees with the implication that fee guidelines should be construed as either a floor or ceiling for certified network contract reimbursement levels or that they would undermine the ability of certified networks to negotiate reimbursement rates. Experience has shown that even with the current conversion factor of 125 percent, networks have negotiated reimbursement rates both above and below the conversion factor. Labor Code §413.011 (relating to Reimbursement Policies and Guidelines; Treatment Guidelines and Protocols) establishes the requirements for fee guidelines that are fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.

Labor Code §413.011 also requires the development of health care reimbursement policies and guidelines that use the most current reimbursement methodologies, models, values or weights used by CMS in order to achieve standardization of reimbursement structures. In determining “fair and reasonable” reimbursement levels the Division must consider several factors

because “fair and reasonable” is a balance of all the required components of the Labor Code. However, the Division is not required to establish reimbursement levels that reflect the average current payment within the current certified network system or to set reimbursement levels that establish a floor for certified network contractual arrangements. Certified network issues and regulations are a separate set of laws and rules under the Workers' Compensation Health Care Network Act, which is codified at Texas Insurance Code Chapter 1305, and is not administered by the Division of Workers' Compensation.

Health care providers affiliated with certified workers' compensation health care networks may favor the benefits of participating in a network as they tend to experience fewer administrative requirements, less confusion with rule interpretation, and experience increased clarity of payment than those providers who are regulated by the requirements of the Labor Code for non-network care of injured employees. Further, Insurance Code §1305.153 provides that the amount of reimbursement for services provided by a network is determined by the contract between the network and the provider or group of providers. Network rules at §10.42(b)(11) require network contracts with providers to contain the schedule of fees that will be paid to the contracting provider. The parties are free to negotiate the schedule of fees and are free to tailor contracts to meet the specific needs of both the network and the health care providers. The

parties are not constrained by the Division's fee guideline reimbursement amounts.

The Division is aware that as certified networks expand, they are likely to comprise a significant portion of the workers' compensation market. However, the Division has significant responsibilities to assure, through the fee guidelines, access to care for injured employees not subject to certified network requirements. The Division has considered this in establishing these fee guidelines, which apply to the population of injured employees who are not in a network. Consequently, while reimbursement rate comparisons of network payment levels and non-network payment structures are a natural process for setting benchmarks, there is no mandated relationship between these two reimbursement systems. There is no reason to believe that an increase or decrease in non-network regulated fee schedules should hinder network negotiations of schedule fees.

Comment: Commenters support a conversion factor that is higher than the proposed conversion factor. For non-surgical care, commenters' recommendations include 140 percent, 150 percent, 155, 175 percent, and 200 percent. For surgical care, some commenters recommend 175 percent and others recommend 190 percent. Commenters state that the recommended 155 percent of Medicare for evaluation and management services and the

recommended 190 percent of Medicare are based on national averages from a comprehensive WCRI study, "Benchmarks for Designing Workers' Compensation Medical Fee Schedules: 2006," Workers' Compensation Research Institute (WCRI Report) that examined all states with workers' compensation fee guidelines.

Commenters state the proposed conversion factors are too low for physicians to continue to treat complex injured worker cases. Other commenters state the proposed conversion factors are too low to bring doctors back into the workers' compensation system. The commenters assert that it is difficult to find physicians willing to treat workers' compensation patients and are concerned that the proposed conversion factors will affect injured worker's access to quality care. The commenters note that patients frequently have to be referred out of town for specialty care because local specialists will not take workers' compensation patients. One commenter states dermatology, neurology, psychiatry, and orthopedic surgery are in short supply. The commenter expresses additional concern with the nationwide shortage and similar experience in San Antonio of family practice physicians. The commenter states that for the last 3-5 years, residency programs are only filling 50 percent of their slots in favor of finding other, more lucrative and less administratively burdensome, patient practices.

Another commenter asserts that it will stop treating workers' compensation patients if the proposed conversion factors are adopted. A commenter notes that in other states workers' compensation reimbursement rates are set higher than commercial payors such as United Healthcare and Humana.

Other commenters assert that conversion factors higher than the proposed conversion factors will help alleviate barriers to keeping the workforce healthy and safe, restore balance, encourage good non-operative care, and will ensure orthopedic surgeons continue to treat workers' compensation patients. One commenter says that conversion factors recommended by the Texas Medical Association will improve medical fees to a level that will significantly improve access to care by re-engaging the surgical and primary care foundation of the workers' compensation system.

The commenters state that physicians not currently in the system, who may not have adequate staff to accommodate the workers' compensation patient population, need sufficient financial inducement in the form of higher reimbursement fees to take on the added costs. The commenters advise that it is the steep administrative burden that impacts the physician's operating costs and erodes the fee received for the medical services provided to workers compensation patients. One commenter notes there are many burdens, such as documentation, reporting, preauthorization, electronic billing requirements, treatment and return to work guidelines, treatment planning, and coordination

with employers, adjusters and case managers. Some commenters also reference compensability and disability issues as factors contributing to administrative costs, as well as denial of legitimate medical care. A commenter notes that these requirements place demands on physician time and often require specially trained staff or consultants to manage the unique reporting and communications intrinsic to workers compensation. A commenter states that it takes twice the time and effort to treat a workers' compensation patient as it does for the same treatment provided to a group health patient.

Agency Response: The Division disagrees that the adopted conversion factors are inadequate and need to be higher. In determining "fair and reasonable" reimbursement levels the Division must look at several factors. The Division is tasked with several rigorous statutory requirements that must be balanced. Section 413.011(d) of the Act requires that a fair and reasonable standard must be met and fees must be "designed to ensure the quality of medical care and to achieve effective medical cost control." In addition, the statute provides that, "The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The Commissioner shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

In reviewing the conversion factors from §134.202 to determine whether the conversion factors should be adjusted to meet the fair and reasonable standard, the Division considers the change in the MEI from 2002 to 2007. The MEI is a weighted average of price changes for goods and services used to deliver physician services. The goods and services include physician time and effort as well as practice expenses. The increases in these practice expenses have not been recognized in the Medicare conversion factor due to other factors in the Medicare's sustainable growth rate (SGR) that effectively negate it. The other components of the SGR serve as major restraints in Medicare's budget neutrality requirements, and do not directly relate to workers' compensation reimbursements. Consequently, the MEI, a direct reflection of physician costs, has increased 15.7 percent since 2002, but Medicare's conversion factor is essentially unchanged from 2002 to 2007.

In addition to the medical practice expenses, the Division examined the administrative requirements of the Texas workers' compensation system. HB 7 realigned many of the administrative requirements. Doctors no longer have a requirement to apply for inclusion on the ADL, but must continue with training requirements related to types of injured employee examinations (e.g., MMI, IRs, and functional restoration). Doctors now must comply with the Division's adopted disability management rules, which include treatment and return to work guidelines. Treatment within the parameters of the treatment guidelines is

presumed medically necessary. Treatment outside or in excess of the guidelines must be preauthorized. Beginning January 1, 2008, providers and carriers are required to be able to exchange billing information electronically unless granted a waiver by the Division.

Comment: Commenters recommend retaining the current 125 percent conversion factor for all services. The commenters state dual conversion factors further encourage the use of more intensive approaches to care when compared to conservative management. It also contributes to medical graduates choosing more lucrative surgical specialties over primary care or non-procedural specialties resulting in shortages of internists, family doctors, neurologists, etc.

The commenters state the current 125 percent conversion factor rate is both fair and reasonable for medical providers and has provided injured workers with ready access to quality medical care. One commenter believes that with the exception of a few isolated cases that would apply to any system, whether it is Medicare or commercial health insurance, employers are not complaining of difficulty in their injured employees finding access to health care. The commenters also state that the current rate, which has been affirmed by the Texas court system, was based on access to care, impact on return to work objectives, special training requirements for medical providers of the workers' compensation system, and the administrative complexity and requirements for

medical providers. In addition, one commenter notes that the current conversion factor was based on various workers' compensation specific factors. The commenter states three of those factors have now disappeared or are in the process of disappearing: paper billing, fear of sustainable growth rates reduction in Medicare rates, and transitional considerations. The commenter believes these factors should be taken out of the equation, which would reduce the current 140 percent proposal back to 125 percent of Medicare.

Agency Response: The Division agrees that reimbursement rate of 125 percent of Medicare's conversion factor was fair and reasonable when it was affirmed by the courts in 2003. The Division has maintained this fixed 125 percent multiplier level of reimbursement for health care providers for four years in an effort to control medical costs, while building other cost and utilization control measures and tools. For example, insurance carriers and employers now have new tools in the form of treatment and return to work guidelines that will aid them in cost containment. Additionally, the network market is envisioned to continue growing and to gain deeper state-wide penetration, and these networks also feature increased management of claims and other cost control measures. In addition, during the intervening period, the practice expenses for HCPs providing health care services to injured employees has increased as reflected by the MEI. With these system changes over the intervening four years and with the experienced decline in health care providers, particularly the decrease in access to

specialists, the Division now determines it timely to establish new benchmarks to build upon.

The Division's new benchmark is the MEI, which is a component of Medicare's Sustainable Growth Rate (SGR), only without the other components of the SGR that serve as restraints necessary to implement Medicare's budget neutrality requirement. Medicare Payment Advisory Commission has recommended to Congress since 2002 that Congress replace the SGR as a methodology to update physician payments. "Replacing the SGR system could allow updates more consistent with efficiency and quality care and would also uncouple payment updates from spending control. If total spending for physician services needs to be controlled, it is necessary to look not only at adjusting payment updates, but at controlling volume growth directly." The American Medical Association also has requested that Congress eliminate the SGR calculation, and instead calculate changes in the physician update based on the MEI. The MEI is a weighted average of price changes for goods and services used to deliver physician services. The goods and services include physician time and effort as well as practice expenses. Building on the MEI, in general, would allow the conversion factor to increase in relation to changes in the prices of such goods and services as measured by the MEI. With the allowed annual adjustment to the MEI, the Division's conversion factor changes and associated cost increases, as described in the proposal preamble for these rules, will more

accurately reflect the increases in costs of providing health care than the previous index to Medicare. Because of the budget neutrality provisions, the expenses are not directly reflected in the Medicare conversion factor. The new benchmark will improve the financial viability of providers to participate in the Texas workers' compensation system.

Comment: Commenter states there is no justification for raising the non-surgical conversion factor above the current conversion factor. The commenter further states that if the differential between the proposed surgical and non-surgical conversion factor is adopted, the surgical conversion factor should be adjusted to 156 percent.

Agency Response: The Division disagrees. Labor Code §413.011 requires the Commissioner to develop one or more conversion factors or other payment adjustment factors in determining appropriate fees, taking into account economic indicators in health care, and to provide reasonable fees for the evaluation and management of care as required by Labor Code §408.025(c) and Division rules. If surgery is necessary, availability of specialty surgeons is paramount for the prompt and appropriate surgical and follow up treatment of the injured employee. Surgery is only performed, if and when it has been determined to be medically necessary by the insurance carrier. If a health care provider performs surgery in a facility, the provider must seek preauthorization.

Additionally Labor Code §413.011 directs the Commissioner to adopt the Medicare methodologies but to also consider the standardized reimbursement structures found on other health care delivery systems. As noted in the certified network surveys conducted by the Department's Research and Evaluation Group and in the WCRI reports it is common for payors to provide a differential for surgical services.

The Division disagrees that the surgical conversion factor should be adjusted to 156 percent of the Medicare rate. The Division has determined that the appropriate differential for surgical services is 25.5 percent over the non-surgical rate. This rate is based on the Division's calculation of the average differential between surgical and non-surgical services as listed in WCRI Report.

§134.203(c)(1)

Comment: Commenter states the proposal preamble's public benefit/cost note makes it sound as though total costs are only increasing to fully account for MEI, but the addition of the surgical conversion should apply to approximately 10 percent of the procedures, driving the weighted average of the conversion factors to 143.5 percent. If it is the Division's intent to limit the increase in costs to the MEI increases, then the surgical conversion factor would be 170.7 percent, the non-surgical conversion factor would be 136.6 percent, and the weighted average of the conversion factor would be 140 percent.

Agency Response: The Division disagrees that the non-surgical rate should be recalculated. The Division did not predetermine the impact of the MEI increase. Based upon the court decision finding the 2002 baseline conversion factor fair and reasonable, the Division applies the annual MEI adjustment activity year-to-year beginning with the baseline year of 2002. This calculation establishes the adoption conversion factor for non-surgical services at \$52.83. The Division applies the differential for surgical versus non-surgical services, based on the WCRI report, to the \$52.83 conversion factor. The MEI is not applied using a weighted average due to the Labor Code 413.011(b), which states in part, "The commissioner may also provide for reasonable fees for the evaluation and management of care as required by Section 408.025(c) and commissioner rules." A weighted average approach would not reflect the actual increases in medical practice expenses.

Comment: Commenter states the proposed increase for surgery codes is higher than any contract negotiation based on commenter's cumulative experience of working in various capacities of provider contracting. On average, many of the surgical contracts were negotiated lower than the 140 percent proposed figure. Commenter believes these proposed rates will adversely affect the initiative to control the rising medical costs in the workers' compensation system.

Agency Response: The Division disagrees. Labor Code §413.011 requires the Commissioner to develop one or more conversion factors or other payment adjustment factors in determining appropriate fees, taking into account economic indicators in health care, and to provide reasonable fees for the evaluation and management of care as required by Labor Code §408.025(c) and Division rules. If surgery is necessary, availability of specialty surgeons is paramount for the prompt and appropriate surgical and follow up treatment of the injured employee. Surgery is only performed, if and when it has been determined to be medically necessary by the insurance carrier. If a health care provider performs surgery in a facility the provider must seek preauthorization.

Additionally Labor Code §413.011 directs the Commissioner to adopt the Medicare methodologies and to also consider the standardized reimbursement structures found in other health care delivery systems. As noted in the certified network surveys conducted by the Department's Research and Evaluation Group and in the WCRI reports, it is common for payors to provide a differential for surgical services. The second conversion factor, to be used for surgical procedures when performed in a facility setting, such as a hospital or ASC, is based on the average reimbursement differential between reimbursement rates for surgical services and overall services of those state workers' compensation systems using RBRVS as listed in Benchmarks for Designing Workers'

Compensation Medical Fee Schedules: 2006 (Workers' Compensation Research Institute, 2006).

Comment: Commenters recommend a single conversion factor so as not to encourage overuse of inappropriate and costly medical treatments. Moving to a multiple conversion factor system defeats the hallmark of the RBRVS system. All internal coherence between medical service categories in a medical fee guideline is achieved only if the guideline has a relative based RVU scale such as RBRVS which values every unique medical procedure or service. Further, the RBRVS system makes reimbursement between different medical procedures and services equitable, and helps discourage inappropriate utilization of health care services. It is important to realize that all extra costs associated with the provision of surgical services are already accounted for in Medicare's RBRVS systems and deviating will seriously jeopardize the medical cost containment measures recently put in place in Texas.

Agency Response: The Division disagrees. Although the Division has adopted two conversion factors, the basic tenets and relationships of the RBRVS system remain in place. Non-surgical services retain their relativities to each other and services within the surgical category generally retain their relativities. Any discrepancy between relativities is based on the differential in the conversion factor and is reflective of the average differential in workers' compensation

systems. Because all of the surgeries in a facility setting require preauthorization by the insurance carrier, the Division notes this process as one of the system's utilization control measures to ensure surgeries are not performed if not medically necessary. The preauthorization process encompasses all requests for surgical services in a facility setting. The Division also notes newly adopted treatment guidelines as tools to consistently identify when those treatments and services are appropriate. While it is still too soon to report on outcomes in Texas as a result of the Division's disability management rules applicable for dates of service on or after May 1, 2007, including the Division's adoption of the *Official Disability Guidelines – Treatment in Workers' Comp*, recent analysis of the reforms in California' workers' compensation system reflect some improvements in that state's utilization control. A report, "Analysis of California Workers' Compensation Reforms" (California Workers' Compensation Institute, January 2007) indicates that prior to 2003, there were virtually no limits on the amount of medical services that an injured worker in the California workers' compensation system might receive, as number of visits was often unlimited. With the reforms implemented in 2004, this study reflects some of the benefits of the most notable reforms – mandatory utilization review, adoption of the *American College of Occupational and Environmental Medicine* guidelines, and a cap on the number of physical therapy and chiropractic care visits. In five of the six fee schedule treatment categories, the authors found the implementation of the medical care

reforms was associated with declines in medical service utilization, particularly in the use of physical therapy and chiropractic manipulation. The use of medicine section services, surgical procedures, and radiology also declined, but to a lesser degree. As was done in California, the Division anticipates close monitoring and analysis of the implementation of the Texas disability management rules for comparable results in a significant cost control measure that is curtailing over-utilization of medical treatments and services.

Comment: Comments were received on the surgical conversion factor. Commenters recommend the higher conversion factor apply to all procedures in the surgery category, relying on Medicare's relative values to properly weight the payments for facility and non-facility services. The commenters suggest that a single surgery conversion factor would encourage cost-effective care in the appropriate setting, eliminate the choice of setting for economic gain, and ensure the choice of setting is only for quality and safety reasons. Other commenters suggest office-based surgery should be higher than facility reimbursement. One commenter recommends that reimbursement for surgeries should not be dependent on setting to allow health care providers to accept workers' compensation patients and treat them in the most medically appropriate setting.

Agency Response: The Division disagrees. Current billing practices allow the designation of the locality where the surgical procedure was performed (e.g.,

office versus facility). The Division was initially concerned that this recommendation might incentivize many providers to perform the surgery in a facility setting for the higher reimbursement, and they might then seek preauthorization to perform the surgery in a facility setting. However, Medicare now allows site of service preference deemed by the physician as long as the procedure may be performed safely in that setting. In the Medicare system, the doctor does not have much of an incentive to move a procedure from his office to the ASC or other facility setting, because he would get paid the facility rate, which in most instances is less than the office rate. In the Texas workers' compensation system, the doctor will get paid more in an ASC than in his office because of the Division's conversion factors. The RVUs for the facility rate is less than RVUs for office rate, because the doctor does not encumber the overhead costs of the facility. Consequently, the Division does not agree that surgical services will necessarily shift to a facility setting or cause over-utilization of surgical services. Because all of the surgeries in a facility setting require preauthorization by the insurance carrier, the Division notes this process as one of the system's utilization control measures to ensure surgeries are not performed if not medically necessary. The preauthorization process encompasses all requests for surgical services in a facility setting. The Division also notes newly adopted treatment guidelines as tools to consistently identify when those treatments and services are appropriate.

The Division plans to closely monitor the system's overall medical cost expenditures, review the fee guidelines on a regular basis as required by Labor Code §413.012, and revise the fee guidelines, if the need is indicated.

Comment: Commenter opposes the reimbursement conversion factor for specialty surgical codes and request information be provided regarding how these codes were chosen. The commenter demonstrates this opposition by suggesting codes 20552 and 20553 be removed from the list of codes qualifying for the higher reimbursement, as both can be performed in a doctor's office, and are relatively minor procedures for such a significant increase.

Agency Response: The Division clarifies the adopted rule does not list CPT codes. The informal working draft included CPT codes that would be reimbursed at a higher conversion factor. However, based on public comment and after a review with the Medical Advisor, the CPT codes were deleted from the rule text, and not included in the proposal. The use of specific CPT codes would have resulted in higher administrative burdens due to the changing nature of the CPT codes. Instead, the adopted rule establishes a higher conversion factor for surgical services when performed in a facility setting. The Division notes that the commenter suggests office-based surgery should be higher than facility reimbursement. If a health care provider plans to perform the surgical services, including those listed in the comment, in a facility setting, it would require

preauthorization. In the Medicare system, the doctor does not have much of an incentive to move a procedure from his office to the ASC or other facility setting, because he would get paid the facility rate, which in most instances is less than the office rate. In the Texas workers' compensation system, the doctor will get paid more in an ASC than in his office because of the Division's conversion factors. The practice expense RVU is lower for similar services performed in a facility setting rather than in an office setting. The RVUs for the facility rate are less than RVUs for office rate because the doctor does not encumber the overhead costs of the facility.

Comment: Commenter recommends that separate conversion factors not be adopted as RBRVS already accounts for differences in time, cost, skill, risk, etc. The commenter further references the WCRI 2006 study indicating most state fee schedules create financial incentives to under-use primary care and overuse invasive and specialty care.

Agency Response: The Division disagrees. Labor Code §413.011 directs the Commissioner to adopt the Medicare methodologies but to also consider the standardized reimbursement structures found on other health care delivery systems. The Division further acknowledges that information contained in the WCRI Report is a study designed to present the comparisons for workers' compensation medical fee schedules to state Medicare fee schedules. The

Division disagrees that the purpose of the WCRI Report is to argue one stance over another, such as the use of one or more conversion factors. The study merely compares those states that have one conversion factor versus states that have developed more than one, even those states that have developed their reimbursement structures based on Medicare's RBRVS using one or more conversion factors. In developing new §134.203, the Division carefully considered the potential financial incentive to create over-utilization of invasive specialty care in favor of primary care, but recognizes that the Division has other tools to control over-utilization, such as the Disability Management rules and the preauthorization process for determining medical necessity. Consequently, the second conversion factor adopted by the Division is a relatively minor subset of all treatments and services with integrated carrier controls to monitor utilization and potential misuse. The Division also acknowledges the certified network surveys conducted by the Department's Research and Evaluation Group indicates it is common for payors to provide a differential for surgical services.

Comment: Commenters have varying recommendations regarding the proposed conversion factors and the issue of injured employees' having adequate and appropriate access to health care. One commenter states a key point of Texas public policy is that approximately 75 percent of physicians in the state currently choose not to participate in the workers' compensation system, and accordingly

improving reimbursement remains crucial to ensuring that injured employees have access to appropriate care. Another commenter believes an increased reimbursement rate is the only incentive that will keep HCPs in and bring other providers back into the workers' compensation system. To adequately measure access to care, states the commenter, one should examine whether or not patients can seek and find HCPs within a reasonable geographical area, not the number of physicians registered to provide care on the ADL. Other commenters state that their medical association's survey data demonstrates cuts to physicians' fees as a result of the 2003 implementation of §134.202 hurt access to care for injured workers. The data in 2002 overall indicated poor access to care with only 46 percent of physicians accepting workers' compensation. Segmenting the 2002 data by physician specialty showed better access to most surgeon specialties than primary care physicians. These commenters indicate that by 2004, the percentage of physicians who would accept all new patients was reduced to less than a third for almost all specialties, and remains low when based on the medical association's 2006 survey. The effect of market forces on access to health care is different than the effect in other fields because ethical and legal considerations compel physicians to provide care without regard to payment. A commenter criticizes misleading Division data that makes this loss of access look less astounding as the Division reports reflect providers as participating if they were involved in any single encounter in an emergency room.

Documented information in the medical advisor's office should reflect the many thousands of requests to help locate a doctor for an injured employee. One commenter describes his own travel from his office to a neighboring town, and the inability to locate a willing orthopedic surgeon to assist with a new case anywhere between, including a nearby city. Some commenters note that even physicians who limit the services they provide to injured patients will continue to care for them when the relationship began in an emergency circumstance. When patients seek medical care in emergency rooms, it increases the costs for everyone.

Other commenters recommend postponing adoption of rules until the Department's Research Evaluation Group completes their access to health care study as this study is more reliable than the survey completed by a medical association. The commenters state that increasing the rate to 140 percent of Medicare will increase medical costs by \$71.6 million, yet no independent studies have been cited regarding an access to quality care problem under the current system. The commenters note that a recent survey conducted by the Division indicates that 86.3 percent of medical doctors on the ADL were still accepting workers' compensation patients, and that recent tort and medical malpractice reforms, have resulted in a sizable influx of new doctors into Texas. Accordingly, the access to care for injured employees in Texas, which is already good and sufficient, should only improve now and in the future. To the extent that local

access to health care has been recognized as a public health issue affecting the health of many rural Texans, a commenter asks if it is appropriate for the cost of resolving a broad societal issue should be borne by the employers who voluntarily participate in the Texas workers' compensation system.

Agency Response: The Division acknowledges commenters' concerns on the issue of injured employee access to health care, and determines this to be a complex issue that cannot be summed up with any one set of findings, which also is why the Division declines to postpone adoption of the rules until the latest research effort is completed by the Department's Research Evaluation Group. The Division cites the findings of a previous agency publication in December 2006, "Biennial Report of the Texas Department of Insurance to the 80th Legislature on the Division of Workers' Compensation" that suggested the data does not support the idea that there are widespread access to care problems for all claims or for primary care. However, the report's findings did reveal certain types of providers and certain regions of the state where access can, and probably is, an issue. Additionally as stated in the WCRI Report, "The construction of a medical fee schedule in workers' compensation involves a delicate balance. If rates are set too high, savings will be negligible and the fee schedule will not achieve its cost containment goal. Conversely, setting rates too low makes treating injured workers uneconomical for providers and jeopardizes workers' access to quality care."

The Division believes, however, that perception on the part of HCPs is relevant. For example, it has been well documented that the Texas workers' compensation system is dependent on the providers' perceptions about the administrative burdens and associated costs to participate as compared to the reimbursement rates they receive. Particular emphasis has been placed on both the increasing number of medical bill denials and compensability issues, which are on the increase in our system over the past few years.

The Division's 2006 Biennial Report also noted a high market concentration of workers' compensation providers whose workers' compensation patient volume only represents 25 percent or less of their total patient volume. One of the public policy questions, therefore, is whether the system wants to increase the percentage of health care providers who treat the majority of Texas workers' compensation patients by increasing participation of those low volume providers whose practice is not completely dependent on workers' compensation reimbursements. The Division determines this to be a viable option, and again re-states its message from the proposal preamble, the Division determines the public will benefit from an increase in reimbursements to health care providers after a four year experience of a 25 percent fixed add-on to Medicare's conversion factor that includes all of the sustainable growth factors that are the Medicare system's budget neutrality requirements, and believes the increase in

conversion factors via these adopted rules will foster continued access to health care and bring increased stability to the system with the new benchmarks that are still based on the standardized Medicare reimbursement methodologies.

Comment: Commenters recommend numerous factors be included in the consideration of establishing new professional services reimbursement rates. The commenters recommend additional reimbursement consideration be given for other specific workers' compensation driven tasks, and reference as examples the justification to a peer reviewer that more care is required than recommended in treatment guidelines; completion of forms; frequent payment denials, or slow payments; and managing multiple case related phone calls. A commenter explains that outcome expectations for the care of injured individuals are different than caring for other types of patients due to return to work considerations, such as whether they are at MMI, and the use of treatment guidelines. One commenter suggests §134.202, with fee schedule reductions and payment denials, is a failed policy that diminishes the 125 percent of Medicare reimbursement rates. Another commenter recommends the adopted conversion factors show recognition of the economic environment for physicians in Texas as compared to other states, and cites the Texas prohibition of corporate practice of medicine in preventing non-physicians from employing physicians, which ensures the integrity of physicians' medical decisions and

without subjugating a professional opinion to accommodate the needs of an employer, and thus, a lower fee schedule.

Agency Response: The Division declines to make the changes, and disagrees that §134.202 is a failed policy. The Division has maintained the fixed 125 percent multiplier level of reimbursement for health care providers for four years in an effort to control medical costs, while building other cost and utilization control measures and tools. In both this and the proposal preamble, the Division has articulated what the factors and considerations are that have formed the policy decision establishing these new conversion factors; new set fees for the responsibility of treating doctors in case management activities and reimbursements for designated doctor examinations. The overall reimbursements have increased as compared to those adopted four years ago in §134.202 and these new rates are not based or reflective of other states' low fee schedules. Additionally, reimbursements for certain required Division forms are addressed in other Division rules.

Comment: Commenters acknowledged that even Medicare doesn't have the rules and regulations that tie up the health care provider's time, as is the case with the workers' compensation patient. One commenter suggested the Brinker study conducted in Houston supports this assertion. The commenters also indicate that the energy and commitment it takes to care for a workers'

compensation patient is approximately 250 percent of the overhead as compared to Medicare.

Agency Response: The Division disagrees with the commenters' statement that Division rules and regulations tie up the healthcare providers' time, and that the energy and commitment to care for a workers' compensation patient is approximately 250 percent of the overhead as compared to Medicare. As most healthcare providers are already familiar with the Medicare policies, the continued use of standardized coding, billing, and methodology should facilitate office operations, eliminating the need to maintain separate systems. This standardization should allow physician office practices to achieve consistency in their workers' compensation and all other health care billing practices, thereby reducing time and administrative costs. The Brinker study, *The Effect of Payor Type on Orthopaedic Practice Expenses*, was a study of a single physician and not necessarily indicative of Medicare or workers compensation costs. In a previous testimony before Congress, Glenn M. Hackbarth, J.D., MedPAC stated, "We lack information on the cost of physician services, so we cannot compare Medicare's payments and costs the way we can for other services, such as hospital care" and "the regulatory burden of the Medicare program is an important concern of physicians. Nevertheless, estimates of the cost of this burden are not available." Without a regulatory burden assessment in the Medicare system, it is difficult to directly compare the administrative burden

between the systems. As stated in the June 25, 2001 edition of The American Medical News, published by the AMA, "Some experts argue that Medicare's procedures aren't any worse than any other payers. The programs pay faster than most, and the administrative and clinical challenges are like other managed care demands these days, they say." In the same article Dr. Darren Carter is quoted as saying, "There is really not much difference about the way Medicare has created these rules from other carriers."

Comment: Commenter recommends no distinction be made in terms of access to care between group health and workers' compensation health care models, and adopted workers' compensation reimbursement rates should reflect similar rates paid in group health or other commercial insurance plans.

Agency Response: The Division agrees that access to health care is a universal concern and should not be exclusive to workers' compensation, but notes that no changes are necessary in response to this comment. The Division is adopting higher conversion factors than those established in previous §134.202, in recognition of multiple system concerns and economic issues. As a result, the newly adopted rules should be reflective and proportionate to other payor systems.

Comment: Commenter opines that these rules are geared toward offering incentives to health care providers to join the system, but clarifies that in testimony before the Legislature, providers have stated that issues are more related to the “hassles” or burdens of the system. The commenter suggests there is little evidence that these proposed fees will increase participation or improve quality of care, and instead, based on historical trends, will only push more employers out of the workers’ compensation system in Texas.

Agency Response: The Division disagrees. The Division has maintained a fixed 125 percent multiplier level of reimbursement for health care providers for four years in an effort to control medical costs, while building other cost and utilization control measures and tools. For example, insurance carriers and employers now have new tools in the form of treatment and return to work guidelines that will aid them in cost containment. Additionally, the certified network market is envisioned to continue growing and to gain deeper state-wide penetration, and these certified networks also feature increased management of claims and other cost control measures. In addition to the medical practice expenses, the Division examines the administrative requirements of the Texas workers’ compensation system. HB 7 realigned many of the administrative requirements. Doctors no longer have a requirement to apply for inclusion on the ADL but must continue with requirements related to types of injured employee examinations (e.g., MMI, IRs, and functional restoration). Doctors now must comply with the Division’s

adopted disability management rules, which include treatment and return to work guidelines. Treatment within the parameters of the treatment guidelines is presumed medically necessary. Treatment outside or in excess of the guidelines must be preauthorized. Beginning January 1, 2008 providers and carriers are required to be able to exchange billing information electronically unless granted a waiver by the Division.

Thus, the Division determines that with these system improvements over the intervening four years, and the experienced decline in health care providers, particularly the decrease in access to specialists, it is timely to establish new benchmarks to build upon.

Comment: Commenter recommends the categories listed in subsection (c)(1) be made consistent with the current year CPT Code book and recommends deletion of "general medicine," and "physical medicine" as these noted exceptions should be classified as "medicine."

Agency Response: The Division declines to make the change. The categories of services as proposed are the same as in §134.202 and there has been no confusion as to the intent of which services are inclusive on the part of system participants. The Division determines that to consolidate the service categories during this update effort will only serve to confuse participants unnecessarily.

Comment: Commenter observes that 175 percent of Medicare's RBRVS is still far below fee schedules in other states.

Agency Response: The Division disagrees that reimbursement rates in Texas for professional services should be reflective of the rates established by those with higher conversion factors or percentages of Medicare. The median of state reimbursements is 123 percent of Medicare for the 42 states listed in Benchmarks for Designing Workers' Compensation Medical Fee Schedules: 2006 (WCRI, 2006). The Division's proposed conversion factor of \$66.45 for surgeries when performed in a facility represents an approximate 175 percent of the Medicare conversion factor applied in calendar year 2007. As a reflection of the final MEI annual percentage adjustment of 1.8 percent for calendar year 2008, the Division's adopted conversion factor of \$66.32 for surgeries when performed in a facility represents 195 percent of the Medicare conversion factor (\$34.0682) for calendar year 2008.

Comment: Commenter recommends that the WCRI conduct an updated study of "The Anatomy of Workers' Compensation Medical Costs and Utilization" with 2008 data, which should also address any access problems so that future decisions on increasing the fee schedule may be based on facts and data and not anecdotal stories. Commenter implies that the study should additionally

reflect that if states set their rates too high, savings will be negligible and fee schedules will not achieve the cost containment goal.

Agency Response: The Division clarifies it has no direct purview as to the selected topics and content of studies and reports that are conducted by the WCRI.

Comment: Commenter, as another basis for recommending the retention of current 125 percent of Medicare rates, suggests the current rate is consistent with the experience of several states with a conversion factor lower than a 125 percent rate, such as Hawaii, a state that has not experienced significant access or quality of care problems since adopting 110 percent of Medicare as a reimbursement level in 1995. Pennsylvania and the District of Columbia with 113 percent have not experienced such issues either.

Agency Response: The Division disagrees that reimbursement rates in Texas for professional services should be reflective of the rates established by those states with lower conversion factors or percentages of Medicare. The requirements of the Labor Code, including the requirements for how Texas is to set reimbursement rates, differ from those of other states. The Division is required to follow the mandates of the Labor Code and associated rules, and not those of other states. Additionally, the states noted by the commenter are not

representative of the Texas experience or economy, and other states do not have comparable health care practices that are the standard for Texas.

Comment: Commenter asks what fee is proposed for anesthesiologists if they are currently getting paid \$47.37 per unit.

Agency Response: The Division clarifies that the adopted conversion factor for anesthesiology for calendar year 2008 is \$52.83.

Comment: Commenters recommend that while a separate conversion factor may be indicated for anesthesia services from the one set by Medicare, the proposed anesthesia conversion factor is set too high, over 315 percent of the Medicare 2007 Anesthesia conversion factor for Texas.

Agency Response: The Division disagrees. While the Medicare system utilizes the American Society of Anesthesiologists (ASA) RVU system for anesthesia services, the Medicare anesthesia conversion factor was determined for \$134.202 to be more than 50 percent below the 1996 MFG anesthesia conversion factor (\$134.201), and a 50 percent reduction in the anesthesia conversion factor would have created a significant negative impact in the entire anesthesia category, and would do so now. Further, a recent 2007 national survey of anesthesia conversion factors used in commercial managed care contracts reflects the volume-weighted national average commercial conversion

factor ranges as between \$52.16 and \$65.06. (American Society of Anesthesiologists NEWSLETTER, Volume 71, Number 7, July 2007) The median is in the \$53 to \$63 range as compared to Medicare's 2007 anesthesia conversion factor of \$16.19. The survey results state, "In anesthesiology third-party payment contracts, conversion factors that do not significantly exceed the Medicare rate are highly implausible. The fact that the Medicare rate is lower in 2007 than it was in 1997, combined with the well-known price competition to attract and retain anesthesia personnel, removes any incentive to provide anesthesiology services other than at a multiple of Medicare." Therefore, as with §134.202, the Division maintains the same conversion factor, \$52.83, for anesthesia services that is established for all other service categories (with the exception of surgical procedures when performed in a facility setting) as there is no reason to drop the reimbursement rate below the market.

§134.203(c)(2)

Comment: Commenters support the MEI adjustment for the fee guideline's multiplier and state the chosen methodology for annually updating the fee schedule should provide an effective method for making sure that reimbursement levels remain current in the years ahead, while avoiding issues related to negative changes to the Medicare rates as a result of federal

budgetary constraints; it is a reasonable solution to a major public policy problem; and a critical improvement.

Agency Response: The Division appreciates the supportive comments.

Comment: Commenters request that §134.203(c)(2) be deleted. One commenter states the use of the MEI is inappropriate, given the fact that the MEI adjustment is already made to the Medicare base payment. Other commenters state this proposed section is more than a minimal modification to the Medicare system, and will cause an added 4 percent annual average medical impact to the system without due process of allowing system stakeholder input as per the Texas Administrative Procedure Act. The commenters assert that adding an automatic increase to the reimbursement rate is inconsistent with the requirement of §413.011 that the Division's fee guideline achieve medical cost control, and that it is also inconsistent with §413.012, which requires fee guidelines to be reviewed and revised at least every two years. One commenter further suggests that as long as there is no evidence of an access problem and no evidence that the current rate is unfair and unreasonable, the current rate should be reaffirmed during the two year review.

Agency Response: The Division declines to make the change. Medicare's Sustainable Growth Rate, which sets the annual conversion factor adjustment, includes the MEI and other utilization and productivity and reimbursement

measures. These measures, other than MEI, are designed to meet the budgetary requirements of the Medicare program. These budgetary constraints are not applicable to workers' compensation. The MEI has increased 15.7 percent since 2002 while the Medicare conversion factor has decreased from \$36.1992 to \$34.0682, or -5.6 percent.

The Division determines the adopted language in §134.203(c)(2) is the appropriate method of creating new benchmarks and it reminds system participants that the Commissioner is obligated by §413.012 of the Labor Code to review fee guidelines. The Commissioner may also review the estimated MEI change as early as March before the new calendar year, and has the authority to take appropriate action as necessary to prevent an undesired consequence. The Division also notes that at least two other states, Georgia and Maryland, have automatic MEI updates included in their rules.

§134.203(d)

Comment: Commenter supports the 125 percent of Medicare and basing reimbursement on the Medicare Fee Schedule as it is a fair and reasonable process for this complex system.

Agency Response: The Division appreciates the support.

Comment: Commenter recommends that an additional reference should be made to the CMS Medicare Fee for Service Part B Drugs (i.e., 125 percent of this fee schedule). Many diagnostic providers render services to injured workers that require the use of various drugs and/or contrast material that should be reimbursed utilizing the CMS Part B Drug Files.

Agency Response: The Division declines to make the change. The rule language addressing this situation has not changed since the 2003 implementation of §134.202 and the Division has not received any information or data showing there to be a problem in correct billing and reimbursement for these items. Additionally, there were no similar suggestions offered when the Informal Working Draft Rules were posted on the Division's website for system participant input.

§134.203(d), (e), (f) and §134.204(b)

Comment: Commenters recommend rules be further modified, with suggested draft language, to make the MEI applicable to fees for the services and/or supplies rendered via HCPCS Level II codes and pathology and laboratory services not addressed in the CPT Code service categories, as well as all services identified in §134.204. Additionally a commenter recommends a language addition applying a yearly MEI percentage adjustment that parallels language adopted in §134.203(c)(2). The commenters say that without

application of the MEI adjustment to these services, the Division will be required to go through the rulemaking process too often.

Agency Response: The Division declines to make the change. Reimbursement for DME in the Medicare system is not based on the Medicare Physicians Fee Schedule, the SGR, or the MEI. Instead, Medicare bases those reimbursements on a different fee schedule, the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule, as was the case with previous §134.202 and adopted new §134.203. Unlike the Medicare conversion factor, the DMEPOS fee schedule is updated quarterly by Medicare, and the Division adopts those changes as they occur. Such an attempt to create a system of reimbursement that takes into consideration the MEI where it is not applicable in the Medicare system would be unnecessary and might not comply with the requirements of §413.011 of the Labor Code.

§134.203(d), (e), (f), and (h)

Comment: Commenters observe that a cynical interpretation of "fair and reasonable" reimbursement determinations by carriers would include a means which is not shared with anyone else, and that carriers manipulate the results to an amount less than the MAR for every service provided by an HCP. Another commenter recommends a new paragraph in subsection (f) of this section that states the Division shall maintain a master record of applicable products and

services for which no relative value unit of payment has been assigned. The commenter suggests that these records could be used to resolve medical fee disputes in a timely manner.

Agency Response: The Division disagrees and declines to make the change. The DMEPOS, Medicare Clinical Fee Schedule, and Medicaid fee schedules cover the majority of items used in the treatment of work-related injuries. For those products and services without an established relative value unit or payment amount, §134.203(f) directs the reimbursement to be made in accordance with §134.1(e) of this chapter (relating to Medical Reimbursement), which incorporates a methodology that carriers are to use to assign a relative value. This default fair and reasonable reimbursement methodology has been maintained by the Division since August 2003, the implementation date of §134.202, and allows use of a wide variety of resources to establish a reimbursement that is fair and reasonable. Maintenance of a log of reimbursements for non-valued services would require additional reporting from both providers and carriers, thus increasing administrative burdens for the system.

§134.203(e)

Comment: Commenters recommend substitute language that provides (1) 125 percent for the whole procedure component of services when applicable; (2) 55

percent of the MAR derived from (1) for the technical component; and (3) 45 percent of the MAR derived from (1) for the professional component. One commenter asserts the substituted language is necessary and proper to ensure payment in accordance with Medicare's reimbursement models.

Agency Response: The Division declines to make the requested change. Such a change would significantly decrease reimbursements to the laboratory and pathology community, and would amount to a reduction in payments to 55 percent of the 125 percent total for the technical component of this service. The recommendation is not consistent with the reimbursements maintained within the MFGs in place since 1996 (§134.201) that allows for a professional component of reimbursement to the pathologist, and has been derived as a ratio of professional and technical components of the overall reimbursement rate, and has been maintained to ensure that pathologists are not cut out of the system. At a time when the Division is suggesting incremental increases to this fee guideline, there appears to be no justifiable reason to cut the fees for laboratory and pathology services.

§134.204(e)

Comment: Commenter expresses support for reimbursement for both treating doctors and other health care providers involved in case management, which is a key component of the treatment planning efforts underway at the Division. Since

extra time and effort are involved, which takes time away from providing direct patient care; it is only fair that providers be reimbursed a reasonable amount for their time. However, notes the commenter, the proposal to reimburse the other providers 25 percent of the treating doctor amount is not sufficient or fair. The commenter recommends that reimbursement to referral health care providers contributing to the case management activities should be at least 50 percent because, in many cases, the other providers have the most information to provide in the case management process.

Agency Response: The Division appreciates the supportive comment but declines to make the suggested changes. The provisions of subsection (e) of this section enhance the ability of the treating doctor to fulfill the requirements of §408.025 and §408.021 of the Labor Code by recognizing that communication between referral providers and the treating doctor for claims requiring medical case management is a normal business practice, and appropriate communication results in efficient care of the injured employee as well as an efficient medical practice. However, the coordination of this activity is the responsibility of the treating doctor, as the Division emphasized in the adoption of Chapter 137 Disability Management Rules. The Division has recognized the contributions of referral health care providers contributing to the activity, and determines that 25 percent of the amount established for the treating doctor's overall case management functions is cost effective and adequate compensation. The 25

percent is considered adequate since the referral HCPs do not have the coordination, administrative, and reporting requirements that are required as part of the treating doctor's case management functions.

Comment: Commenters recommend deletion of §134.204(e), as the services listed are included in Division §180.22(c) as responsibilities of the treating doctor and are normal services provided as the medical "standard of care." The "standard of care" includes treatment planning for all patients, whether preauthorization is required or not. A commenter cites statements from the preambles associated with the development and adoption of §134.202 that speak to the increase in reimbursement rates for Evaluation and Management Codes, and support this increase as treating doctors, the gatekeepers in the workers' compensation system, are most often the users of Evaluation and Management Codes. Another commenter's reason for recommending the deletion of subsection (e) is because case management services should be covered by the rule's non-surgical conversion factor. The commenter recommends that, if not deleted, the non-surgical conversion factor should be reduced to remove the costs associated with those services.

Agency Response: The Division declines to make the changes. Except for the establishment of rates where none previously were provided by rule, the provisions of this subsection are not new and the concepts were also contained

in §134.202. The doctor's responsibility for case management services are specific Evaluation and Management Codes that are delineated in the 2007 CPT Code book, and consequently they are additionally a necessary component in the workers' compensation system. The rephrasing of these provisions in this rule proposal include the establishment of reimbursement rates that are not valued by the RBRVS system (e.g., left to the individual insurance carrier's determination of a fair and reasonable reimbursement), and further describes the treating doctor's responsibilities that are intended to enhance the ability of the treating doctor to manage workers' compensation cases, and lends certainty of payment for this important function to system participants. The Division notes this is especially necessary since Medicare does not specifically address return to work initiatives. The Division further clarifies that the function of case management in the Texas workers' compensation system is to effectively coordinate care and to facilitate the injured employee's timely and productive return to work. The purpose of the Division's medical fee guidelines are to provide reimbursement for the services that are listed in the Division's §180.22. While §180.22 delineates the role and responsibilities of treating doctors as "primarily responsible for the efficient management of health care and for coordinating the health care for an injured employee's compensable injury," the rule also lists the roles and responsibilities of several other doctor functions in the Texas workers' compensation system but does not list the reimbursement

amounts for the services provided by the other doctors. Therefore, to use \$180.22 as a basis for deleting case management services and reimbursement in §134.204(e), would imply that the reimbursement for services provided by consulting, referring, required medical examination, and designated doctor functions as listed in that rule should also be deleted.

Comment: Commenter states that Labor Code §413.021(a) gives insurance carriers the option of independently determining whether or not case management is needed. The commenter states this includes the assumption of a right to contract with the case manager to pay a certain amount, and that this provision is not designed to be a contractual arrangement through the treating doctor for case management. The commenter notes that the Division's 2004 Question Resolution Log states that case management is not separately reimbursable regardless of whether the case manager is an independent contractor hired by the physician or a member of the physician's staff.

Agency Response: Labor Code at §413.021(a) provides insurance carriers with a tool to facilitate return to work initiatives, including claims management services and does not relieve the treating doctor of duties to medically manage health care provided to an injured employee. This section revision is not for the purpose of addressing the insurance carrier's claims management processes. Instead, this rule revision addresses medical case management and it is the

treating doctor's responsibility to manage the medical care. Additionally this section is a rephrasing of §134.202(e)(3) and adds reimbursements that have been set for the treating doctor's case management responsibilities and with recognition of those referral health care providers contributing to the doctor's case management activities. Subsection (e) contains workers' compensation specific services that are a necessary component in the workers' compensation system and not necessarily addressed by Medicare's payment policies. The case management language included in this section enhances the ability of the treating doctor to manage workers' compensation cases, this is especially necessary since Medicare does not specifically address return to work initiatives. The Division clarifies, as stated in §134.202(e)(3) (and now in §134.204(e)), that case management activities are only reimbursable when performed by the treating doctor and not when done by a team member. Since a contractor hired to do case management would not be the treating doctor, there is no provision for reimbursement for those services.

Comment: Commenter observes that there is no mention of preparing a treatment plan. The commenter recommends that treatment planning activities be included in case management and that a set fee be established.

Agency Response: The Division clarifies that the planning and development of treatment plans are addressed in this §134.204(3)(B), and reimbursement

amounts for case management services are listed at (4)(A)-(E). Currently the Division is working with stakeholders to develop treatment planning parameters including reimbursement amounts, which will be addressed in future treatment planning rules. Several carriers have agreed to participate in a treatment planning pilot that is currently underway. The outcome of the pilot will help the Division establish permanent treatment planning policies.

Comment: Commenters recommend added language or clarification that allows for the billing and reimbursement of both a case management activity and an initial evaluation and treatment visit, or any other services that are performed on the same day as a case management activity. The commenters assert that experience has shown that carriers uniformly bundle these services and pay only the main service. Another commenter recommends no additional reimbursement is warranted for a case manager to attend an office visit with the injured employee, as some physician's practices are to refuse to see the case manager in order to be able to work with the case manager on a different date, and be assured of payment for the doctor's role in the case management activity.

Agency Response: The Division declines to make the change. The case management activities are to be documented by the treating doctor, under the general parameters established by this section, but do not include other basic treating doctor functions, such as referring the injured employee for physical

therapy treatments and presuming to bill this as a case management activity. The inclusion of such recommended language would too easily lead to such inappropriate use of the terminology. The function of case management in the context of this section is for HCPs, especially the treating doctor, to effectively coordinate care and to facilitate the injured employee's timely and productive return to work. Under workers' compensation, case management usage is specific regarding time parameters and is limited to the development or revision of treatment plan, altering or clarifying previous instructions, coordination of care for employees with catastrophic or multiple injuries and coordinating with employer, employee and/or assigned case manager. The case management language included in this rule enhances the ability of the treating doctor to manage workers' compensation cases. This is necessary since Medicare does not specifically address return to work initiatives. The Division disagrees that further clarification is required in the rule for case management services since the rule lists CPT codes for specific case management services that are different from other service CPT codes.

§134.204(e)(2)

Comment: Commenter recommends substituted language stating team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of

"developing or substantially revising a treatment plan requested by the carrier or any treatment plans required by the Division rules. A team conference or telephone conference call may be held for the purpose of coordinating return to work for the injured employee." The commenter further reasons that treatment plans are not required or necessary for all injuries.

Agency Response: The Division declines to make the change, but agrees that treatment plans are not required or necessary for all injuries. The Division will monitor the case management activities in conjunctions with Division disability management rules to assure compliance with the intent of the statutory requirements.

§134.204(e)(4)

Comment: Commenter recommends rule language modification to require that each HCP that contributes to the case management activity submit documentation to support the services provided and billed.

Agency Response: The Division declines to make the change. The section requires the treating doctor to provide identification of HCPs that contribute to the case management activity as well as documentation listing the purpose and outcome of team conferences or phone calls, thus eliminating this burden from the referral health care providers as well. The reimbursement amount for the treating doctor's services takes into account this responsibility of providing

documentation when billing for case management services. Conversely, the lower reimbursement amount allotted to other HCPs participating in the case management activities is reflective of less responsibility in the case management activities, including not having to routinely provide documentation when billing for case management.

Comment: Commenter recommends that the Division amend this subsection to provide a modifier for the referral HCP, which will ensure consistent reimbursement for the service provided and minimize disputes related to inappropriate code-modifier combinations. The commenter notes that in Medicare, the proposed codes all have a status indicator of "B-bundled". Only the treating doctor and the referral provider would be subject to reimbursement provided documentation supports the level of service.

Agency Response: The Division declines to make the change. The section provides for the treating doctor to apply a specific modifier when billing for case management services, and the treating doctor's submitted information is meant to identify those referral HCPs who contributed to the activity. Therefore, the bills submitted by other HCPs should be easily recognizable by the carriers for the appropriate reimbursement.

§134.204(f)

Comment: Commenter requests that the Division clarify the reimbursement provisions for home health services. The commenter notes that the subsection suggests that reimbursement is either Medicaid or the contracted rate or, if there is no contracted rate, the lesser of the MAR, fair/reasonable, or usual and customary. The commenter asks how a provider would know whether Medicaid billing applies versus when billing for non-contracted rates apply, and whether it is the lesser of these two formulas if there is not a contracted rate.

Agency Response: The Division agrees that the reimbursement provisions for home health services should be clarified. The MAR for home health services provided through a licensed home health agency is 125 percent of the published Texas Medicaid fee schedule for home health agencies. Subsection (f) has been revised to clarify this.

§134.204(g)

Comment: Commenter states that the limit of three FCEs, when applied judiciously, could significantly hamper efforts to safely return injured employees to appropriate duty. The commenter requests clarification regarding the limit of three FCEs for each compensable injury, asking who this limit applies to and the statutory right to request an FCE/medical examination.

Agency Response: The Division disagrees the limit of three FCEs may hamper injured employees return to work. Pursuant to Labor Code §413.018(c), the

adopted rule recognizes that the Division may require a treating or examining doctor, on the request of the employer, insurance carrier, or Division, to provide a FCE of an injured employee. As such, subsection (g) of the rule specifies that FCEs ordered by the Division do not count toward the three FCEs allowed. This allows injured employees the opportunity to obtain these evaluations as is required by their compensable injury. The Division clarifies that three FCEs are allowed for each compensable injury, unless the FCEs are ordered by the Division. This is true whether the evaluations are performed by different health care providers or the evaluations are requested by different insurance carrier representatives. The limits on the frequency of FCEs are necessary in the provision of this service to ensure only necessary testing is provided to injured employees.

§134.204(h)

Comment: Commenter recommends language change from "should" to "...shall meet the specific program standards..." to improve the quality and outcomes of return to work rehabilitation programs.

Agency Response: The Division declines to make the change. In essence, the commenter's recommendation could eliminate many return to work rehabilitation programs that are not accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) from participating in the Texas workers'

compensation system because they may not meet every requirement of CARF specific program standards. Such a significant change from the proposed rules would require the Division to re-propose this recommendation as it would otherwise prevent other system participants from providing input. The Division believes the current language encouraging compliance with CARF standards, and the monitoring of non-CARF accredited programs that requires them to seek preauthorization approval for medical necessity, are all sufficient reasons to encourage programs to meet the highest program standards.

§134.204(i)

Comment: Commenter expresses support for addition of this subsection, stating it will ensure Division-ordered examinations are completed timely and reimbursed correctly.

Agency Response: The Division appreciates the supportive comment.

Comment: Commenter recommends the adoption of §134.204(i) without changes and supports the idea of new modifiers that are associated with the expanded duties and important role of a designated doctor. The commenter commends the Division's efforts to provide additional compensation to treating doctors for new responsibilities as a result of disability management and the adoption of treatment and return to work guidelines.

Agency Response: The Division appreciates the supportive comment.

Comment: Commenter suggests adding a new §134.204(i)(1)(G) to read: "(G) A designated doctor may be reimbursed only for those examination services performed under paragraph (1)(A)-(F) of this subsection that are specified in the Division order. Some practitioners may bill for MMI/IR when the Division's order requires only examination for 'extent of injury' under (C). The carrier should not be liable for the MMI/IR determination in this example."

Agency Response: The Division disagrees. The DWC Form-32 (Request for Designated Doctor) provides spaces to indicate the requested examinations. Designated doctors are not to do examinations other than those requested and by extension are not allowed to bill for examinations other than those requested. Improper billing would subject the designated doctor to possible sanctions under Labor Code §413.044(a) and the provisions of Chapter 415 (Administrative Violations).

§134.204(i) and (k)

Comment: Commenter provided a sampling analysis of 40 designated doctor examinations, which support a conclusion that the proposed rules reduce the overall designated doctor reimbursement fees by an average of 4.6 percent.

Agency Response: The Division appreciates the commenter's information. The commenter presented information at two different stages in the development of the reimbursement rules. In the earlier submission, the commenter, based on a sample of 51 cases, showed that the rules would increase the overall designated doctor reimbursement by an average of 0.5 percent. The second submission, based on 40 cases, showed that the overall reimbursement would be reduced by an average of 4.6 percent. The Division considers both of the differences to be within a reasonable variation from the adopted amount.

Comment: Commenter recommends reimbursements for designated doctors be at least comparable to that provided to IROs, who receive \$650 with no examination requirements.

Agency Response: The Division disagrees. Certified IROs are governed under Insurance Code Chapter 4202 and 28 TAC §12.01, et seq. Under those requirements, the IRO has mandated requirements that are not placed on the designated doctors. Those requirements contribute to administrative overheads that the designated doctors are not mandated to incur. An example of that would be the requirement that under 28 TAC §12.207 IROs have appropriate personnel reasonably available to utilization review agents by telephone at least 40 hours per week during normal business hours, in both time zones in Texas, if applicable, to discuss patients' care and allow response to telephone review

questions. Additionally, IROs are to have a telephone system capable of accepting or recording or providing instructions to incoming calls from utilization review agents during other than normal business hours and shall respond to such calls not later than two working days of the later of the date on which the call was received or the date the details necessary to respond have been received from the caller. While the \$650.00 goes to the IRO, only a portion goes to the reviewer. That amount would be determined according to the contract between the IRO and the reviewer. As was noted by the Medical Advisor, the designated doctors often work through an agent that does scheduling for them and as such do not receive the entire amount of the reimbursement for the examinations they perform. While they do that, it is done as a matter of convenience for them rather than as the result of a mandated requirement.

§134.204(i), (j) and (k)

Comment: Commenter recommends that proposed fees for designated doctor activities be increased by 30-45 percent. This recommendation is based on commenter's consultation with Livingstone-Lopez Consulting in the analysis of California's designated doctor fees, which found that Texas fees lag far behind California's.

Agency Response: The Division declines to make the requested changes and disagrees that the adopted reimbursement rates are too low based on

expectations of the designated doctor's examinations. The Division, in consultation with the Medical Advisor, determined that the fee for designated doctor activities is fair and reasonable after consideration of duties involved, including the additional duties added by HB 7. While the commenter indicated that the recommendation was made based on an analysis of California's designated doctor fees, the commenter did not provide the Division with the basis for its recommendations or the basis of California's rates. Absent more information that would allow for a detailed comparison, the Division will rely on its understanding of the Texas designated doctor information.

§134.204(j)(1) and (2)

Comment: Commenter recommends that reimbursements overall for MMI and IR examinations be raised based on Consumer Price Index (CPI) adjustments, and observes that since 1996 the reimbursements have remained unchanged, and have steadily declined by 24.8 percent based on the CPI.

Agency Response: The Division disagrees that reimbursements for MMI/IR examinations should be increased. The adoption of §134.202, Medical Fee Guideline, in 2002 changed the reimbursement structure to allow for a net increase in reimbursements for MMI/IR examinations. The CPI is not a cost-of-living index. It is a measure of the average change over time in the prices paid by urban consumers for a market basket of consumer goods and services. The

CPI market basket is general and varied. It includes “medical care,” but also includes, for example, “food and beverages,” “housing,” and “transportation.”

MMI/IR examinations are a very unique service specific to workers' compensation. Increasing MMI/IR reimbursement by the CPI would not be a viable option in observing statutory mandates of controlling medical costs.

§134.204(j)(3)

Comment: Commenter asks if reimbursement for an MMI evaluation is the same reimbursement as the applicable office visit if a modifier V1, V2, V3, V4 or V5 is used in addition to the established patient office visit level.

Agency Response: The Division clarifies that both the appropriate established office visit level and the appropriate modifier that corresponds with the last digit of the applicable office visit are appropriate for determining the reimbursement “for an MMI evaluation performed by the treating doctor. Reimbursement for an MMI evaluation performed by the treating doctor should be equal to the reimbursement of the applicable established patient office visit level associated with the examination.” The Division also notes the rule provides for additional reimbursement if an IR is performed as well.

§134.204(j)(4)(C)

Comment: Commenter recommends substitute language that it asserts will improve upon current language that has caused confusion among health care providers as to what they may or may not bill for: "(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used to render the impairment rating. (ii) If the range of motion model is used to render impairment rating: (a) \$300 for the first musculoskeletal body area; and (b) \$150 for each additional musculoskeletal body area."

Agency Response: The Division disagrees with the recommendation. The recommended substitute language deletes the subsection which defines the musculoskeletal body areas that may be billed and reimbursed for an IR. The definition of a musculoskeletal body area is very important in determining overall IR reimbursement and its deletion would result in confusion and an increase in medical disputes.

§134.204(j)(4)(D)

Comment: Commenter supports the continued reimbursement of specialty testing, including psychological testing, at the MFG rate for the services provided. This section maintains a fair reimbursement approach when testing is done for

clinical purposes, and allows the examining doctor to refer out for specialty evaluation as required or recommended by AMA Guides and Division rules.

Agency Response: The Division appreciates the supportive comment.

§134.204(k)

Comment: Commenter asks if treating and/or designated doctors are to use both modifiers "RE" and "W8" when performing RTW evaluations.

Agency Response: The Division clarifies that use of both modifiers by a designated doctor is accurate, but a treating doctor is not to use modifier "W8," as it is only to be used by a designated doctor when determining the ability of an employee to return to work. Subsection (b) of this section addresses modifiers and states when two or more modifiers are applicable to a single HCPCS code, indicate each modifier on the bill.

Comment: Commenter recommends additional reimbursement for designated doctors who are required to submit letters of clarification for the work performed, and cites such requests occurring on 20-50 percent of cases.

Agency Response: The Division declines to make the requested changes. The reimbursement structure for MMI examinations is one which provides one reimbursement amount for almost all MMI evaluations. The established

reimbursement is intended to compensate for the instances where a doctor is required to provide further clarification on a certification.

Comment: Commenter states that designated doctor reimbursements are too low due to the added responsibilities and expectations for potentially referencing MDA, ODG , AMA Guides, etc. The commenter recommends a fee schedule of \$500 per seven noted designated doctor responsibilities and areas to evaluate as follows: (1) impairment rating, all body parts included, only if calculated; (2) maximum medical improvement, whether at MMI or not at MMI; (3) return to work; (4) extent of injury; (5) duration of disability; (6) SIBS question; and (7) other. Alternatively, the commenter recommends a cap of \$2000 maximum on any single date of examination. The commenter also suggests that additional required testing be billed separately according to CPT code.

Agency Response: The Division disagrees that reimbursement rates are too low based on expectations of the designated doctor's examinations, and declines to make the requested changes. The reimbursement structure for MMI examinations is one which provides one reimbursement amount for almost all MMI evaluations. All MMI/IR determinations (except those performed by treating doctors or referral doctors who have previously been treating the injured employee) maintain a basic reimbursement of \$350. Subsection (j) of this section maintains the provision that when performing an IR evaluation, body

areas are reimbursed as well, and also maintains an additional reimbursement of \$50 for each additional IR calculation when multiple IRs are required as a component of a designated doctor examination.

In establishing the prorated payment method for the four remaining examinations that could also be requested of a designated doctor, the Division, in consultation with the Medical Advisor, determined that the requirements of a designated doctor to perform multiple examinations and be paid accordingly has merit. Subsections (i) and (k) of this section are designed to note and address these newer designated doctor responsibilities, to raise the overall reimbursement rate for these other examinations, and to establish a cap with a prorated payment method for the four remaining examinations that could also be requested of the designated doctor. The increase from \$350 (reimbursement rate allowed by §134.202) to \$500 for an examination is appropriate and commensurate with the increase in designated doctor examination responsibilities as required by HB 7 and changes to the Labor Code at §408.0041.

Comment: Commenters recommend that return to work (RTW) and extent of medical care (EMC) examinations should not be reimbursed at 100 percent if there are other concurrent examinations taking place and that there is no separate examination that is needed in order to address the RTW and EMC

issue. Additionally, the commenters suggest that no RTW or EMC exam can be used for the purpose of certifying MMI."

Agency Response: The Division agrees with the commenter that RTW and EMC examinations should not be reimbursed at 100 percent if there are other concurrent examinations taking place and there are no separate examinations needed in order to address the RTW and EMC issues. Section 413.204(i)(2) addresses the issue of payments where there are concurrent examinations including RTW and EMC examinations. The only time an RTW or EMC examination would be reimbursed at 100 percent would be if the examination was the only one of the examinations listed under §413.204(i)(1)(C)-(F) performed under the Division order. If both RTW and EMC examinations were done concurrently, only the first would be reimbursed at 100 percent under (i)(2)(A) and the second would be reimbursed at 50 percent under (i)(2)(B).

Comment: Commenter requests clarification of methodology used for increase from \$350 to \$500. The commenter states that a carrier should not be liable for the MMI/IR determination when practitioners bill for MMI/IR if the Division's order requires only examination for "extent of injury" under (C).

Agency Response: The Division agrees that a carrier should not be liable for an MMI/IR determination when the Division order requires only an examination for "extent of injury" and current practice conforms to that understanding. The DWC

Form-32 (Request for Designated Doctor) provides spaces to indicate the requested examinations. Designated doctors are not to do examinations other than those requested and by extension are not allowed to bill for examinations other than those requested. In the case presented, the designated doctor would not be allowed to bill for any examination other than one for "extent of injury."

§134.204(I)

Comment: Commenter states that the proposal makes no mention of reimbursement for TDI required reports (specifically the DWC Form-73, Work Status Report), and further recommends that reimbursement, which historically has been \$15, be increased to \$20, and recommends this section, or another Division rule, reference this. Another commenter recommends the Division mandate a specific reimbursement amount for required reports such as the DWC Form-73, and further recommend a section in the rules that address payment for required forms that are clearly functions separate and apart from the care of patients, but necessary for all parties to have knowledge of patients' status. The commenters observe that carriers often deny these payments because the rules are unclear and not enforced.

Agency Response: The Division disagrees with the first commenter's statement, noting that the Work Statutes Report referenced by the commenter is mentioned in the rule at §134.204(I). As noted in §134.204(I), a provider billing for a Work

Status Report that is not conducted as part of the examinations outlined in §134.204(i) or (j) should refer to Division rule §129.5. Because billing for a Work Status Report that is not conducted as part of the examinations outlined in §134.204(i) or (j) is controlled by Division rule §129.5, it would be inappropriate to set different regulations in §134.204.

The commenters do not specify what other forms should have fees set in a new section. However, addition of a new section would be a substantive change requiring a rule proposal prior to adoption, thus would be inappropriate in this adoption order. If commenters believe additional rule sections are necessary to provide fee guidelines for required reports, they are encouraged to notify the Division of specific reports that should be addressed by a new section.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE PROPOSAL

For: Individuals; Empi, Inc.; Midtown Orthopaedics & Sports Medicine, P.A.; North Texas SpineCare; Orthopaedic Specialists of Austin; ReAble Therapeutics, Inc.; Restora Austin Plastic Surgery Centre; Texas Sports Medicine; and Waco Bone & Joint Clinic.

For, with changes: Individuals; Advanced Sports Medicine and Orthopaedics, American Insurance Association, Arlington Orthopedic Associates, P.A.; Cen-Tex Billing and Professional Services; Churchill Evaluation Centers; Coastal Bend

Neurology; Concentra, Inc.; Corridor Medical Clinic; DeTar MedWorks; Glen Lakes Orthopaedic Clinic; Health at Work; Industrial & Family Practice Clinic; Insurance Council of Texas; KSF Orthopedic Associates; Medtronic, Inc.; MES Solutions, Inc.; Mid Valley Physicians Association; Mission Orthopaedics, P.A.; Occupational Orthopaedics Specialists; Office of Injured Employee Counsel; Orthopedic Associates of Corpus Christi; Orthopaedic Center of Mesquite; Progressive Medical, Inc.; Property Casualty Insurers Association of America; the San Antonio Orthopedic Group; SKS Plastic Surgery, P.A.; South Texas Radiology Group, P.A.; Southwest Orthopaedic Group; State Office of Risk Management; Texas Association of Neurological Surgeons; Texas Association of Business; Texas Association of School Boards; Texas Medical Association; Texas MedClinic; Texas Mutual Insurance Company; Texas Neurological Society; Texas Orthopaedic Association; Texas Osteopathic Medical Association; Texas Pain Society; Texas Physical Medicine and Rehabilitation Society; Texas Society of Anesthesiologists; Texas Spine Society; and the Hand and Upper Extremity Institute of South Texas.

Against: Individuals, Angelica Plastic Surgery, the Boeing Company, and Restora Austin Plastic Surgery Centre.

Neither For or Against: Individuals; Advanced Orthopaedics & Sports Medicine; Azalea Orthopedics; Bronson Clinic; Healthesystems; North Texas SpineCare; and Tejas Anesthesia, P.A.

6. STATUTORY AUTHORITY. The amended rule and new rules are adopted under the Labor Code §§408.021, 413.002, 413.007, 413.011, 413.012, 413.0511, 408.0252, 413.013, 413.014, 413.015, 413.016, 413.017, 413.019, 413.031; 402.0111, and 402.061. Section 408.021 entitles an injured employee who sustains a compensable injury to all health care reasonably required by the nature of the injury as and when needed. Section 413.002 requires the Division to monitor health care providers, insurance carriers and claimants to ensure compliance with rules adopted by the Commissioner of workers' compensation, including fee guidelines. Section 413.007 sets out information to be maintained by the Division for use by the Commissioner and the Division in adopting medical policies, fee guidelines, and rules. Section 413.011 mandates that the Division, by rule, establish medical policies and guidelines. Section 413.012 requires the Division to review and revise the medical policies and fee guidelines at least every two years to reflect fair and reasonable fees. Section 413.0511 requires the Medical Advisor to make recommendations regarding the adoption of rules and policies to develop, maintain, and review guidelines as provided by §413.011. Section 408.0252 allows the Commissioner of workers' compensation to identify areas of the state in which access to health care provides is less available and adopt appropriate standards, guidelines, and rules regarding the delivery of health care in those areas. Section 413.013 requires the Division by

rule to establish programs related to health care treatments and services for dispute resolution, monitoring, and review. Section 413.014 requires preauthorization by the insurance carrier for specified health care treatments and services. Section 413.015 requires insurance carriers to pay charges for medical services as provided in the statute and requires that the Division ensure compliance with the medical policies and fee guidelines through audit and review. Section 413.016 provides for refund of payments made in violation of the medical policies and fee guidelines. Section 413.017 provides a presumption of reasonableness for medical services fees that are consistent with the medical policies and fee guidelines. Section 413.019 provides for payment of interest on delayed payments refunds or overpayments. Section 413.031 provides for procedures for medical dispute resolution. Section 402.00111 provides that the Commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code and other laws of this state. Section 402.061 provides that the commissioner of workers' compensation has the authority to adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

7. TEXT.

Subchapter A. Medical Reimbursement Policies

§134.1. Medical Reimbursement.

(a) "Maximum allowable reimbursement" (MAR), when used in this chapter, is defined as the maximum amount payable to a health care provider in the absence of a contractual fee arrangement that is consistent with §413.011 of the Labor Code, and Division rules.

(b) Medical reimbursement for health care services provided to injured employees subject to a workers' compensation health care network established under Insurance Code Chapter 1305 shall be made in accordance with the provisions of Insurance Code Chapter 1305, except as provided in subsections (c) and (d) of this section.

(c) Examinations conducted pursuant to Labor Code §§408.004, 408.0041, and 408.151 shall be reimbursed in accordance with §134.204 of this chapter (relating to Medical Fee Guideline for Workers' Compensation Specific Services).

(d) Examinations conducted pursuant to Labor Code §408.0042 shall be reimbursed in accordance with §126.14 of this title (relating to Treating Doctor Examination to Define the Compensable Injury).

(e) Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with:

(1) the Division's fee guidelines;

(2) a negotiated contract; or

(3) in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section.

(f) Fair and reasonable reimbursement shall:

(1) be consistent with the criteria of Labor Code §413.011;

(2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and

(3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.

(g) The insurance carrier shall consistently apply fair and reasonable reimbursement amounts and maintain, in reproducible format, documentation of the insurance carrier's methodology(ies) establishing fair and reasonable reimbursement amounts. Upon request of the Division, an insurance carrier shall provide copies of such documentation.

§134.2. Incentive Payments for Workers' Compensation Underserved Areas.

(a) When required by Division rule, an incentive payment shall be added to the maximum allowable reimbursement (MAR) for services performed in a designated workers' compensation underserved area.

(b) The following list of ZIP Codes comprise the Division designated workers' compensation underserved areas: 75134, 75135, 75161, 75181, 75212, 75410, 75558, 75603, 75630, 75650, 75653, 75654, 75658, 75660, 75663, 75666, 75667, 75672, 75687, 75692, 75704, 75750, 75752, 75763, 75789, 75849, 75915, 75933, 75949, 75964, 75969, 75973, 75980, 76023, 76055, 76060, 76066, 76088, 76119, 76226, 76239, 76247, 76271, 76380, 76443, 76534, 76621, 76640, 76657, 76682, 76711, 76932, 76935, 77033, 77050, 77053, 77078, 77336, 77354, 77363, 77389, 77396, 77466, 77496, 77517, 77561, 77632, 77808, 77905, 77968, 78025, 78123, 78132, 78140, 78141, 78210, 78220, 78239, 78242, 78333, 78335, 78343, 78368, 78370, 78383, 78407, 78535, 78574, 78583, 78590, 78605, 78640, 78669, 78802, 78830, 78836, 78877, 78884, 78935, 78960, 79010, 79107, 79108, 79114, 79118, 79311, 79367, 79408, 79411, 79511, 79521, 79536, 79561, 79563, 79778, 79782, 79836, 79838, 79849, 79901, 79922, 79934.

* The amended rule and new rules are adopted under the Labor Code §§408.021, 413.002, 413.007, 413.011, 413.012, 413.0511, 408.0252, 413.013, 413.014, 413.015, 413.016, 413.017, 413.019, 413.031; 402.0111, and 402.061. Section 408.021 entitles an injured employee who sustains a compensable injury to all health care reasonably required by the nature of the injury as and when needed. Section 413.002 requires the Division to monitor health care providers, insurance carriers and claimants to ensure compliance with rules adopted by the

Commissioner of workers' compensation, including fee guidelines. Section 413.007 sets out information to be maintained by the Division for use by the Commissioner and the Division in adopting medical policies, fee guidelines, and rules. Section 413.011 mandates that the Division, by rule, establish medical policies and guidelines. Section 413.012 requires the Division to review and revise the medical policies and fee guidelines at least every two years to reflect fair and reasonable fees. Section 413.0511 requires the Medical Advisor to make recommendations regarding the adoption of rules and policies to develop, maintain, and review guidelines as provided by §413.011. Section 408.0252 allows the Commissioner of workers' compensation to identify areas of the state in which access to health care provides is less available and adopt appropriate standards, guidelines, and rules regarding the delivery of health care in those areas. Section 413.013 requires the Division by rule to establish programs related to health care treatments and services for dispute resolution, monitoring, and review. Section 413.014 requires preauthorization by the insurance carrier for specified health care treatments and services. Section 413.015 requires insurance carriers to pay charges for medical services as provided in the statute and requires that the Division ensure compliance with the medical policies and fee guidelines through audit and review. Section 413.016 provides for refund of payments made in violation of the medical policies and fee guidelines. Section 413.017 provides a presumption of reasonableness for medical services fees that

are consistent with the medical policies and fee guidelines. Section 413.019 provides for payment of interest on delayed payments refunds or overpayments. Section 413.031 provides for procedures for medical dispute resolution. Section 402.00111 provides that the Commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code and other laws of this state. Section 402.061 provides that the commissioner of workers' compensation has the authority to adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

Subchapter C. Medical Fee Guidelines

§134.203. Medical Fee Guideline for Professional Services.

(a) Applicability of this rule is as follows:

(1) This section applies to professional medical services provided in the Texas workers' compensation system, other than:

(A) workers' compensation specific codes, services, and programs described in §134.204 of this title (relating to Medical Fee Guideline for Workers' Compensation Specific Services);

(B) prescription drugs or medicine;

(C) dental services;

(D) the facility services of a hospital or other health care facility; and

(E) medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in Insurance Code Chapter 1305.

(2) This section applies to professional medical services provided on or after March 1, 2008.

(3) For professional services provided between August 1, 2003 and March 1, 2008, §134.202 of this title (relating to Medical Fee Guideline) applies.

(4) For professional services provided prior to August 1, 2003, §134.201 of this title (relating to Medical Fee Guideline for Medical Treatments and Services Provided under the Texas Workers' Compensation Act) and §134.302 of this title (relating to Dental Fee Guideline) apply.

(5) "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.

(6) Notwithstanding Medicare payment policies, chiropractors may be reimbursed for services provided within the scope of their practice act.

(7) Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision

adopted or utilized by CMS in administering the Medicare program. Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.

(8) Whenever a component of the Medicare program is revised, use of the revised component shall be required for compliance with Division rules, decisions, and orders for professional services rendered on or after the effective date, or after the effective date or the adoption date of the revised component, whichever is later.

(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:

(1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

(2) A 10 percent incentive payment shall be added to the maximum allowable reimbursement (MAR) for services outlined in subsections (c) – (f) and

(h) of this section that are performed in designated workers' compensation underserved areas in accordance with §134.2 of this title (relating to Incentive Payments for Workers' Compensation Underserved Areas).

(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007.

(d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:

(1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;

(2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or

(3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.

(e) The MAR for pathology and laboratory services not addressed in subsection (c)(1) of this section or in other Division rules shall be determined as follows:

(1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and,

(2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service.

(f) For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or

§134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).

(g) When there is a negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the negotiated or contracted amount that applies to the billed services.

(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the:

- (1) MAR amount;
- (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or
- (3) fair and reasonable amount consistent with the standards of §134.1 of this title.

(i) Health care providers (HCPs) shall bill their usual and customary charges using the most current Level I (CPT codes) and Level II HCPCS codes. HCPs shall submit medical bills in accordance with the Labor Code and Division rules.

(j) Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS codes. Division-specific modifiers are identified and shall be applied in accordance with §134.204(n) of this title (relating to Medical Fee Guideline for

Workers' Compensation Specific Services). When two or more modifiers are applicable to a single CPT code, indicate each modifier on the bill.

§134.204. Medical Fee Guideline for Workers' Compensation Specific Services.

(a) Applicability of this rule is as follows:

(1) This section applies to workers' compensation specific codes, services and programs provided in the Texas workers' compensation system, other than:

(A) professional medical services described in §134.203 of this title (relating to Medical Fee Guideline for Professional Services);

(B) prescription drugs or medicine;

(C) dental services;

(D) the facility services of a hospital or other health care facility; and

(E) medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in §134.1 of this title and Insurance Code Chapter 1305.

(2) This section applies to workers' compensation specific codes, services and programs provided on or after March 1, 2008.

(3) For workers' compensation specific codes, services and programs provided between August 1, 2003 and March 1, 2008, §134.202 of this title (relating to Medical Fee Guideline) applies.

(4) For workers' compensation specific codes, services and programs provided prior to August 1, 2003, §134.201 of this title (relating to Medical Fee Guideline for Medical Treatments and Services Provided under the Texas Workers' Compensation Act) and §134.302 of this title (relating to Dental Fee Guideline) apply.

(5) Specific provisions contained in the Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program. Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.

(b) Payment Policies Relating to coding, billing, and reporting for workers' compensation specific codes, services, and programs are as follows:

(1) Billing. Health care providers (HCPs) shall bill their usual and customary charges using the most current Level I (CPT codes) and Level II

Healthcare Common Procedure Coding System (HCPCS) codes. HCPs shall submit medical bills in accordance with the Labor Code and Division rules.

(2) Modifiers. Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS codes. Where HCPCS modifiers apply, carriers shall treat them in accordance with Medicare and Texas Medicaid rules. Additionally, Division-specific modifiers are identified in subsection (n) of this section. When two or more modifiers are applicable to a single HCPCS code, indicate each modifier on the bill.

(3) Incentive Payments. A 10 percent incentive payment shall be added to the maximum allowable reimbursement (MAR) for services outlined in subsections (d), (e), (g), (i), (j), and (k) of this section that are performed in designated workers' compensation underserved areas in accordance with §134.2 of this title (relating to Incentive Payments for Workers' Compensation Underserved Areas).

(c) When there is a negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the negotiated or contracted amount that applies to the billed services.

(d) When there is no negotiated or contracted amount that complies with §413.011 of the Labor Code, reimbursement shall be the least of the:

(1) MAR amount;

(2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or

(3) fair and reasonable amount consistent with the standards of §134.1 of this title (relating to Medical Reimbursement).

(e) Case Management Responsibilities by the Treating Doctor is as follows:

(1) Team conferences and telephone calls shall include coordination with an interdisciplinary team.

(A) Team members shall not be employees of the treating doctor.

(B) Team conferences and telephone calls must be outside of an interdisciplinary program. Documentation shall include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in a phone call.

(2) Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee.

(3) Contact with one or more members of the interdisciplinary team more often than once every 30 days shall be limited to the following:

(A) coordinating with the employer, employee, or an assigned medical or vocational case manager to determine return to work options;

(B) developing or revising a treatment plan, including any treatment plans required by Division rules;

(C) altering or clarifying previous instructions; or

(D) coordinating the care of employees with catastrophic or multiple injuries requiring multiple specialties.

(4) Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows:

(A) CPT Code 99361.

(i) Reimbursement to the treating doctor shall be \$113. Modifier "W1" shall be added.

(ii) Reimbursement to the referral HCP shall be \$28 when a HCP contributes to the case management activity.

(B) CPT Code 99362.

(i) Reimbursement to the treating doctor shall be \$198. Modifier "W1" shall be added.

(ii) Reimbursement to the referral HCP shall be \$50

when a HCP contributes to the case management activity.

(C) CPT Code 99371.

(i) Reimbursement to the treating doctor shall be \$18.

Modifier "W1" shall be added.

(ii) Reimbursement to a referral HCP contributing to this case management activity shall be \$5.

(D) CPT Code 99372.

(i) Reimbursement to the treating doctor shall be \$46.

Modifier "W1" shall be added.

(ii) Reimbursement to the referral HCP contributing to this case management activity shall be \$12.

(E) CPT Code 99373.

(i) Reimbursement to the treating doctor shall be \$90.

Modifier "W1" shall be added.

(ii) Reimbursement to the referral HCP contributing to this case management action shall be \$23.

(f) To determine the MAR amount for home health services provided through a licensed home health agency, the MAR shall be 125 percent of the published Texas Medicaid fee schedule for home health agencies.

(g) The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. FCEs shall include the following elements:

(1) A physical examination and neurological evaluation, which include the following:

- (A) appearance (observational and palpation);
- (B) flexibility of the extremity joint or spinal region (usually observational);
- (C) posture and deformities;
- (D) vascular integrity;
- (E) neurological tests to detect sensory deficit;
- (F) myotomal strength to detect gross motor deficit; and
- (G) reflexes to detect neurological reflex symmetry.

(2) A physical capacity evaluation of the injured area, which includes the following:

(A) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and

(B) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative database. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes.

(3) Functional abilities tests, which include the following:

(A) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);

(B) hand function tests that measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices;

(C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and

(D) static positional tolerance (observational determination of tolerance for sitting or standing).

(h) The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General

Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier.

(1) Accreditation by the CARF is recommended, but not required.

(A) If the program is CARF accredited, modifier “CA” shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR.

(B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR.

(2) For Division purposes, General Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Conditioning.

(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier “WC.” Each

additional hour shall be billed using CPT Code 97546 with modifier “WC.” CARF accredited Programs shall add “CA” as a second modifier.

(B) Reimbursement shall be \$36 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

(3) For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.

(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier “WH.” Each additional hour shall be billed using CPT Code 97546 with modifier “WH.” CARF accredited Programs shall add “CA” as a second modifier.

(B) Reimbursement shall be \$64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes.

(4) The following shall be applied for billing and reimbursement of Outpatient Medical Rehabilitation Programs.

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier “MR” for each hour. The number of hours shall be indicated

in the units column on the bill. CARF accredited Programs shall add “CA” as a second modifier.

(B) Reimbursement shall be \$90 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

(5) The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs.

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier “CP” for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add “CA” as a second modifier.

(B) Reimbursement shall be \$125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.

(i) The following shall apply to Designated Doctor Examinations.

(1) Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and shall be billed and reimbursed as follows:

(A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier “W5” is the first modifier to be applied when performed by a designated doctor;

(B) Attainment of maximum medical improvement shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier “W5” is the first modifier to be applied when performed by a designated doctor;

(C) Extent of the employee’s compensable injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier “W6;”

(D) Whether the injured employee’s disability is a direct result of the work-related injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier “W7;”

(E) Ability of the employee to return to work shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier “W8”; and

(F) Issues similar to those described in subparagraphs (A) - (E) of this paragraph shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier “W9.”

(2) When multiple examinations under the same specific Division order are performed concurrently under paragraph (1)(C) - (F) of this subsection:

(A) the first examination shall be reimbursed at 100 percent of the set fee outlined in subsection (k) of this section;

(B) the second examination shall be reimbursed at 50 percent of the set fee outlined in subsection (k) of this section; and

(C) subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in subsection (k) of this section.

(j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:

(1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include:

(A) the examination;

(B) consultation with the injured employee;

(C) review of the records and films;

(D) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and,

(E) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in

the Act and Division rules in Chapter 130 of this title (relating to Impairment and Supplemental Income Benefits).

(2) An HCP shall only bill and be reimbursed for an MMI/IR examination if the doctor performing the evaluation (i.e., the examining doctor) is an authorized doctor in accordance with the Act and Division rules in Chapter 130 of this title.

(A) If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier “NM” shall be added.

(B) If the examining doctor determines MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not warranted and only the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection.

(C) If the examining doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed in accordance with paragraphs (3) and (4) of this subsection.

(3) The following applies for billing and reimbursement of an MMI evaluation.

(A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier.

(i) Reimbursement shall be the applicable established patient office visit level associated with the examination.

(ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit.

(B) If the treating doctor refers the injured employee to another doctor for the examination and certification of MMI (and IR); and, the referral examining doctor has:

(i) previously been treating the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(A) of this subsection; or,

(ii) not previously treated the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(C) of this subsection.

(C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350.

(4) The following applies for billing and reimbursement of an IR evaluation.

(A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form.

(B) When multiple IRs are required as a component of a designated doctor examination under §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings), the designated doctor shall bill for the number of body areas rated and be reimbursed \$50 for each additional IR calculation. Modifier “MI” shall be added to the MMI evaluation CPT code.

(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.

(i) Musculoskeletal body areas are defined as follows:

(I) spine and pelvis;

(II) upper extremities and hands; and,

(III) lower extremities (including feet).

(ii) The MAR for musculoskeletal body areas shall be as follows.

(I) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.

(II) If full physical evaluation, with range of motion, is performed:

(-a-) \$300 for the first musculoskeletal body area; and

(-b-) \$150 for each additional musculoskeletal body area.

(iii) If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier "WP." Reimbursement shall be 100 percent of the total MAR.

(iv) If, in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment), the examining doctor performs the MMI examination and assigns the IR, but does not perform the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the examining doctor shall bill using the appropriate MMI CPT code with CPT modifier "26." Reimbursement shall be 80 percent of the total MAR.

(v) If a HCP, other than the examining doctor, performs the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the HCP shall bill using the appropriate MMI CPT code with

modifier "TC." In accordance with §130.1 of this title, the HCP must be certified.

Reimbursement shall be 20 percent of the total MAR.

(D) Non-musculoskeletal body areas shall be billed and reimbursed using the appropriate CPT code(s) for the test(s) required for the assignment of IR.

(i) Non-musculoskeletal body areas are defined as follows:

(I) body systems;

(II) body structures (including skin); and,

(III) mental and behavioral disorders.

(ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides.

(iii) When the examining doctor refers testing for non-musculoskeletal body area(s) to a specialist, then the following shall apply:

(I) The examining doctor (e.g., the referring doctor) shall bill using the appropriate MMI CPT code with modifier "SP" and indicate one unit in the units column of the billing form. Reimbursement shall be \$50 for incorporating one or more specialists' report(s) information into the final assignment of IR. This reimbursement shall be allowed only once per examination.

(II) The referral specialist shall bill and be reimbursed for the appropriate CPT code(s) for the tests required for the assignment of IR. Documentation is required.

(iv) When there is no test to determine an IR for a non-musculoskeletal condition:

(I) The IR is based on the charts in the AMA Guides. These charts generally show a category of impairment and a range of percentage ratings that fall within that category.

(II) The impairment rating doctor must determine and assign a finite whole percentage number rating from the range of percentage ratings.

(III) Use of these charts to assign an IR is equivalent to assigning an IR by the DRE method as referenced in subparagraph (C)(ii)(I) of this paragraph.

(v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be \$150.

(5) If the examination for the determination of MMI and/or the assignment of IR requires testing that is not outlined in the AMA Guides, the appropriate CPT code(s) shall be billed and reimbursed in addition to the fees outlined in paragraphs (3) and (4) of this subsection.

(6) The treating doctor is required to review the certification of MMI and assignment of IR performed by another doctor, as stated in the Act and Division Rules, Chapter 130 of this title. The treating doctor shall bill using CPT Code 99455 with modifier "VR" to indicate a review of the report only, and shall be reimbursed \$50.

(k) The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be \$500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.

(l) The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports).

(m) The following shall apply to Treating Doctor Examination to Define the Compensable Injury. When billing for this type of examination, refer to §126.14 of this title (relating to Treating Doctor Examination to Define Compensable Injury).

(n) The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes.

(1) CA, Commission on Accreditation of Rehabilitation Facilities (CARF) Accredited programs - This modifier shall be used when a HCP bills for a Return To Work Rehabilitation Program that is CARF accredited.

(2) CP, Chronic Pain Management Program - This modifier shall be added to CPT Code 97799 to indicate Chronic Pain Management Program services were performed.

(3) FC, Functional Capacity - This modifier shall be added to CPT Code 97750 when a functional capacity evaluation is performed.

(4) MR, Outpatient Medical Rehabilitation Program - This modifier shall be added to CPT Code 97799 to indicate Outpatient Medical Rehabilitation Program services were performed.

(5) MI, Multiple Impairment Ratings – This modifier shall be added to CPT Code 99455 when the designated doctor is required to complete multiple impairment ratings calculations.

(6) NM, Not at Maximum Medical Improvement (MMI) - This modifier shall be added to the appropriate MMI CPT code to indicate that the injured employee has not reached MMI when the purpose of the examination was to determine MMI.

(7) RE, Return to Work (RTW) and/or Evaluation of Medical Care (EMC) - This modifier shall be added to CPT Code 99456 when a RTW or EMC examination is performed.

(8) SP, Specialty Area - This modifier shall be added to the appropriate MMI CPT code when a specialty area is incorporated into the MMI report.

(9) TC, Technical Component - This modifier shall be added to the CPT code when the technical component of a procedure is billed separately.

(10) VR, Review report - This modifier shall be added to CPT Code 99455 to indicate that the service was the treating doctor's review of report(s) only.

(11) V1, Level of MMI for Treating Doctor - This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to a "minimal" level.

(12) V2, Level of MMI for Treating Doctor - This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to "self limited or minor" level.

(13) V3, Level of MMI for Treating Doctor - This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to "low to moderate" level.

(14) V4, Level of MMI for Treating Doctor - This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to “moderate to high severity” level and of at least 25 minutes duration.

(15) V5, Level of MMI for Treating Doctor - This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to “moderate to high severity” level and of at least 45 minutes duration.

(16) WC, Work Conditioning - This modifier shall be added to CPT Code 97545 to indicate work conditioning was performed.

(17) WH, Work Hardening - This modifier shall be added to CPT Code 97545 to indicate work hardening was performed.

(18) WP, Whole Procedure - This modifier shall be added to the CPT code when both the professional and technical components of a procedure are performed by a single HCP.

(19) W1, Case Management for Treating Doctor - This modifier shall be added to the appropriate case management billing code activities when performed by the treating doctor.

(20) W5, Designated Doctor Examination for Impairment or Attainment of Maximum Medical Improvement – This modifier shall be added to the appropriate examination code performed by a designated doctor when determining impairment caused by the compensable injury and in attainment of maximum medical improvement.

(21) W6, Designated Doctor Examination for Extent - This modifier shall be added to the appropriate examination code performed by a designated doctor when determining extent of the employee's compensable injury.

(22) W7, Designated Doctor Examination for Disability - This modifier shall be added to the appropriate examination code performed by a designated doctor when determining whether the injured employee's disability is a direct result of the work-related injury.

(23) W8, Designated Doctor Examination for Return to Work - This modifier shall be added to the appropriate examination code performed by a designated doctor when determining the ability of employee to return to work.

(24) W9, Designated Doctor Examination for Other Similar Issues - This modifier shall be added to the appropriate examination code performed by a designated doctor when determining other similar issues.

8. CERTIFICATION. This agency certifies that the adopted sections have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on _____, 2007.

Norma Garcia
General Counsel
Texas Department of Insurance,
Division of Workers' Compensation

IT IS THEREFORE THE ORDER of the Commissioner of Workers' Compensation that the amendments to §134.1 and the new §§134.2, 134.203, and 134.204 specified herein, concerning medical fee guidelines, are adopted.

AND IT IS SO ORDERED.

ALBERT BETTS
COMMISSIONER OF WORKERS' COMPENSATION
TEXAS DEPARTMENT OF INSURANCE

ATTEST:

Norma Garcia
General Counsel

COMMISSIONER'S ORDER NO. _____