



## Texas Department of Insurance

### Division of Workers' Compensation

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## New Medical Fee Guidelines FAQs

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**1. What is Medicare's conversion factor for calendar year 2008?**

The Medicare conversion factor for the months of January through June 2008 is \$38.0870.

**2. What conversion factors are applicable under the Medical Fee Guideline?**

Rule 134.202 is applicable for dates of service through February 29, 2008. Rule 134.202 applies a 125% or 1.25 multiplier to the current Medicare conversion factor, which means that the Medicare conversion factor of \$38.0870 is to be multiplied by 1.25 to derive the Division's maximum allowable reimbursement (MAR) amount.

Beginning March 1, 2008 new §134.203 and §134.204 are the applicable Medical Fee Guideline rules. The conversion factor to be applied for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting is \$52.83. For Surgery performed in a facility setting (e.g., ambulatory surgical center or hospital surgery department), the established conversion factor to be applied is \$66.32. Please note that these new rules use specific conversion factors to derive the Division's MAR, rather than a percentage of the Medicare conversion factor to arrive at the MAR.

**3. With the new MFG rules there is no longer a multiplier of Medicare, so how can we determine what the MAR amount is without having the percentage of Medicare's reimbursement?**

Both the Centers for Medicare and Medicaid Services (CMS) ([www.cms.hhs.gov](http://www.cms.hhs.gov)) and the Texas Medicare Contract Administrator, TrailBlazer Health Enterprises ([www.trailblazerhealth.com](http://www.trailblazerhealth.com)), provide detailed Medicare reimbursement information that is free of charge. The following are the basic steps in calculating the MAR amount, and much of the information in these steps is available at these two websites:

Step 1. (A) - Multiply the work value by the geographic practice cost index (GPCI) work value = geographically adjusted work value.

Step 2. (B) - Multiply the Practice Expense (PE) by the GPCI PE = geographically adjusted PE value

Step 3. (C) – Multiply the Malpractice Expense (MP) by the GPCI MP = geographically adjusted MP value.

Step 4. (D) – Add the three geographically adjusted values (A) + (B) + (C) = total RVUs.

Step 5. MAR – Multiply the total RVU (D) by the Division Conversion Factor (\$52.83) or (\$66.32 for surgery when performed in a facility setting).

**4. How will I know when the Medicare Economic Index (MEI) changes and what Division conversion factor to use?**

The Division adopted, as part of §134.203, a provision that will automatically update the conversion factor each year based on the MEI. The MEI annual percentage adjustment is published early each November in the *Federal Register* as a part of the Medicare Physician Fee Schedule update. The Division will monitor the resulting annual percentage adjustment change to the MEI and will most likely post on its website in late November or early December the Division's conversion factors for the subsequent year.

**5. Will there be any instructions or education pertaining to the new MFG rules?**

The Division is preparing and updating educational materials to be posted to the Division's website, and will be conducting seminars throughout the state to facilitate the implementation of these rules.

**6. Do the new and amended rules apply to Certified Workers' Compensation Health Care Networks?**

For the most part, the answer is no, §§134.1, 134.2, 134.203, and 134.204 only apply to non-network medical services. However, all designated doctor examinations and required medical examinations are subject to the provisions of §134.204. Specific provisions are listed in §134.1.

**7. Can a health care provider be reimbursed both the HPSA and workers' compensation underserved area incentive payments?**

The health care provider may not be paid both the HPSA and the workers' compensation underserved area incentive payment. One of the criteria for being designated a workers' compensation underserved area was that the ZIP Code was not in a Health Care Provider Shortage Area (HPSA). Workers' compensation underserved areas and HPSAs are mutually exclusive.

**8. Is it necessary for the health care provider (HCP) to use a modifier to indicate that the medical service was provided in a workers' compensation underserved area?**

No modifier is required. The workers' compensation incentive payment will be paid based on the ZIP Code where the medical service is provided (Block 32 on the CMS-1500).

**9. Can health care providers other than doctors be paid the workers' compensation underserved area incentive payment?**

Yes, the workers' compensation underserved area incentive payment is paid to all health care providers when billing for medical services. Please note, these rules indicate that the workers' compensation underserved area incentive payment is not applicable:

- When there is a negotiated or contracted amount;
- For home health services; and
- For Return to Work Rehabilitation Programs.

**10. What codes are used for case management services and how are these services billed?**

Although the AMA changed the CPT Codes for case management services in 2008, case management services continue to be identified by the 2007 AMA CPT Codes. The new 2008 AMA CPT Codes addressing case management services were not widely available or accessible during rule development.

Fees for case management 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 new §134.204, the Division has set the case management fees, using 2007 AMA CPT Codes and descriptors to facilitate uniform reimbursement to HCPs performing Texas workers' compensation specific case management activities. Use of 2007 AMA CPT Codes in §134.204, with established reimbursement rates and a modifier, at this time is more suitable to the specific needs and disability management concepts of the workers' compensation system.

**11. How will I get reimbursed if I provide a treatment plan to an insurance carrier, but I am not the treating doctor?**

The coordination of this workers' compensation case management activity is the responsibility of the treating doctor, as the Division emphasized in the adoption of Chapter 137 Disability Management Rules. Therefore, any treatment plans developed by HCPs other than the treating doctor, should be done in coordination with the treating doctor in order to receive the reimbursement amount allowed by §134.204. The Division has recognized the contributions of referral health care providers contributing to the activity 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.

**12. Are the durable medical equipment (DME) fees also increased based on the MEI annual percentage changes?**

No. The reimbursement for DME services was not developed as part of the Medicare Physicians Fee Schedule and has not been subject to the sustainable growth rate provisions that are required by the Medicare budget neutrality provisions. In addition, Medicare updates the DMEPOS fee schedule throughout the year and the Division adopts these updates as they occur.

**13. Has the MAR for Designated Doctor Examinations for MMI/IR changed?**

No, the basic provisions for the billing and reimbursement for the determination of Maximum Medical Improvement and evaluation of Permanent Impairment (MMI/IR) has not changed in the new MFG rules, and billing and reimbursement for MMI/IR is fully addressed in new rule 134.204(j). (See Table 1 below)

Table 1

<b>MMI/IR Examinations Performed by a Designated Doctor</b>	<b>Rule Subsection for Billing &amp; Reimbursement</b>	<b>Modifier</b>	<b>Reimbursement</b>
Attainment of maximum medical improvement	134.204(j)	W5	\$350
Impairment caused by the compensable injury	134.204(j)	W5	First body area \$300 (ROM) or \$150 (DRE) ----- \$150 per additional body area(s) (ROM or DRE)
Multiple impairment ratings	134.204(j)	MI	\$50 per additional area

**14. How does a Designated Doctor bill and receive reimbursement for MMI/IR examinations in combination with other Division ordered Designated Doctor Examinations?**

New §134.204(i) describes all six examinations performed by designated doctors, but directs the reimbursement for MMI/IR examinations performed by designated doctors to subsection (j), and excludes reimbursement for MMI/IR from the tiered reimbursement structure of subsection (i) for multiple examinations performed by the designated doctor. MMI/IR examinations performed by designated doctors do not result in the tiering of the non-MMI/IR examinations.

When conducting exams for issues other than MMI/IR, apply the new tiered reimbursement method described in rule 134.204(i) to the remaining four exams. Reimbursement for one of these exams is \$500. When conducting more than one of these exams under the same request, the first exam is reimbursed at 100% of the fee for the exam, \$500; the second exam is reimbursed at 50% of the fee for the exam, \$250; and the subsequent exam(s) are reimbursed at 25% of the fee for the examination, \$125. (See Table 2 below)

A Division order to a designated doctor to conduct one or more of these four exams, plus an MMI/IR exam, requires the designated doctor to be reimbursed by all provisions of §134.204(i), (j), and (k).

Tables 1 and 2 illustrate the separation of the reimbursement methodologies for designated doctor examinations.

*Table 2*

<b>Examinations Other Than MMI/IR Performed by a Designated Doctor</b>	<b>Rule Subsection for Billing &amp; Reimbursement</b>	<b>Modifier</b>	<b>Reimbursement</b>
Extent of the employee’s compensable injury	134.204(i) and (k)	W6	\$500
Whether the injured employee’s disability is a direct result of the work-related injury	134.204(i) and (k)	W7	\$500
Employee’s ability to return to work	134.204(i) and (k)	W8	\$500
Issues similar to those described above	134.204(i) and (k)	W9	\$500
Multiple examinations under the same specific Division order are performed concurrently (other than MMI/IR)	134.204(i) and (k)		1 <sup>st</sup> = 100% of fee 2 <sup>nd</sup> = 50% of fee subsequent = 25% of fee