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Rulemaking Hearing Rule(s) Filing Form

Rulemaking Hearing Rules are rules filed after and as a result of a rulemaking hearing. T.C.A. § 4-5-205

Agency/Board/Commission:	Department of Labor and Workforce Development
Division:	Workers' Compensation
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Revision Type (check all that apply):

- Amendment
 New
 Repeal

Rule(s) Revised (ALL chapters and rules contained in filing must be listed here. If needed, copy and paste additional tables to accommodate multiple chapters. Please enter only ONE Rule Number/Rule Title per row)

Chapter Number	Chapter Title
0800-02-12	Drug Free Workplace Programs
Rule Number	Rule Title
0800-02-12-.03	Definitions
0800-02-12-.07	Testing

Chapter Number	Chapter Title
0800-02-17	Medical Cost Containment Program
Rule Number	Rule Title
0800-02-17-.06	Procedures for Which Codes Are Not Listed
0800-02-17-.09	Independent Medical Examination to Evaluate Medical Aspects of Case
0800-02-17-.10	Payment
0800-02-17-.12	Recovery of Payment
0800-02-17-.20	Utilization Review
0800-02-17-.21	Process for Resolving Differences Between Carriers and Providers Regarding Bills
0800-02-17-.24	Provider and Facility Fees for Copies of Medical Records

Chapter Number	Chapter Title
0800-02-18	Medical Fee Schedule
Rule Number	Rule Title
0800-02-18-.02	General Information and Instructions for Use
0800-02-18-.04	Surgery Guidelines
0800-02-18-.07	Ambulatory Surgical Centers and Outpatient Hospital Care (Including Emergency Room Facility Charges)

0800-02-18-.08	Chiropractic Services Guidelines
0800-02-18-.09	Physical and Occupational Therapy Guidelines
0800-02-18-.10	Durable Medical Equipment and Implant Guidelines
0800-02-18-.12	Pharmacy Schedule Guidelines
0800-02-18-.13	Ambulance Services Guidelines

Chapter Number	Chapter Title
0800-02-19	In-patient Hospital Fee Schedule
Rule Number	Rule Title
0800-02-19-.03	Special Ground Rules – Inpatient Hospital Services

(Place substance of rules and other info here. Statutory authority must be given for each rule change. For information on formatting rules go to <http://state.tn.us/sos/rules/1360/1360.htm>)

Chapter 0800-02-12
Drug Free Workplace Programs

Amendments

Rule 0800-02-12-.03 Definitions, subsection (17)(a) is amended by deleting the current language and replacing it with the following:

- (17) (a) "Prohibited Levels" for a drug or a drug's metabolites means cut-off levels on screened specimens which are equal to or exceed the following and shall be considered to be presumptively positive;

1. Cut-off levels on initially screened specimens:

Amphetamines	500 ng/mL
Marijuana (cannabinoids)	50 ng/mL
Cocaine (benzoyllecgonine)	150 ng/mL
Opiates (codeine, morphine, heroin)	2,000 ng/mL
PCP (phencyclidine)	25 ng/mL
6-Acetylmorphine (heroin)	10 ng/mL
MDMA (ecstasy)	500 ng/mL

2. Cut-off levels on confirmation specimens:

Amphetamines	250 ng/mL
Marijuana (cannabinoids)	15 ng/mL
Cocaine (benzoyllecgonine)	100 ng/mL
Opiates (codeine, morphine, heroin)	2,000 ng/mL
PCP (phencyclidine)	25 ng/mL
6-Acetylmorphine (heroin)	10 ng/mL
MDMA (ecstasy)	250 ng/mL

Authority: T.C.A. §§50-9-103, 50-9-106, 50-9-109, and 50-9-111.

Rule 0800-02-12-.07 Testing, section (1) is amended by adding two new subsections, which shall read:

- (g) 6-Acetylmorphine (heroin)
(h) MDMA (ecstasy)

Authority: T.C.A. §§50-9-101(a) and (b), 50-9-104, 50-9-106(a)(1), 50-9-107(a) and (c), 50-9-110, and 50-9-111.

Chapter 0800-02-17
Medical Cost Containment Program

Amendments

0800-02-17-.06 Procedures for Which Codes Are Not Listed, section (1) is amended by adding the phrase "or revenue code, as applicable" at the end of the first sentence, so that it reads as follows:

- (1) If a procedure is performed which is not listed in the Medicare Resource Based Relative Value Scale ("RBRVS"), the health care provider must use an appropriate CPT procedure code or revenue code, as applicable. The provider must submit an explanation, such as copies of operative reports, consultation reports, progress notes, office notes or other applicable documentation, or description of equipment or supply (when that is the bill).

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

0800-02-17-.09 Independent Medical Examination to Evaluate Medical Aspects of Case, section (2) is amended by adding the following sentence at the end:

Physicians may only require pre-payment of \$500.00 for an IME; provided, that following the completion of the IME and report, the physician may bill for other amounts appropriately due and the payer may recover any amounts that were overpaid.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

0800-02-17-.09 Independent Medical Examination to Evaluate Medical Aspects of Case is amended by adding the following as a new section (4):

- (4) Physicians who perform consultant services and/or records review in order to determine whether to accept a new patient shall not bill for an IME. Rather, such physicians shall bill using CPT codes 99358 and 99359. The reimbursement shall be \$200.00 for the first hour of review and \$100.00 for each additional hour; provided, that each quarter hour shall be pro-rated.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

0800-02-17-.10 Payment, section (4) is amended by adding the following sentence at the end:

If the Division does not designate a specific form, then the proper form shall be according to Medicare guidelines.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

0800-02-17-.10 Payment, section (12) is amended by deleting the current language and replacing it with the following:

- (12) Payments to providers for initial examinations and treatment authorized by the carrier or employer shall be paid by that carrier or employer and shall not later be subject to reimbursement by the employee, even if the injury or condition for which the employee was sent to the provider is later determined non-compensable under the Act.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

0800-02-17-.12 Recovery of Payment, section (1) is amended by adding the following sentence at the end:

If the timeframes in these Rules are not met, then the Medical Care and Cost Containment Committee will decline to review the dispute, but such failure shall not provide an independent basis for denying payment or recovery of payment.

Authority: T.C.A. §§ 50-6-204, 50-6-205, 50-6-226 and 50-6-233 (Repl. 2005).

0800-02-17-.20 Utilization Review, subsection (1)(a) is amended by changing "Tenn. Code Ann. § 50-6-102(18)" to "Tenn. Code Ann. § 50-6-102(17)."

Authority: T.C.A. §§ 50-6-102, 50-6-122, 50-6-124, 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

0800-02-17-.21 Process for Resolving Differences Between Carriers and Providers Regarding Bills, subsection (4)(b) is amended by deleting the first sentence and replacing it with the following:

- (b) Valid requests for Administrative Review must be accompanied by a form prescribed by the Division, must be legible, and must contain copies of the following:

Authority: T.C.A. §§ 50-6-126, 50-6-204, 50-6-205, 50-6-226 and 50-6-233 (Repl. 2005).

0800-02-17-.21 Process for Resolving Differences Between Carriers and Providers Regarding Bills, section (4) is amended by adding the following as a new subsection (d):

- (d) If the request for review does not contain proper documentation, then the MCCCC will decline to review the dispute. Likewise, if the timeframes in this Rule are not met, then the MCCCC will decline to review the dispute, but such failure shall not provide an independent basis for denying payment or recovery of payment.

Authority: T.C.A. §§ 50-6-126, 50-6-204, 50-6-205, 50-6-226 and 50-6-233 (Repl. 2005).

0800-02-17-.24 Provider and Facility Fees for Copies of Medical Records, section (1) is amended by adding the following sentence at the end:

The cost set forth in this subsection shall also apply to paper records transmitted on a disc or by other electronic means based upon the number of pages reproduced on the disc or other media.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

0800-02-17-.24 Provider and Facility Fees for Copies of Medical Records, section (2) is amended by deleting the current language and replacing it with the following:

- (2) Health care providers and facilities must furnish an injured employee or the employee's attorney and carriers/self-insureds or their legal representatives copies of records and reports as set forth in Tenn. Code Ann. § 50-6-204, as amended.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

Chapter 0800-02-18
Medical Fee Schedule

Amendments

0800-02-18-.02 General Information and Instructions for Use, subsection (2)(b) is amended by adding the following as a new subsection:

- 6. The "lesser of" comparison among (1) the provider's usual charge, (2) the maximum allowable amount pursuant to these Rules, or (3) any other contracted amount, should be determined based on the entire bill or amount due for a particular service, rather than on a line-by-line basis.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

0800-02-18-.02 General Information and Instructions for Use, section (4) is amended by deleting the section in its entirety and replacing it with the following:

- (4) Practitioner fees shall be based on the conversion factor of 33.9764, which shall be used in conjunction with the most current Medicare RVUs. The Division may designate another baseline conversion factor at any time through the rulemaking process. The Tennessee-specific conversion factors listed below should be applied to the service category in order to calculate the appropriate amount.

Service Category	TN Conversion Factor
Anesthesiology.....	\$75.00 per unit
Orthopaedic and Neurosurgery* .....	.275%
General Surgery.....	.200%
Radiology.....	.200%
Pathology.....	.200%

Physical/Occupational Therapy.....	130%
Chiropractic.....	130%
General Medicine (including evaluation & management).....	160%
Emergency Care.....	200%
Dentistry.....	100%

* Orthopaedic and neurosurgeons may use the modifier "ON" on the HCFA 1500 form when submitting surgical charges. If the modifier or another indicator is not placed on the form, then the Tennessee Department of Health's database may be consulted in order to determine the provider's specialty.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

0800-02-18-.04 Surgery Guidelines, section (1) is amended by deleting the current language and replacing it with the following:

- (1) Multiple Procedures: Maximum reimbursement shall be based on 100% of the appropriate Medical Fee Schedule amount for the major procedure plus 50% of the lesser or secondary procedure(s). The major procedure shall be determined to be the procedure with the highest Medicare reimbursement.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

0800-02-18-.07 Ambulatory Surgical Centers and Outpatient Hospital Care (Including Emergency Room Facility Charges), subsection (1)(c) is amended by deleting the current language and replacing it with the following:

- (c) Under the Medical Fee Schedule Rules, the OPSS reimbursement system shall be used for reimbursement for all outpatient services, wherever they are performed, in a free-standing ASC or hospital setting. The most current, effective Medicare APC rates shall be used as the basis for facility fees charged for outpatient services and shall be reimbursed at a maximum of 150% of current value for such services. Depending on the services provided, ASCs and hospitals may be paid for more than one APC for an encounter. When multiple surgical procedures are performed during the same surgical session, maximum reimbursement shall be based on 100% of the appropriate Medical Fee Schedule amount for the major procedure plus 50% of the lesser or secondary procedure(s); provided, that the major procedure shall be determined to be the procedure with the highest Medicare reimbursement. Only separate and distinct surgical procedures shall be billed. Medicare guidelines shall be consulted and used in determining separate and distinct surgical procedures.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

0800-02-18-.07 Ambulatory Surgical Centers and Outpatient Hospital Care (Including Emergency Room Facility Charges), subsection (1)(h)(2) is amended by deleting the current language and replacing it with the following:

- 2. Laboratory Services (including pathology)

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

0800-02-18-.07 Ambulatory Surgical Centers and Outpatient Hospital Care (Including Emergency Room Facility Charges), subsection (k) is amended by deleting the current language and replacing with the following:

- (k) There may be emergency cases or other occasions in which the patient was scheduled for outpatient surgery and it becomes necessary to admit the patient. All hospitals with ambulatory patients who stay longer than 23 hours past ambulatory surgery and are formally admitted to the hospital as an inpatient will be paid according to the In-patient Hospital Fee Schedule Rules,

0800-02-19. All ASCs shall be paid pursuant to this Rule 0800-02-18-.07 regardless of the patient's length of stay.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

0800-02-18-.08 Chiropractic Services Guidelines, section (2) is amended by deleting the current language in its entirety and substituting instead the following:

- (2) For chiropractic services, an office visit may only be billed on the same day as a manipulation when it is the patient's initial visit with that provider.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

Rule 0800-02-18-.09 Physical and Occupational Therapy Guidelines, section (5) is amended by deleting the current language in its entirety and replacing it with the following:

- (5) Whenever physical therapy and/or occupational therapy services exceed twelve (12) visits, such treatment shall be reviewed pursuant to the carrier's utilization review program in accordance with the procedures set forth in Chapter 0800-02-06 of the Division's Utilization Review rules before further physical therapy and/or occupational therapy services may be certified for payment by the carrier. Such certification shall be completed within the timeframes set forth in Chapter 0800-02-06 to assure no interruption in delivery of needed services. Failure by a provider to properly certify such services as prescribed herein shall result in the forfeiture of any payment for uncertified services. Failure by an employer or utilization review agent to conduct utilization review in accordance with this Chapter 0800-02-18 and Chapter 0800-02-06 shall result in no more than twelve (12) additional visits being deemed certified. The initial utilization review of physical therapy and/or occupational therapy services shall, if necessary and appropriate, certify an appropriate number of visits. If necessary, further subsequent utilization review shall be conducted to certify additional physical therapy and/or occupational therapy services as is appropriate; provided, that further certifications are not required to be in increments of twelve (12) visits.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

Rule 0800-02-18-.10 Durable Medical Equipment and Implant Guidelines, section (1) is amended by adding the phrase "or, for hospital reimbursements, a UB 04 form." at the end of the last sentence, so that it reads as follows:

- (1) Reimbursement for durable medical equipment and implants for which billed charges are \$100.00 or less shall be limited to eighty (80%) of billed charges. Durable medical equipment and implants for which billed charges exceed \$100.00 shall be reimbursed at a maximum amount of the supplier or manufacturer's invoice amount, plus the lesser of 15% of invoice or \$1,000.00, and coded using the HCPCS codes. These calculations are per item and are not cumulative. Charges for durable medical equipment and implants are in addition to, and shall be billed separately from, all facility and professional service fees. Codes to be used are found in the HCPCS. Charges should be submitted on a HCFA 1500 form or, for hospital reimbursements, a UB 04 form.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

Rule 0800-02-18-.12 Pharmacy Schedule Guidelines, subsection (1)(c) is amended by deleting the phrase "subsection (5) of this section" and replacing it instead with "the following subsections."

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

Rule 0800-02-18-.12 Pharmacy Schedule Guidelines, subsection (1)(e)(2)(v) is amended by deleting the reference to "Rule 0800-2-11-.10" and replacing it with "Rule 0800-02-17-.10."

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

Rule 0800-02-18-.12 Pharmacy Schedule Guidelines, subsection (1)(f)(2) is amended by deleting the reference to "(4)(b)" and replacing it with "(e)(2)."

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

Rule 0800-02-18-.12 Pharmacy Schedule Guidelines, section (1) is amended by adding a new subsection (h) at the end, which should read as follows:

(h) Repackaged or Compounded Products

All pharmaceutical bills submitted for repackaged or compounded products must include the NDC Number of the original manufacturer registered with the U.S. Food & Drug Administration or its authorized distributor's stock package used in the repackaging or compounding process. The reimbursement allowed shall be based on the current published manufacturer's AWP of the product or ingredient, calculated on a per unit basis, as of the date of dispensing. A repackaged or compounded NDC Number shall not be used and shall not be considered the original manufacturer's NDC Number. If the original manufacturer's NDC Number is not provided on the bill, then the reimbursement shall be based on the AWP of the lowest priced therapeutically equivalent drug, calculated on a per unit basis. The filling fees otherwise provided in these Rules shall be payable when applicable.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

0800-02-18-.13 Ambulance Services Guidelines, section (4) is amended by deleting the current language in its entirety and replacing it with the following:

- (4) Reimbursement shall be based upon the lesser of the submitted charge or 150% of the current Medicare rate. To the extent permitted by federal law, the rates determined in the preceding sentence shall also apply to air ambulance services.

Authority: T.C.A. §§ 50-6-204, 50-6-205 and 50-6-233 (Repl. 2005).

Chapter 0800-02-19
In-patient Hospital Fee Schedule

Amendments

0800-02-19-.03 Special Ground Rules – Inpatient Hospital Services, subsection (2)(e) is amended by deleting the current language and replacing it with the following:

- (e) The items listed in subsection (d)(4) shall be reimbursed according to the Medical Cost Containment Program Rules (Chapter 0800-02-17) and Medical Fee Schedule Rules (Chapter 0800-02-18) payment limits. Refer to the maximum rates set forth in Rule 0800-02-18-.02(4) for practitioner fees. Items not listed in the Rules shall be reimbursed at the usual and customary rate as defined in Rule 0800-02-17-.03(80), unless otherwise indicated herein.

Authority: T.C.A. §§ 50-6-125, 50-6-128, 50-6-204 and 50-6-205 (Repl. 2005).

0800-02-19-.03 Special Ground Rules – Inpatient Hospital Services, subsection (4)(d) is amended by deleting the current language and replacing it with the following:

- (d) Example: DRG 222: Knee Procedures W/O CC

Hospital Peer Group: 1 – Surgical admission
Maximum rate per day: \$1,800 for first 7 days; 1,500 for 2 additional days
Number Billed Days: 9
Total Billed Charges
(after subtracting amounts for implants, radiology, etc.):\$53,650.00

Maximum allowable payment for Normal DRG stay..... \$15,600.00

Total difference, charges over and above maximum payments \$38,050.00

(if this amount is \$15,000 or less, then stop-loss is not applicable)

Difference over and above \$15,000 Stop-loss is..... \$23,050.00
Payable under Stop-loss (80% of \$23,050.00).....\$18,440.00

Amounts due hospital for implants, radiology, etc.....\$3,525.00

Maximum fee schedule amount: 15,600.00 + 18,440.00 + 3,525.00 = \$37,565.00

Proper reimbursement would be the lesser of billed charges, maximum fee schedule amount, or other contracted or negotiated rate

Authority: T.C.A. §§ 50-6-125, 50-6-128, 50-6-204 and 50-6-205 (Repl. 2005).

* If a roll-call vote was necessary, the vote by the Agency on these rulemaking hearing rules was as follows:

Board Member	Aye	No	Abstain	Absent	Signature (if required)

I certify that this is an accurate and complete copy of rulemaking hearing rules, lawfully promulgated and adopted by the commissioner (board/commission/ other authority) on 11/7/11 (mm/dd/yyyy), and is in compliance with the provisions of T.C.A. § 4-5-222.

I further certify the following:

Notice of Rulemaking Hearing filed with the Department of State on: 8/8/11

Rulemaking Hearing(s) Conducted on: (add more dates). 9/28/11

Date: 11/7/11

Signature: Karla Davis

Name of Officer: Karla Davis

Title of Officer: Commissioner of Labor & Workforce Development



Subscribed and sworn to before me on: November 07, 2011

Notary Public Signature: Vickie H. Gregory

My commission expires on: December 31, 2012

All rulemaking hearing rules provided for herein have been examined by the Attorney General and Reporter of the State of Tennessee and are approved as to legality pursuant to the provisions of the Administrative Procedures Act, Tennessee Code Annotated, Title 4, Chapter 5.

RE Cooper, Jr.

Robert E. Cooper, Jr.
Attorney General and Reporter

12-6-11

Date

Department of State Use Only

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 PUBLIC AFFAIRS

Filed with the Department of State on: 03/12/2012

Effective on: 06/10/2012

Tre Hargett

Tre Hargett
Secretary of State

Public Hearing Comments

One copy of a document containing responses to comments made at the public hearing must accompany the filing pursuant to T.C.A. § 4-5-222. Agencies shall include only their responses to public hearing comments, which can be summarized. No letters of inquiry from parties questioning the rule will be accepted. When no comments are received at the public hearing, the agency need only draft a memorandum stating such and include it with the Rulemaking Hearing Rule filing. Minutes of the meeting will not be accepted. Transcripts are not acceptable.

1) Comment: The Department should consider revising the in-patient per diem and stop-loss amounts. Alternatively, the in-patient fees should be based on Medicare. Under either system, the in-patient rules should adhere to the Medicare bundling guidelines. Otherwise, hospital costs could experience a significant increase. Due to the complexities involved, this may be an issue that the Medical Care & Cost Containment Committee should study and then make a recommendation.

Response: Currently, the data on hospital reimbursements is insufficient to fully analyze this amendment. That data should be available in the next year. As such, the Department agrees that this is a change that should await more concrete data to analyze the impact and we will exclude it from the current amendments.

2) Comment: The wording in the in-patient bundling amendment should be changed from "are not controlling" to "do not apply" for clarity purposes.

Response: In light of the response to Comment #1, this comment is moot.

3) Comment: Maximum ambulance fees should remain as they currently are, rather than being based on Medicare, since Medicare covers different types of patients and emergencies than workers' compensation insurance.

Response: While the Department recognizes that Medicare covers a different type of patient than workers' compensation, we have used a Medicare-based fee schedule for most aspects of medical costs since the fee schedule was first implemented in 2005. The original reimbursement formula for ambulances was the lesser of submitted charges or the average price in the geographical locality. The database for the latter is now obsolete, so ambulance services have been able to receive up to their submitted charges, which can be significant amounts. In looking for ways to control those costs, the fairest and most accessible option appears to be setting a reimbursement amount as a percentage of Medicare. Going forward, we will continue to consider moving the medical fee schedule rates for all services away from a Medicare-based system as other commenters have also suggested.

4) Comment: Many commenters recommended that generic equivalent average price ("GEAP") should not be incorporated into the pharmacy fee schedule because it is inaccessible and only covers a small percentage of drugs.

Response: Due to the inaccessibility and lack of information in the GEAP database, the Department agrees with the commenters and will remove references to GEAP in the final rule.

5) Comment: There is support for addressing repackaged and/or compounded drugs, but the proposed wording should be clarified so that the responsibilities of the parties are clearer.

Response: The Department agrees that the language in the final rule should be revised to better convey the intent. While we received several suggestions on how the language should be revised, we will take the aspects of those suggestions that best convey the intent and reformulate the language.

6) Comment: There is concern that restricting the payments for repackaged and compounded drugs to average wholesale price ("AWP") will discourage physicians from dispensing, especially when dispensing physicians have a 100% fill rate, whereas pharmacy prescriptions have a 70-80% fill rate. This change could also lead to access to care problems if it is no longer financially viable for physicians to dispense drugs.

Response: Currently, the pharmacy fee schedule uses AWP as a basis for drug prices, but repackaged and compounded drugs are not adequately addressed by the current language. As such, the amendment is to fill a

gap and ensure that drug prices are based on AWP whenever possible. In no way does the rule amendment prohibit physician-dispensing or the practice of repackaging or compounding drugs.

7) Comment: There is opposition to the decrease in maximum professional fees from physicians, as well as chiropractors and physical therapists. Some providers have advised that the 11% cut in the maximum allowable amount may cause them to discontinue treating workers' compensation patients.

Response: Amendments to the medical fee schedule in 2009 designated a conversion factor of 38.0870 in the formula for maximum professional fees because of anticipated cuts to Medicare. In the last two years, the Medicare cuts have not materialized and, as a result, the medical fee schedule's maximum professional fees have increased by 20% since August 2009, which included an 8.8% increase at the beginning of 2011, according to the National Council on Compensation Insurance ("NCCI"). As such, the maximum professional fees have become significantly higher than was anticipated when the 2009 amendments took effect. The current amendment would update the designated conversion factor to current Medicare, which is 33.9764.

While we would be disappointed to see any physician decline to see workers' compensation patients because of this amendment and do recognize that such cases can provide more administrative hassles, the amended reimbursement formula would still allow for percentages significantly higher than Medicare (i.e., 275% for orthopaedic and neurosurgery, 200% for general surgery, 160% for office visits). In addition, the final amendment will insulate the providers from further decreases to Medicare's conversion factor.

8) Comment: The NCCI pricing method used in the law-only filing as a basis for the reduction in professional fees is flawed because it does not account for prices actually paid and it uses outdated Medicare studies.

Response: The pricing method used in NCCI's filing is based on trending. While actual prices paid are not used in the filing, the method accounts for increases and decreases by assuming that a certain percentage change in the medical fee schedule will correlate to a very similar change in actual prices paid. As for the Medicare study, that is only utilized with projected reductions in costs, whereas the commenters take issue with the projected increases in the filing. Accordingly, that study had no impact on the commenters' areas of interest.

9) Comment: A recent Workers Compensation Research Institute ("WCRI") study showed that Tennessee was the only one of 25 study states to have medical costs below its 2002 level. As such, there should be no reduction in maximum professional fees.

Response: The WCRI study did show that Tennessee's medical costs are lower than in 2002. The medical fee schedule did not go into effect, however, until 2005. As such, the data showing that costs are very close, albeit still lower, than the 2002 levels is actually disconcerting for the purposes of the medical fee schedule. In addition, the study only used data up to June 2010, whereas the largest increase from the previous conversion factor designation on maximum professional fees occurred in January 2011. Accordingly, that study has not yet accounted for the most recent increase in medical costs.

10) Comment: Going to a two-tiered surgical reimbursement system based on CPT codes will cause some codes that have traditionally been paid at the higher level to be paid at the lower level, which would significantly increase medical costs.

Response: Tennessee is the only state that uses a two-tiered surgical reimbursement system based on the board-certification/eligibility status of the physician, which has caused issues with improper reimbursements. Due to the concerns about increased costs, however, the Department will revise the proposed language to maintain the orthopaedic and neurosurgeon distinction, but with additional language aimed at alleviating the issues with improper reimbursements.

11) Comment: There is a concern among several commenters that the administrative hassles involved in workers' compensation will result in a decrease in the number of providers willing to see those patients.

Response: While many of the areas that concern the commenters are outside of the scope of these rule amendments, one change that should help ease this burden is the clarifying language mentioned in the response to Comment 10.

12) Comment: The multiple procedures reduction will reduce reimbursement for providers, especially physical therapists who perform several modalities in one session.

Response: The multiple procedures reduction has been in the medical fee schedule since its implementation in 2005. The present amendment merely clarifies which procedures are primary, i.e., to be paid in full, and which are secondary, i.e., to be paid at half. Accordingly, the amendment is only to clarify an ambiguous area and should not have a significant impact.

13) Comment: There is concern that the prohibition on line-by-line comparisons will increase costs and impede bill reviewers from applying contracted discounts.

Response: The Department has always interpreted the Medical Fee Schedule "lesser of" comparison to apply to entire bills, rather than a line-by-line comparison of each item in the bill. As such, the amendment is merely to clarify the rule. Nothing in the amendment should prevent contracting or negotiating for discounts below the maximum rates.

Regulatory Flexibility Addendum

Pursuant to T.C.A. §§ 4-5-401 through 4-5-404, prior to initiating the rule making process as described in T.C.A. § 4-5-202(a)(3) and T.C.A. § 4-5-202(a), all agencies shall conduct a review of whether a proposed rule or rule affects small businesses.

STATEMENT OF ECONOMIC IMPACT TO SMALL BUSINESSES

1. The type or types of small business and an identification and estimate of the number of small businesses subject to the proposed rule that would bear the cost of, or directly benefit from the proposed rule: The amended rules will affect small employers that fall under the Tennessee Workers' Compensation Laws, which would be employers with at least five employees, or in the construction industry, at least one employee. The rule amendments should result in premium decreases for such employers.

2. The projected reporting, recordkeeping and other administrative costs required for compliance with the proposed rule, including the type of professional skills necessary for preparation of the report or record: Employers' insurance carriers or third party administrators will be responsible for complying with changes to the medical fee schedule, so no administrative impact would be expected for small businesses. Drug testing companies will be responsible for complying with the updated drug testing, but the update merely mirrors the U.S. Department of Transportation's drug panel, which is widely utilized, so any administrative costs should be minimal.

3. A statement of the probable effect on impacted small businesses and consumers: Employers will pay lower workers' compensation premiums, which is a benefit that can then be passed on to employees and consumers.

4. A description of any less burdensome, less intrusive or less costly alternative methods of achieving the purpose and objectives of the proposed rule that may exist, and to what extent the alternative means might be less burdensome to small business: There are no less burdensome methods to achieve the purposes and objectives of the amended rule.

5. Comparison of the proposed rule with any federal or state counterparts: The medical fee schedule rates are based on a percentage above Medicare rates. The Drug Free Workplace Program's drug panel is based on the U.S. Department of Transportation's rules (49 C.F.R. 40.87).

6. Analysis of the effect of the possible exemption of small businesses from all or any part of the requirements contained in the proposed rule: It would be detrimental to small businesses that fall under the Tennessee Workers' Compensation Laws to be exempt from the medical fee schedule since it contains costs.

Impact on Local Governments

Pursuant to T.C.A. §§ 4-5-220 and 4-5-228 "any rule proposed to be promulgated shall state in a simple declarative sentence, without additional comments on the merits of the policy of the rules or regulation, whether the rule or regulation may have a projected impact on local governments." (See Public Chapter Number 1070 (<http://state.tn.us/sos/acts/106/pub/pc1070.pdf>) of the 2010 Session of the General Assembly)

Local governments have the option to accept the provisions of the workers' compensation laws pursuant to T.C.A. § 50-6-106(6), but are not required to do so. For those local governments that do accept the provisions of the workers' compensation laws, the impact of the rule amendments will be a decrease in their workers' compensation insurance premiums.

Additional Information Required by Joint Government Operations Committee

All agencies, upon filing a rule, must also submit the following pursuant to TCA 4-5-226(i)(1).

- (A)** A brief summary of the rule and a description of all relevant changes in previous regulations effectuated by such rule;

The medical fee schedule has been in place since 2005. These amendments make several changes, some substantive and some minor. A substantive change is reducing the maximum professional fees, which are based upon a percentage above Medicare rates. Changes to Medicare's reimbursement formula have caused a steep increase in these rates that was not previously anticipated. The rule amendment would return the rates to more moderate levels, which will alleviate the burden on Tennessee employers. Other substantive changes include: capping pathology fees at 200% of applicable Medicare; linking repackaged and compounded drugs to the average wholesale price of the original national drug code number; capping ground ambulance rates at 150% of applicable Medicare; allowing chiropractors to charge for an office visit on the same day as the initial treatment; and, removing the requirement that physical therapy must go through utilization review after six visits. In addition, the amendments update the Drug Free Workplace drug-testing panel to the new U.S. Department of Transportation panel.

- (B)** A citation to and brief description of any federal law or regulation or any state law or regulation mandating promulgation of such rule or establishing guidelines relevant thereto;

Pursuant to T.C.A. 50-6-204(i), the Commissioner of Labor & Workforce Development is required to implement and update a medical fee schedule for services provided to workers' compensation claimants. While the Department's rules base the medical fee schedule's reimbursement rates on the federally-administered Medicare program, the state statutes do not mandate such. Pursuant to T.C.A. 50-9-103(6)-(8) & 50-9-111, the Commissioner is directed to use the U.S. Department of Transportation's drug testing rules as a model for the Tennessee Drug Free Workplace Program.

- (C)** Identification of persons, organizations, corporations or governmental entities most directly affected by this rule, and whether those persons, organizations, corporations or governmental entities urge adoption or rejection of this rule;

Employers, insurers, and medical providers will be affected by this rule. Since these amendments will reduce some of the maximum reimbursement rates for medical services, insurance companies and employers urge adoption. Medical providers urge rejection because of the reduced rates, but those rates are still well above Medicare rates.

- (D)** Identification of any opinions of the attorney general and reporter or any judicial ruling that directly relates to the rule;

None.

- (E)** An estimate of the probable increase or decrease in state and local government revenues and expenditures, if any, resulting from the promulgation of this rule, and assumptions and reasoning upon which the estimate is based. An agency shall not state that the fiscal impact is minimal if the fiscal impact is more than two percent (2%) of the agency's annual budget or five hundred thousand dollars (\$500,000), whichever is less;

State and local governments have the option to accept the provisions of the workers' compensation laws pursuant to T.C.A. § 50-6-106(6), but are not required to do so. For those governmental agencies that do adhere to the medical fee schedule and Drug Free Workplace Program, their workers' compensation premiums should decrease, though it is difficult at this time to ascertain by exactly how much.

- (F)** Identification of the appropriate agency representative or representatives, possessing substantial knowledge and understanding of the rule;

Landon Lackey, attorney with the Division of Workers' Compensation, may be contacted for more information.

(G) Identification of the appropriate agency representative or representatives who will explain the rule at a scheduled meeting of the committees;

Landon Lackey will explain the rule at a scheduled meeting of the committees.

(H) Office address, telephone number, and email address of the agency representative or representatives who will explain the rule at a scheduled meeting of the committees; and

220 French Landing Drive
Nashville, Tennessee 37243
615-532-0370
landon.lackey@tn.gov

(I) Any additional information relevant to the rule proposed for continuation that the committee requests.

None.

CHAPTER 0800-2-12

DRUG FREE WORKPLACE PROGRAMS

0800-2-12-.03 DEFINITIONS.

(17) (a) "Prohibited Levels" for a drug or a drug's metabolites means cut-off levels on screened specimens which are equal to or exceed the following and shall be considered to be presumptively positive;

1. Cut-off levels on initially screened specimens:

Amphetamines	.....	10500 ng/mL
Marijuana (cannabinoids)	.....	50 ng/mL
Cocaine (benzoyllecgonine)	.....	30150 ng/mL
Opiates (codeine, morphine, heroin)	.....	2,000 ng/mL
PCP (phencyclidine)	.....	25 ng/mL
<u>6-Acetylmorphine (heroin)</u>	.....	<u>10 ng/mL</u>
<u>MDMA (ecstasy)</u>	.....	<u>500 ng/mL</u>

2. Cut-off levels on confirmation specimens:

Amphetamines	.....	50250 ng/mL
Marijuana (cannabinoids)	.....	15 ng/mL
Cocaine (benzoyllecgonine)	.....	15100 ng/mL
Opiates (codeine, morphine, heroin)	.....	2,000 ng/mL
PCP (phencyclidine)	.....	25 ng/mL
<u>6-Acetylmorphine (heroin)</u>	.....	<u>10 ng/mL</u>
<u>MDMA (ecstasy)</u>	.....	<u>250 ng/mL</u>

0800-2-12-.07 TESTING.

(1) A covered employer shall be required to test employees and job applicants for the following drugs:

- (a) Alcohol-Not required for job applicant testing.
- (b) Amphetamines
- (c) Cannabinoids, (THC)
- (d) Cocaine
- (e) Opiates
- (f) Phencyclidine
- (g) 6-Acetylmorphine (heroin)
- (h) MDMA (ecstasy)

Chapter 0800-02-17
Medical Cost Containment Program

0800-02-17-.06 PROCEDURES FOR WHICH CODES ARE NOT LISTED.

(1) If a procedure is performed which is not listed in the Medicare Resource Based Relative Value Scale ("RBRVS"), the health care provider must use an appropriate CPT procedure code or revenue code, as applicable. The provider must submit an explanation, such as copies of operative reports, consultation reports, progress notes, office notes or other applicable documentation, or description of equipment or supply (when that is the bill).

0800-02-17-.09 INDEPENDENT MEDICAL EXAMINATION TO EVALUATE MEDICAL ASPECTS OF CASE.

- (2) An independent medical examination, performed to evaluate the medical aspects of a case (other than one conducted under the Division's MIRR Program), shall be billed using the appropriate independent medical examination procedure, and shall include the practitioner's time only. Time spent shall include face-to-face time with the patient, time spent reviewing records, reports and studies, and time spent preparing reports. The office visit bill is included with the code and shall not be billed separately. The total amount for an IME under this Rule shall not exceed \$500.00 per hour, and shall be pro-rated per quarter hour, i.e. two and one half hours may not exceed \$1,250.00. Physicians may only require pre-payment of \$500.00 for an IME; provided, that following the completion of the IME and report, the physician may bill for other amounts appropriately due and the payer may recover any amounts that were overpaid.
- (4) Physicians who perform consultant services and/or records review in order to determine whether to accept a new patient shall not bill for an IME. Rather, such physicians shall bill using CPT codes 99358 and 99359. The reimbursement shall be \$200.00 for the first hour of review and \$100.00 for each additional hour; provided, that each quarter hour shall be pro-rated.

0800-02-17-.10 PAYMENT.

- (4) Billing for provider services shall be submitted on forms approved by the Division, UB-92 and CMS-1500, or their official replacement forms. If the Division does not designate a specific form, then the proper form shall be according to Medicare guidelines.
- (12) Payments to providers for initial examinations and treatment authorized by the carrier or ~~self-insured~~ employer shall be paid by that carrier or ~~self-insured~~ employer and shall not later be subject to reimbursement by the employee ~~or~~, even if the injury or condition for which the employee was sent to the provider is later determined non-compensable under the Act.

0800-02-17-.12 RECOVERY OF PAYMENT.

- (1) Nothing in these Rules shall preclude the recovery of payment already made for services and bills which may later be found to have been medically paid at an amount which exceeds the maximum allowable payment. Likewise, nothing in these Rules shall preclude any provider from receiving additional payment for services or supplies if it is properly due that provider and does not exceed the amount allowed by these Rules. If the timeframes in these Rules are not met, then the Medical Care and Cost Containment Committee will decline to review the dispute, but such failure shall not provide an independent basis for denying payment or recovery of payment.

0800-02-17-.20 UTILIZATION REVIEW.

- (1) Scope of this part:
 - (a) Requirements contained in this Rule pertain to Utilization Review activity as defined by Tenn. Code Ann. § 50-6-102(178) (Repl. 2005) with respect to services by a provider for health care or health related services furnished as a result of a compensable injury, illness or occupational disease arising out of and in the course of employment. The Division's Utilization Rules, Chapter 0800-02-6, provide detailed specifics regarding Utilization Review and must be consulted

as they are incorporated in this Rule as if set forth fully herein. Notwithstanding any other provision in this Chapter which may be to the contrary, this Rule is intended to merely supplement Chapter 800-2-6 on Utilization Review and does not in any way displace the Utilization Review Rules, Chapter 0800-02-6.

0800-02-17-.21 PROCESS FOR RESOLVING DIFFERENCES BETWEEN CARRIERS AND PROVIDERS REGARDING BILLS.

- (4) Disputes
 - (b) Valid requests for Administrative Review ~~do not require a particular form but must be accompanied by a form prescribed by the Division,~~ must be legible and contain copies of the following:
 - (d) If the request for review does not contain proper documentation, then the MCCCC will decline to review the dispute. Likewise, if the timeframes in this Rule are not met, then the MCCCC will decline to review the dispute, but such failure shall not provide an independent basis for denying payment or recovery of payment.

0800-02-17-.24 PROVIDER AND FACILITY FEES FOR COPIES OF MEDICAL RECORDS.

- (1) Health care providers and facilities are entitled to recover an amount in accordance with Tenn. Code Ann. § 50-6-204 to cover the cost of copying documents requested by the carrier, self-insured employer, employee, attorneys, etc. Documentation which is submitted by the provider and/or facility, but was not specifically requested by the carrier, shall not be allowed a copy charge. The cost set forth in this subsection shall also apply to paper records transmitted on a disc or by other electronic means based upon the number of pages reproduced on the disc or other media.
- (2) Health care providers and facilities must furnish an injured employee or the employee's attorney and carriers/self-insureds or their legal representatives copies of records and reports upon request. The maximum charge allowed shall be the same as that set out as set forth in Tenn. Code Ann. § 50-6-204, as amended.

Chapter 0800-02-18 Medical Fee Schedule

0800-02-18-.02 GENERAL INFORMATION AND INSTRUCTIONS FOR USE.

- (b) Reimbursement to all providers shall be the lesser of the following:
 - 6. The "lesser of" comparison among (1) the provider's usual charge, (2) the maximum allowable amount pursuant to these Rules, or (3) any other contracted amount, should be determined based on the entire bill or amount due for a particular service, rather than on a line-by-line basis.
- (4) ~~(a) Monetary Conversion Factors are based on the CMS' unit amount in effect on March 4, 2008. These Factors are subject to change based upon any change in the Medicare unit amount. If the Medicare Conversion Factor falls below the unit amount in effect on March 4, 2008, the Department will adjust the Tennessee Medical Fee Schedule Conversion Factors listed on the Division's website to maintain the equivalent maximum allowable reimbursement which would have been allowed had the Medicare Conversion Factor remained at the amount in effect on March 4, 2008. In no event shall reimbursement amounts under this Chapter be less than the amounts applicable~~

on March 4, 2008.

(b) The appropriate conversion factor must be determined by the type of CPT code for the procedure performed in all cases except those involving orthopedic and neurosurgery. Board-eligible and certified neurosurgeons and orthopedic surgeons shall use the separate neurosurgery and orthopedic surgery conversion factors listed on the Division's website for all surgery CPT codes.

Practitioner fees shall be based on the conversion factor of 33.9764, which shall be used in conjunction with the most current Medicare RVUs. The Division may designate another baseline conversion factor at any time through the rulemaking process. The Tennessee-specific conversion factors listed below should be applied to the service category in order to calculate the appropriate amount.

<u>Service Category</u>	<u>TN Conversion Factor</u>
<u>Anesthesiology.....</u>	<u>\$75.00 per unit</u>
<u>Orthopaedic and Neurosurgery*</u>	<u>.275%</u>
<u>General Surgery.....</u>	<u>.200%</u>
<u>Radiology.....</u>	<u>.200%</u>
<u>Pathology.....</u>	<u>.200%</u>
<u>Physical/Occupational Therapy.....</u>	<u>.130%</u>
<u>Chiropractic.....</u>	<u>.130%</u>
<u>General Medicine</u> <u>(including evaluation & management).....</u>	<u>.160%</u>
<u>Emergency Care.....</u>	<u>.200%</u>
<u>Dentistry.....</u>	<u>.100%</u>

* Orthopaedic and neurosurgeons may use the modifier "ON" on the HCFA 1500 form when submitting surgical charges. If the modifier or another indicator is not placed on the form, then the Tennessee Department of Health's database may be consulted in order to determine the provider's specialty.

0800-02-18-.04 SURGERY GUIDELINES.

- (1) Multiple Procedures: Maximum R reimbursement shall be based on 100% of the physician's usual charge of the appropriate Medical Fee Schedule amount for the major procedure (not to exceed 100% of the TDWC Medical Fee Schedule amount allowable) plus 50% of the physician's usual charge for the lesser or secondary procedure (s) (not to exceed 50% of the TDWC Medical Fee Schedule allowable). The major procedure shall be determined to be the procedure with the highest Medicare reimbursement.

0800-02-18-.07 AMBULATORY SURGICAL CENTERS AND OUTPATIENT HOSPITAL CARE (INCLUDING EMERGENCY ROOM FACILITY CHARGES).

- (1) (c) Under the Medical Fee Schedule Rules, the OPSS reimbursement system shall be used for reimbursement for all outpatient services, wherever they are performed, in a free-

standing ASC or hospital setting. The most current, effective Medicare APC rates shall be used as the basis for facility fees charged for outpatient services and shall be reimbursed at a maximum of 150% of current value for such services. Depending on the services provided, ASCs and hospitals may be paid for more than one APC for an encounter. When multiple surgical procedures are performed during the same surgical session, the maximum reimbursement shall be made at 100% of the appropriate rate-Medical Fee Schedule amount for the highest charge surgical procedure and 50% of the appropriate rate for all additional surgical procedures; provided, that the major procedure shall be determined to be the procedure with the highest Medicare reimbursement. Only separate and distinct surgical procedures shall be billed. Medicare guidelines shall be consulted and used in determining separate and distinct surgical procedures.

- (h) 2. Laboratory services (including pathology, ~~which is reimbursed at the usual and customary amount regardless of where performed~~)
- (k) There may be occasions in which the patient was scheduled for outpatient surgery and it becomes necessary to admit the patient. All hospitals with ambulatory patients who are admitted to the hospital and stay longer than 23 hours past ambulatory surgery and are formally admitted to the hospital as an inpatient will be paid according to the In-patient Hospital Fee Schedule Rules, 0800-2-19. All ASCs shall be paid pursuant to this Rule 0800-02-18-.07 regardless of the patient's length of stay.

0800-02-18-.08 CHIROPRACTIC SERVICES GUIDELINES.

- (2) For chiropractic services, an office visit shall not may only be billed on the same day as a manipulation is billed when it is the patient's initial visit with that provider.

0800-02-18-.09 PHYSICAL AND OCCUPATIONAL THERAPY GUIDELINES.

- (5) Whenever physical therapy and/or occupational therapy services exceed six (6) visits, or in cases which are post-operative, twelve (12) visits, such treatment shall be reviewed pursuant to the carrier's utilization review program in accordance with the procedures set forth in Chapter 0800-02-06 of the Division's Utilization Review rules before further physical therapy and/or occupational therapy services may be certified for payment by the carrier. Such certification shall be completed within the timeframes set forth in Chapter 0800-02-06 to assure no interruption in delivery of needed services. Failure by a provider to properly certify such services as prescribed herein shall result in the forfeiture of any payment for uncertified services. Failure by an employer or utilization review agent to conduct utilization review in accordance with this Chapter 0800-02-18 and Chapter 0800-02-06 shall result in no more than twelve (12) additional visits being deemed certified. The initial utilization review of physical therapy and/or occupational therapy services shall, if necessary and appropriate, certify an appropriate number of visits. If necessary, further subsequent utilization review shall be conducted to certify additional physical therapy and/or occupational therapy services as is appropriate; provided, that further certifications are not required to be in increments of twelve (12) visits.

0800-02-18-.10 DURABLE MEDICAL EQUIPMENT AND IMPLANT GUIDELINES.

- (1) Reimbursement for durable medical equipment and implants for which billed charges are \$100.00 or less shall be limited to eighty (80%) of billed charges. Durable medical equipment and implants for which billed charges exceed \$100.00 shall be reimbursed at a maximum amount of the supplier or manufacturer's invoice amount, plus the lesser of 15% of invoice or \$1,000.00, and coded using the HCPCS codes. These calculations are per item and are not cumulative. Charges for durable medical equipment and implants are in addition to, and shall be billed separately from, all facility and professional service

fees. Codes to be used are found in the HCPCS. Charges should be submitted on a HCFA 1500 form or, for hospital reimbursements, a UB 04 form.

0800-02-18-.12 PHARMACY SCHEDULE GUIDELINES.

- (1) The Pharmacy Fee Guideline maximum allowable amount for prescribed drugs (medicines by pharmacists and dispensing practitioners) under the Tennessee workers' compensation laws is the lesser of:

(c) The fees established by the formula for brand-name and generic pharmaceuticals as described in subsection (5) of this section the following subsections.

(e) Reimbursement

2. (v) If allowable payment for prescriptive drugs is not paid by employers or carriers for prescriptions provided to employees who have suffered a compensable work-related injury under the Workers' Compensation Law within thirty-one (31) days from the date of receipt by the employer or insurer of the bill for prescriptive drugs provided to such an employee, interest at the rate of 2.08% /month of the payment allowed pursuant to these rules may be charged by a hospital, pharmacy, or provider of such service as set forth in Rule 0800-2-174-.10 of the Medical Cost Containment Program Rules.

(f) "Patent" or "Proprietary Preparations"

2. Generic substitution as discussed in (4)(b)-(e)(2) above applies also to "over-the-counter" preparations.

(h) Repackaged or Compounded Products

All pharmaceutical bills submitted for repackaged or compounded products must include the NDC Number of the original manufacturer registered with the U.S. Food & Drug Administration or its authorized distributor's stock package used in the repackaging or compounding process. The reimbursement allowed shall be based on the current published manufacturer's AWP of the product or ingredient, calculated on a per unit basis, as of the date of dispensing. A repackaged or compounded NDC Number shall not be used and shall not be considered the original manufacturer's NDC Number. If the original manufacturer's NDC Number is not provided on the bill, then the reimbursement shall be based on the AWP of the lowest priced therapeutically equivalent drug, calculated on a per unit basis. The filling fees otherwise provided in these Rules shall be payable when applicable.

0800-02-18-.13 AMBULANCE SERVICES GUIDELINES.

- (4) Reimbursement shall be based upon the lesser of the submitted charge or 150% of the current Medicare rate. To the extent permitted by federal law, the rates determined in the preceding sentence shall also apply to air ambulance services. the average reimbursement rate for ambulances within the geographic locality. These charges shall not exceed the average charges in that locality for comparable services under comparable circumstances and commensurate with the services actually performed. Ambulance services shall be paid on a two (2) part basis, the first level being the level of care, the second being a mileage allowance. The services rendered are independent of the type of call received.

0800-02-19-.03 SPECIAL GROUND RULES – INPATIENT HOSPITAL SERVICES.

- (2) General Information
 - (e) The items listed in subsection (d)(4) shall be reimbursed according to the Medical Cost Containment Program Rules (Chapter 0800-02-17) and Medical Fee Schedule Rules (Chapter 0800-02-18) payment limits. Refer to the maximum rates set forth in Rule 0800-02-18-.02(4) for practitioner fees. Items not listed in the Rules shall be reimbursed at the usual and customary rate as defined in Rule 0800-02-17-.03(80), unless otherwise indicated herein.

(4) Stop-Loss Method

- (d) Example: DRG 222: Knee Procedures W/O CC

Hospital Peer Group: 1 – Surgical admission
 Maximum rate per day: \$1,800 for first 7 days; 1,500 for 2 additional days
 Number Billed Days: 9
 Total Billed Charges: \$37,600.00
(after subtracting amounts for implants, radiology, etc.): \$53,650.00

Maximum allowable payment for Normal DRG stay \$15,600.00

~~Versus: billed charges \$37,600.00~~

~~Amount Payable Before Stop-Loss,
 Lower of Charge vs. Maximum Allowable \$15,600.00~~

Total difference, charges over and above maximum
 payments..... ~~\$22,000.00~~ \$38,050.00
(if this amount is \$15,000 or less, then stop-loss is not applicable)

Difference over and above \$15,000 Stop-loss
 is..... ~~\$7,000.00~~ \$23,050.00
 Payable under Stop-loss (80% of
~~7,000.00~~ \$23,050.00)..... ~~\$5,600.00~~ \$18,440.00

Amounts due hospital for implants, radiology, etc.....\$3,525.00

Total payment
 due hospital: \$21,200.00 (15,600+5,600)

Maximum fee schedule amount:15,600.00 + 18,440.00 + 3,525.00 =
 \$37,565.00

Proper reimbursement would be the lesser of billed charges, maximum fee
 schedule amount, or other contracted or negotiated rate