

MISSISSIPPI WORKERS' COMPENSATION COMMISSION

IN THE MATTER OF:

**ADOPTION OF AMENDMENTS TO THE MISSISSIPPI WORKERS' COMPENSATION
MEDICAL FEE SCHEDULE - EFFECTIVE JULY 1, 2010**

ORDER

This matter came before the Commission to consider the adoption of changes to the Mississippi Workers's Compensation Medical Fee Schedule. The Commission, after having given public notice of these proposed changes, having held a public hearing thereon, and having heard and considered the public comments offered by interested parties, does hereby find and order as follows, to-wit:

I.

On May 5, 2010, the Commission filed notice with the Secretary of State of its intent to adopt certain changes to the Medical Fee Schedule, in compliance with the provisions of Miss. Code Ann. §25-43-3.101 et seq. (Rev. 2006), as amended. These notices also advised that a public hearing on the proposed changes would be held at the Office of the Commission on May 27, 2010.

II.

A public hearing to receive comments on these proposed changes to the Workers' Compensation Medical Fee Schedule was held at the Mississippi Workers' Compensation Commission building on May 27, 2010. All interested parties who attended were given the opportunity to present their views, opinions, and suggestions, and to ask questions of the Commission relative to the proposed changes to the Medical Fee Schedule.

III.

The Commission, after having considered all of the relevant evidence, research, written and

oral comments, and opinions, has determined that it will be in the best public interest to amend the Mississippi Workers' Compensation Medical Fee Schedule in accordance with the notice previously filed by the Commission. In certain instances, the final rule adopted by the Commission differs from the proposed rule, but the differences, as hereafter detailed, are either editorial in nature, or clearly within the scope of the matter announced in the previously filed notice of proposed rule adoption, are in character with the issues raised in the previously filed notice of proposed rule adoption, and represent a logical outgrowth of the contents of the previously filed notice and the comments submitted in response thereto. Furthermore, the previously filed notice provided fair warning that the outcome of this rule making proceeding could be the rule we adopt this day. Neither the subject matter of the adopted rule, nor the effect of the adopted rule, differ in any unforeseeable or prejudicial way from the proposed rule.

IV.

A copy of the 2010 Mississippi Workers' Compensation Medical Fee Schedule, as amended, is attached and incorporated herein, with the adopted changes indicated either by strikethrough or underlined formatting. An Executive Summary is also attached and incorporated herein, and when compared alongside the previously filed Executive Summary, reflects the changes between the proposed rule and the final rule as adopted herein.

Based on the foregoing, the herein described amendments to the Medical Fee Schedule are hereby **ADOPTED** as a final rule of the Commission with an effective date of July 1, 2010.

SO ORDERED on JUN 01 2010



Dr. Wilbur

John R. Jenkins D

Augusta L. Collins
COMMISSIONERS

ATTEST:

Phyllis Clark
Commission Secretary



Mississippi Workers' Compensation Commission

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Liles Williams, Chairman
John R. Junkin, Commissioner
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Scott Clark, Senior Attorney

June 1, 2010

EXECUTIVE SUMMARY OF 2010 AMENDMENTS TO MISSISSIPPI WORKERS' COMPENSATION MEDICAL FEE SCHEDULE

The Mississippi Workers' Compensation Commission has adopted changes to its Medical Fee Schedule, to become effective July 1, 2010. Below is a summary of the final changes. A full copy of the text is available online at www.mwcc.state.ms.us, or by contacting the Commission at 601-987-4200. When reviewing the full text, all changes are marked either with a strikethrough or underlining. Words or phrases with a strike through represented deletions from the current Schedule; words or phrases underlined represent additions to the Schedule which will become effective July 1, 2010.

I. Introduction

- a. Added language to the provision on "Medical Necessity" which prohibits treatment or reimbursement decisions being made solely on the basis of clinical guidelines, without also considering individual facts as documented by the provider.

II. General Rules

- a. Added rule that medical impairment ratings may only be rendered by a medical doctor, and established a maximum fee of \$250.00 for conducting a rating evaluation.
- b. Deleted functional capacity evaluation from the list of services which require pre-authorization, and added to this list an interdisciplinary pain rehabilitation program, and intraoperative neurophysiologic monitoring.
- c. Added a provision which limits the number of drug screens which may be conducted on the same patient on the same day.
- d. Added a provision to clarify the mileage reimbursement due a patient getting treatment under the Workers' Compensation Law.

III. Dispute Resolution Rules

- a. Added a provision stating that dispute resolution requests will not be considered by the Commission if filed more than one year after the date of service, absent compelling circumstances.

b Added a 14 day time limit for parties to comply with a final decision of the Cost Containment Division in a fee dispute matter.

c Added a procedure for seeking enforcement of a decision rendered in a fee dispute where no appeal is taken and the decision is final.

IV Utilization Review Rules

a Added a provision which requires utilization reviewers to have their written policies available for review by the provider or Commission upon request, along with a copy of the license or certification from the Department of Health.

b Added language which permits electronic notification to provider of review decisions.

c Changed the time a utilization reviewer is allowed to process a standard appeal from 30 days down to 21 days.

d Added language requiring notification to the provider on retrospective review determinations within 14 days.

e Added language which explicitly provides that either the provider or the patient may appeal a review determination.

f Added a provision stating that failure of the utilization reviewer to timely notify the provider of its decision within the times specified in these rules shall constitute approval of the treatment in question, and make the payer automatically liable for payment.

g Added a provision stating that a reviewer's failure without reasonable ground to comply with the time requirements of these rules may be considered sanctionable conduct under Miss. Code Ann. section 71-3-59.

V Nurse Practitioner and Physician Assistant Rules

a Added a provision which limits the reimbursement for services provided by a Physical or Occupational Therapist Assistant to 85% of the maximum allowable fee for the service being provided.

b Added a new two letter modifier, "T", which is to be used when billing for services provided by a physical or occupational therapist assistant.

VI Pharmacy Rules

a. Added rules regarding the payment for physician-dispensed, repackaged or compounded medications. This rule is designed to insure that payment for physician dispensed and/or repackaged medications is no greater than if the patient had obtained the medication at the pharmacy of his choice. Compounded medications shall be reimbursed based on the total fee due for each individual medication used in the compounds.

VII. Home Health Rules

a. Added a provision that overtime hours are not billable or reimbursed in Home Health; all hours worked are paid at the same rate.

VIII. Anesthesia Rules

a. Increased the unit price for anesthesia services from \$42.00 to \$45.00.

IX. Pain Management Rules

a. Changed reimbursement basis from the anesthesia unit system to the RBRVS system.

b. Added a rule limiting the number of pain management procedures reimbursable per day - changed this to one procedure per day.

c. Added rule limiting the number of epidural injections to one, absent evidence of positive patient response, and even then, no more than 3 such injections can be given in a 12-month period. Documentation of positive patient response after each injection is required.

d. Added rule requiring a certain level of benefit from therapeutic facet joint injections before a repeat injection will be allowed.

e. Added rule limiting use of sacroiliac arthroscopy to once every 12 months.

f. Added rule requiring at least 4 weeks analgesic response or at least 50% pain reduction before a repeat sacroiliac injection will be allowed; no more than 2 such injection per 12 month period.

X. Surgery Rules

a. Added requirements for use and approval of intraoperative neurophysiologic monitoring.

XI. Physical Medicine Rules

a. Added rules which limit reimbursement for EMG/NCS testing only to a licensed physical medicine doctor or neurologist, disallowing payment for automated NCS, and giving the ordering provider discretion to select the physical medicine or neurology provider to conduct the EMG/NCS.

b. Added guidelines for approval, use and reimbursement for an Interdisciplinary Pain Rehabilitation Programs which involve the use of physical medicine treatments as well as psychological treatments and therapy to treat the chronic pain patient.

c. Added rule which designates VAX-D therapy as experimental or investigational, and hence not reimbursable.

XII. Inpatient - Outpatient Facility Rules

a. Added rules which implements the Ambulatory Payment Classification system as developed by CMS for reimbursement of all outpatient services. Implants, however, will continue to be reimbursed separately; all C and E status codes will be included; an outlier rule applies.

XIII. Fee Data Changes

1. All professional fees are based on existing RBRVS values and conversion factors as of August 1, 2007. EXCEPT:

- a. New CPT codes from 2008 are valued using 2008 RBRVS.
- b. New CPT codes from 2009 and 2010 are valued using 2010 RBRVS with no change to current conversion factors.
- c. Anesthesia units are updated to the 2010 ASA Relative Value Guide;
- d. Dental codes are updated to the 2010 RBRVS.

2. Outpatient facility fees are based on the 2010 Ambulatory Payment Classification system, with a base rate of \$91.19.



Mississippi Workers' Compensation Commission

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May 5, 2010

EXECUTIVE SUMMARY OF PROPOSED AMENDMENTS TO MISSISSIPPI WORKERS' COMPENSATION MEDICAL FEE SCHEDULE

The Mississippi Workers' Compensation Commission is proposing to adopt certain changes to its Medical Fee Schedule, to become effective July 1, 2010. Below is a summary of the proposed changes. A full copy of the text is available online at www.mwcc.state.ms.us, or by contacting the Commission at 601-987-4200.

I. Introduction

a. Added language to the provision on "Medical Necessity" which prohibits treatment or reimbursement decisions being made solely on the basis of diagnosis, and/or on the basis of extraneous guidelines such as ODG.

II. General Rules

a. Medical impairment ratings may only be rendered by a medical doctor, and the fee for conducting a rating evaluation is \$250.00.

b. Deleted functional capacity evaluation from the list of services which require pre-authorization, and added to this list an interdisciplinary pain rehabilitation program, and intraoperative neurophysiologic monitoring.

c. Added a provision which limits the number of drug screens which may be conducted on the same patient on the same day.

d. Added a provision to clarify the mileage reimbursement due a patient getting treatment under the Workers' Compensation Law.

III. Dispute Resolution Rules

a. Added a provision stating that dispute resolution requests will not be considered by the Commission if filed more than one year after the date of service, absent compelling circumstances.

b. Set a 14 day tie limit for parties to comply with a final decision of the Cost Containment Division in a fee dispute matter.

c. Added a procedure for seeking enforcement of a decision rendered in a fee dispute where no appeal is taken and the decision is final.

IV. Utilization Review Rules

a. Combined current three levels of review into two steps.

b. Requires licensed physician in the same or similar specialty to make the decision to deny treatment or service; any licensed professional, including nurses, may approve treatment.

c. Requires licensed MS physician in the same specialty to make the review determination at the second level of review.

d. Requires UR agents to have their written policies available for review by the provider or Commission upon request, along with a copy of the license or certification from the Department of Health.

e. Permits electronic notification to provider of review decisions.

f. Requires notification of review decision on non-emergency admissions within 2 days, as opposed to 2 business days.

g. Changes the time a UR agent is allowed to process a standard appeal from 30 days down to 7 days.

h. Requires notification to the provider on retrospective review determinations within 14 days.

i. Explicitly provides that either the provider or the patient may appeal a UR determination.

j. Adds a provision stating that failure of the UR agent to notify the provider of its decision within the times provided in these rules will constitute approval of the treatment in question.

k. Adds a provision stating that failure without reasonable ground to comply with the time requirements of these rules may be considered sanctionable conduct under section 71-3-59.

V. Nurse Practitioner and Physician Assistant Rules

a. Adds a provision allowing Physical Therapy Assistants to get reimbursed at 50% of the maximum allowable fee for the Physical Therapist.

VI. Pharmacy Rules

a. Adds rules regarding the payment for physician-dispensed, repackaged or compounded medications. Rule is designed to insure that payment for these medications is in line with the other provisions of the Pharmacy rules which allow payment at average wholesale price.

VII. Home Health Rules

a. Added a provision that overtime hours are not billable or reimbursed in Home Health; all hours worked are paid at the same rate.

VIII. Anesthesia Rules

a. Increased the unit price for anesthesia services from \$42.00 to \$45.00.

IX. Pain Management Rules

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- b. Added guidelines for approval and conduct and payment for Interdisciplinary Pain Rehabilitation Programs which involve the use of physical medicine treatments as well as psychological treatments and therapy to treat the chronic pain patient.

- c. Rule which designates VAX-D therapy as experimental or investigational, and hence not reimbursable.

XII. Inpatient - Outpatient Facility Rules

- a. Implements the Ambulatory Payment Classification system as developed by CMS for reimbursement of all outpatient services. Implants, however, will continue to be reimbursed separately; all C and E status codes will be included; an outlier rule applies.

XIII. Fee Data Changes

1. All professional fees are based on existing RBRVS values and conversion factors as of August 1, 2007, EXCEPT:

- a. New CPT codes from 2008 are valued using 2008 RBRVS;
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2. Outpatient facility fees are based on the 2010 Ambulatory Payment Classification system, with a base rate of \$91.19.

Introduction

Pursuant to Mississippi Code Annotated (MCA), section 71-3-15(3)(Rev. 2000), the following Fee Schedule, including Cost Containment and Utilization Management rules and guidelines, is hereby established in order to implement a medical cost containment program. This Fee Schedule, and accompanying rules and guidelines, applies to medical services rendered after the effective date of ~~August 1, 2008~~, July 1, 2010, and, in the case of inpatient treatment, to services where the discharge date is on or after ~~August 1, 2008~~, July 1, 2010. This Fee Schedule establishes the maximum level of medical and surgical reimbursement for the treatment of work-related injuries and/or illnesses, which the Mississippi Workers' Compensation Commission deems to be fair and reasonable.

This Fee Schedule shall be used by the Workers' Compensation Commission, insurance payers, and self-insurers for approving and paying medical charges of physicians, surgeons, and other health care providers for services rendered under the Mississippi Workers' Compensation Law. This Fee Schedule applies to all medical services provided to injured workers by physicians, and also covers other medical services arranged for by a physician. In practical terms, this means professional services provided by hospital-employed physicians, as well as those physicians practicing independently, are reimbursed under this Fee Schedule.

The Commission will require the use of the most current version of the CPT book and HCPCS codes and modifiers in effect at the time services are rendered. All coding, billing and other issues, including disputes, associated with a claim, shall be determined in accordance with the CPT rules and guidelines in effect at the time service is rendered, unless otherwise provided in this Fee Schedule or by the Commission. As used in this Fee Schedule, CPT refers to the American Medical Association's *Current Procedural Terminology* codes and nomenclature. CPT is a registered trademark of the American Medical Association. HCPCS is an acronym for the Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System and includes codes for procedures, equipment, and supplies not found in the CPT book. However, the inclusion of a service, product or supply in the CPT book or HCPCS book does not necessarily imply coverage, reimbursement or endorsement.

I. FORMAT

This Fee Schedule is comprised of the following sections: Introduction; General Rules; Billing and Reimbursement Rules; Medical Records Rules; Dispute Resolution Rules; Utilization Review Rules; Rules for Modifiers and Code Exceptions; Pharmacy Rules; Nurse Practitioner and Physician Assistant Rules; Home Health Rules; Skilled Nursing Facility Rules; Evaluation and Management; Anesthesia; Pain Management; Surgery; Radiology; Pathology and Laboratory; Medicine Services; Physical Medicine; Dental; Durable Medical Equipment (DME), Orthotics, Prosthetics and Other HCPCS Codes; Inpatient Hospital Payment Schedule and Rules; and Forms. Each section listed above has specific instructions (rules/guidelines). The Fee Schedule is divided into these sections for structural purposes only. Providers are to use the specific section(s) that contains the procedure(s) they perform or the service(s) they render. In the event a rule/guideline contained in one of the specific service sections conflicts with a general rule/guideline, the specific section rule/guideline will supersede.

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This Fee Schedule utilizes *Current Procedural Terminology* (CPT) codes and guidelines under copyright agreement with the American Medical Association. The descriptions included are full procedure descriptions. A complete list of modifiers is included in a separate section for easy reference.

II. SCOPE

The *Mississippi Workers' Compensation Medical Fee Schedule* does the following:

- A. Establishes rules/guidelines by which the employer shall furnish, or cause to be furnished, to an employee who suffers a bodily injury or occupational disease covered by the Mississippi Workers' Compensation Law, reasonable and necessary medical, surgical, and hospital services, medicines, supplies or other attendance or treatment as necessary. The employer shall provide to the injured employee such medical or dental surgery, crutches, artificial limbs, eyes, teeth, eyeglasses, hearing apparatus, and other appliances which are reasonable and necessary to treat, cure, and/or relieve the employee from the effects of the injury/illness, in accordance with MCA §71-3-15 (Rev. 2000), as amended.
- B. Establishes a schedule of maximum reimbursement allowances (MRA) for such treatment, attendance, service, device, apparatus, or medicine.
- C. Establishes rules/guidelines by which a health care provider shall be paid the lesser of (a) the provider's total billed charge, or (b) the maximum reimbursement allowance (MRA) established under this Fee Schedule.
- D. Establishes rules for cost containment to include utilization review of health care and health care services, and provides for the acquisition by an employer/payer, other interested parties, and the Mississippi Workers' Compensation Commission, of the necessary records, medical bills, and other information concerning any health care or health care service under review.
- E. Establishes rules for the evaluation of the appropriateness of both the level and quality of health care and health care services provided to injured employees, based upon medically accepted standards.
- F. Authorizes employers/payers to withhold payment from, or recover payment from, health facilities or health care providers that have made excessive charges or which have provided unjustified and/or unnecessary treatment, hospitalization, or visits.
- G. Provides for the review by the employer/payer or Commission any health facility or health care provider records and/or medical bills that have been determined not to be in compliance with the schedule of charges established herein.
- H. Establishes that a health care provider or facility may be required by the employer/payer to explain in writing the medical necessity of health care or health care service that is not usually associated with, is longer and/or more frequent than, the health care or health care service usually accompanying the diagnosis or condition for which the patient is being treated.
- I. Provides for medical cost containment review and decision responsibility. The rules and definitions hereunder are not intended to supersede or modify the Workers' Compensation Act, the administrative rules of the Commission, or court decisions interpreting the Act or the Commission's administrative rules.
- J. Provides for the monitoring of employer/payers to determine their compliance with the criteria and standards established by this Fee Schedule.
- K. Establishes deposition/witness fees.
- L. Establishes fees for medical reports.

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- M. Provides for uniformity in billing of provider services.
- N. Establishes rules/guidelines for billing.
- O. Establishes rules/guidelines for reporting medical claims for service.
- P. Establishes rules/guidelines for obtaining medical services by out-of-state providers.
- Q. Establishes rules/guidelines for Utilization Review to include pre-certification, concurrent review, discharge planning and retrospective review.
- R. Establishes rules for dispute resolution which includes an appeal process for determining disputes which arise under this Fee Schedule.
- S. Establishes a Peer Review system for determining medical necessity. Peer review is conducted by professional practitioners of the same specialty as the treating medical provider on a particular case.
- T. Establishes the list of health care professionals who are considered authorized providers to treat employees under the Mississippi Workers' Compensation Law, and who, by reference in this rule, will be subject to the rules, guidelines and maximum reimbursement limits in this Fee Schedule.
- U. Establishes financial and other administrative penalties to be levied against payers or providers who fail to comply with the provisions of the Fee Schedule, including but not limited to interest charges for late billing or payment, percentage penalties for late billing or payment, and additional civil penalties for practices deemed unreasonable by the Commission.

III. MEDICAL NECESSITY

The concept of medical necessity is the foundation of all treatment and reimbursement made under the provision of section 71-3-15, Mississippi Code of 1972, as amended. For reimbursement to be made, services and supplies must meet the definition of "medically necessary." Utilization management or review decisions shall not be based solely on the application of clinical guidelines, but must include review of clinical information submitted by the provider and represent an individualized determination based on the worker's current condition and the concept of medical necessity predicated on objective or appropriate subjective improvements in the patient's clinical status.

- A. For the purpose of the Workers' Compensation Program, any reasonable medical service or supply used to identify or treat a work-related injury/illness which is appropriate to the patient's diagnosis, is based upon accepted standards of the health care specialty involved, represents an appropriate level of care given the location of service, the nature and seriousness of the condition, and the frequency and duration of services, is not experimental or investigational, and is consistent with or comparable to the treatment of like or similar non-work related injuries, is considered "medically necessary." The service must be widely accepted by the practicing peer group, based on scientific criteria, and determined to be reasonably safe. It must not be experimental, investigational, or research in nature except in those instances in which prior approval of the payer has been obtained. For purposes of this provision, "peer group" is defined as similarly situated physicians of the same specialty, licensed in the State of Mississippi, and qualified to provide the services in question.
- B. Services for which reimbursement is due under this Fee Schedule are those services meeting the definition of "medically necessary" above and includes such testing or other procedures reasonably necessary and required to determine or diagnose whether a work-related injury or illness has been sustained, or which are required for the remedial treatment or diagnosis of an on-the-job injury, a

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work-related illness, a pre-existing condition affected by the injury or illness, or a complication resulting from the injury or illness, and which are provided for such period as the nature of the injury or process of recovery may require.

- C. Treatment of conditions unrelated to the injuries sustained in an industrial accident may be denied as unauthorized if the treatment is directed toward the non-industrial condition or if the treatment is not deemed medically necessary for the patient's rehabilitation from the industrial injury.

IV. DEFINITIONS

Act means Mississippi Workers' Compensation Law, Mississippi Code Annotated (MCA), section 71-3-1 et seq. (Rev. 2000 as amended).

Adjust means that a payer or a payer's agent reduces or otherwise alters a health care provider's request for payment.

Appropriate care means health care that is suitable for a particular patient, condition, occasion, or place.

Bill means a claim submitted by a provider to a payer for payment of health care services provided in connection with a covered injury or illness.

Bill adjustment means a reduction of a fee on a provider's bill, or other alteration of a provider's bill.

By report (BR) means that the procedure is new, or is not assigned a maximum fee, and requires a written description included on or attached to the bill. "BR" procedures require a complete listing of the service, the dates of service, the procedure code, and the payment requested. The report is included in the reimbursement for the procedure.

Carrier means any stock company, mutual company, or reciprocal or inter-insurance exchange authorized to write or carry on the business of Workers' Compensation Insurance in this State, or self-insured group, or third-party payer, or self-insured employer, or uninsured employer.

CMS-1500 means the CMS-1500 form and instructions that are used by noninstitutional providers and suppliers to bill for outpatient services. Use of the most current CMS-1500 form is required.

Commission means the Mississippi Workers' Compensation Commission.

Case means a covered injury or illness occurring on a specific date and identified by the worker's name and date of injury or illness.

Consultation means a service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. If a consultant, subsequent to the first encounter, assumes responsibility for management of the patient's condition, that physician becomes a treating physician. The first encounter is a consultation and shall be billed and reimbursed as such. A consultant shall provide a written report of his/her findings. *A second opinion is considered a consultation.*

Controverted claim is a workers' compensation claim which is pending before the Commission and in which the patient or patient's legal representative has filed a Petition to Controvert.

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Covered injury or illness means an injury or illness for which treatment is mandated under the Act.

Critical care means care rendered in a variety of medical emergencies that requires the constant attention of the practitioner, such as cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, and is usually provided in a critical care unit or an emergency department.

Day means a continuous 24-hour period.

Diagnostic procedure means a service that helps determine the nature and causes of a disease or injury.

Durable medical equipment (DME) means specialized equipment designed to stand repeated use, appropriate for home use, and used solely for medical purposes.

Expendable medical supply means a disposable article that is needed in quantity on a daily or monthly basis.

Follow-up care means the care which is related to the recovery from a specific procedure and which is considered part of the procedure's maximum reimbursement allowance, but does not include complications.

Follow-up days are the days of care following a surgical procedure which are included in the procedure's maximum reimbursement allowance amount, but which do not include complications. The follow-up day period begins on the day of the surgical procedure(s).

Health care review means the review of a health care case, bill, or both by the payer or the payer's agent.

Incident to means that the services and supplies are commonly furnished as an integral part of the primary service or procedure.

Incidental surgery means surgery performed through the same incision, on the same day, by the same doctor, not increasing the difficulty or follow-up of the main procedure, or not related to the diagnosis.

Incorrect payment means the provider was not reimbursed according to the rules/guidelines of the Fee Schedule and the payer has failed to provide any reasonable basis for the adjusted payment.

Independent medical examination (IME) means a consultation provided by a physician to evaluate a patient at the request of the Commission. This evaluation may include an extensive record review and physical examination of the patient and requires a written report.

Independent procedure means a procedure that may be carried out by itself, completely separate and apart from the total service that usually accompanies it.

Inpatient services means services rendered to a person who is admitted as an inpatient to a hospital.

Maximum reimbursement allowance (MRA) means the maximum fee allowed for medical services as set forth in this Fee Schedule.

Medical only case means a case that does not involve more than five (5) days of disability or lost work time and for which only medical treatment is required.

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Medically accepted standard means a measure set by a competent authority as the rule for evaluating quality or quantity of health care or health care services and which may be defined in relation to any of the following:

- Professional performance
- Professional credentials
- The actual or predicted effects of care
- The range of variation from the norm

Medically necessary means any reasonable medical service or supply used to identify or treat a work-related injury/illness which is appropriate to the patient's diagnosis, is based upon accepted standards of the health care specialty involved, represents an appropriate level of care given the location of service, the nature and seriousness of the condition, and the frequency and duration of services, is not experimental or investigational, and is consistent with or comparable to the treatment of like or similar non-work related injuries. Utilization management or review decisions shall not be based on application of clinical guidelines, but must include review of clinical information submitted by the provider and represent an individualized determination based on the worker's current condition and the concept of medical necessity predicated on objective or appropriate subjective improvements in the patient's clinical status.

Medical record means a record in which the medical service provider records the subjective findings, objective findings, diagnosis, treatment rendered, treatment plan, and return to work status and/or goals and impairment rating as applicable.

Medical supply means either a piece of durable medical equipment or an expendable medical supply.

Observation services means services rendered to a person who is designated or admitted to a hospital or facility as observation status.

Operative report means the practitioner's written description of the surgery and includes all of the following:

- A preoperative diagnosis;
- A postoperative diagnosis;
- A step-by-step description of the surgery;
- A description of any problems that occurred in surgery; and
- The condition of the patient upon leaving the operating room.

Optometrist means an individual licensed to practice optometry.

Orthotic equipment means an orthopedic apparatus designed to support, align, prevent, or correct deformities, or improve the function of a moveable body part.

Orthotist means a person skilled in the construction and application of orthotic equipment.

Outpatient service means services provided to patients at a time when they are not hospitalized as inpatients.

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Payer means the employer or self-insured employed group, carrier, or third-party administrator (TPA) who pays the provider billings.

Pharmacy means the place where the science, art, and practice of preparing, preserving, compounding, dispensing, and giving appropriate instruction in the use of drugs is practiced.

Practitioner means a person licensed, registered, or certified as an acupuncturist, audiologist, doctor of chiropractic, doctor of dental surgery, doctor of medicine, doctor of osteopathy, doctor of podiatry, doctor of optometry, massage therapist, nurse, nurse anesthetist, nurse practitioner, occupational therapist, orthotist, pharmacist, physical therapist, physician assistant, prosthetist, psychologist, or other person licensed, registered, or certified as a health care professional or provider.

Primary procedure means the therapeutic procedure most closely related to the principal diagnosis, and in billing, the CPT code with the highest relative value unit (RVU) that is neither an add-on code nor a code exempt from modifier 51 shall be considered the primary procedure. Reimbursement for the primary procedure is not dependent on the ordering or re-ordering of codes.

Procedure means a unit of health service.

Procedure code means a five-digit numerical sequence or a sequence containing an alpha character and preceded or followed by four digits, which identifies the service performed and billed.

Properly submitted bill means a request by a provider for payment of health care services submitted to a payer on the appropriate forms with appropriate documentation and within the time frame established under the guidelines of the Medical Fee Schedule.

Prosthesis means an artificial substitute for a missing body part.

Prosthetist means a person skilled in the construction and application of prostheses.

Provider means a facility, health care organization, or a practitioner who provides medical care or services.

Secondary procedure means a surgical procedure performed during the same operative session as the primary surgery but considered an independent procedure that may not be performed as part of the primary surgery.

Special report means a report requested by the payer to explain or substantiate a service or clarify a diagnosis or treatment plan.

Specialist means a board-certified practitioner, board-eligible practitioner, or a practitioner otherwise considered an expert in a particular field of health care service by virtue of education, training, and experience generally accepted by practitioners in that particular field of health care service.

Usual and customary rate/fee is a reimbursement allowance equal to the amount displayed by the Ingenix MDR Charge Payment System (Mississippi State Version) for the procedure at the 40th percentile. The Ingenix MDR Charge Payment System is a national database of Relative and Actual Charge Data (RACD) which includes charge information for the State of Mississippi.

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V. HOW TO INTERPRET THE FEE SCHEDULE

CPT Code

The first column lists the American Medical Association's (AMA) CPT code. CPT 2008 codes are used by arrangement with the AMA.

Add-on Codes

* denotes procedure codes that are considered "add-on" codes as defined in the CPT book.

Modifier 51 Exempt

* denotes procedure codes that are exempt from the use of modifier 51 and are not designated as add-on procedures/services as defined in the CPT book.

Conscious Sedation

K denotes procedure codes that include conscious sedation as an inherent part of providing the procedure.

Description

This Fee Schedule uses actual 2008 CPT full descriptions.

Relative Value

This column lists the relative value unit (RVU) assigned to each procedure. There are, however, procedures too variable to accept a set value—these are "by report" procedures and are noted BR.

Amount

This column lists the total reimbursable as a monetary amount.

PC Amount

Where there is an identifiable professional and technical component to a procedure, the portion considered to be the professional component is listed. The professional component gives the total reimbursable as a monetary amount. The technical component can be identified as the Amount minus the PC Amount.

FUD

Follow-up days included in a surgical procedure's global charge are listed in this column.

Assist Surg

The assistant surgeon column identifies procedures that are approved for an assistant to the primary surgeon whether a physician, physician assistant (PA), registered nurse first assistant (RNFA, RA), or other individual qualified for reimbursement as an assistant under the Fee Schedule.

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Ambulatory Surgery Center (ASC) payment is made for facility services furnished in conjunction with outpatient surgical procedures.

Facility Fee

The facility fee is paid to the facility for the technical portion of services provided in conjunction with outpatient pain management, pathology, laboratory, and radiology procedures.

VI. AUTHORIZED PROVIDERS

The following health care providers are recognized by the Mississippi Workers' Compensation Commission as acceptable to provide treatment to injured workers under the terms of the Act, and must comply with the rules, guidelines, billing and reimbursement policies and maximum reimbursement allowance (MRA) contained in this Fee Schedule when providing treatment or service under the terms of the Act.

Acupuncturist (L.A.C.)
 Audiologist
 Certified Registered Nurse Anesthetist (C.R.N.A.)
 Doctor of Chiropractic (D.C.)
 Doctor of Dental Surgery (D.D.S.)/Doctor of Dental Medicine (D.D.M.)
 Doctor of Osteopathy (D.O.)
 Licensed Clinical Social Worker (L.C.S.W.)
 Licensed Nursing Assistant
 Licensed Practical Nurse (L.P.N.)
 Massage Therapist
 Medical Doctor (M.D.)
 Nurse Practitioner (N.P.)
 Occupational Therapist (O.T.)
 Optometrist (O.D.)
 Oral Surgeon (M.D., D.O., D.M.D., D.O.S.)
 Pharmacist (R.Ph.)
 Physical Therapist (P.T.)
Physical or Occupational Therapist Assistant (P.T.A.)
 Physician Assistant (P.A.)
 Podiatrist (D.P.M.)
 Prosthetist or Orthotist
 Psychologist (Ph.D.)
 Registered Nurse (R.N.)
 Registered Nurse First Assistant (R.N.F.A., R.A.)
 Speech Therapist

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All health care providers, as listed herein, are subject to the rules, limitations, exclusions, and maximum reimbursement allowances of this Fee Schedule. Medical treatment under the terms of the Act may be provided by any other person licensed, registered or certified as a health care professional if approved by the payer or Commission, and in such case, said provider and payer shall be subject to the rules and guidelines, including maximum reimbursement amounts, provided herein.

VII. INFORMATION PROGRAM

The Workers' Compensation Commission shall provide ongoing information regarding this Fee Schedule for providers, payers, their representatives and any other interested persons or parties. This information shall be provided primarily through informational sessions and seminar presentations at our Annual Education Conference as well as the distribution of appropriate information materials via the Commission's website, and by other means as needed.

General Rules

I. CONFIRMATORY CONSULTATION

As provided in section 71-3-15(1) of the Act, and in M.W.C.C. General Rule 9, a payer/employer may request a second opinion examination or evaluation for the purpose of evaluating temporary or permanent disability or medical treatment being rendered. This examination is considered a confirmatory consultation. The confirmatory consultation is billed using the appropriate level and site-specific consultation code with modifier 32 appended to indicate a mandated service and paid in accordance with the Fee Schedule.

II. CODING STANDARD

- A. The most current version of the American Medical Association's *Current Procedural Terminology (CPT)* book, and, where appropriate, the codes and descriptors of the American Society of Anesthesiologists' *Relative Value Guide™*, in effect at the time service is rendered or provided shall be the authoritative coding guide, unless otherwise specified in this Fee Schedule.
- B. The most current version of HCPCS Level II codes developed by CMS in effect at the time service is rendered or provided shall be the authoritative coding guide for durable medical equipment, prosthetics, orthotics, and other medical supplies (DMEPOS), unless otherwise specified in this Fee Schedule.

III. DEPOSITION/WITNESS FEES; MEDICAL RECORDS AFFIDAVIT

- A. Any health care provider who gives a deposition or is otherwise subpoenaed to appear in proceedings pending before the Commission shall be paid a witness fee as provided by M.W.C.C. Procedural Rule 18(h) in the amount of \$25.00 per day plus mileage reimbursement at the rate authorized by M.W.C.C. General Rule 14. Procedure code 99075 must be used to bill for a deposition.
- B. In addition to the above fee and mileage reimbursement, any health care provider who gives testimony by deposition or who appears in person to testify at a hearing before the Commission shall be paid \$500.00 for the first hour and \$125.00 per quarter hour thereafter. This fee includes necessary preparation time. In the event a deposition is cancelled through no fault of the provider, the provider shall be entitled to a payment of \$250.00 unless notice of said cancellation is given to the provider at least 72 hours in advance. In the event a deposition is cancelled through no fault of the provider within 24 hours of the scheduled time, then, in that event, the provider shall be paid the rate due for the first hour of a deposition. Nothing stated herein shall prohibit a medical provider and a party seeking to take the medical provider's deposition from entering into a separate contract which provides for reimbursement other than as above provided.

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- C. Pursuant to Mississippi Workers' Compensation Commission Procedural Rule 9, an examining or treating physician may execute an affidavit in lieu of direct testimony. The Physician's Medical Record Custodian is allowed to sign the affidavit in lieu of the physician's signature. Such charge for execution of the affidavit is limited to a maximum reimbursement of \$25.00. Reimbursement for copies of medical records that are attached to affidavits shall be made as outlined elsewhere in the Fee Schedule.

IV. IMPAIRMENT RATING

- A. In determining the extent of permanent impairment attributable to a compensable injury, the provider shall base this determination on the most current edition of the *Guides to the Evaluation of Permanent Impairment*, as published and copyrighted by the American Medical Association which is in effect at the time the service is rendered. Only a medical doctor is entitled under these rules to reimbursement for conducting an impairment rating evaluation.
- B. A provider is entitled to reimbursement for conducting an impairment rating evaluation and determining the extent of permanent impairment, and should bill for such services using CPT codes 99455 or 99456. The reimbursement for CPT code 99455 shall be \$250.00.

V. INDEPENDENT MEDICAL EXAMINATION (IME)

- A. An independent medical examination (IME) may be ordered by the Mississippi Workers' Compensation Commission or its Administrative Judges. A practitioner other than the treating practitioner must do the medical examination, and the Commission or Judge shall designate the examiner.
- B. An independent medical examination (IME) shall include a study of previous history and medical care information, diagnostic studies, diagnostic x-rays, and laboratory studies, as well as an examination and evaluation. An IME can only be ordered by the Workers' Compensation Commission or one of its Administrative Judges. A copy of the report must be sent to the patient, or his attorney if represented, the payer, and the Mississippi Workers' Compensation Commission.
- C. The fee for the IME may be set by the Commission or Judge, or negotiated by the payer and provider prior to setting the appointment, and in such cases, reimbursement shall be made according to the order of the Commission or Judge, or according to the mutual agreement of the parties. In the absence of an agreement or order regarding reimbursement for an IME, the provider shall bill for the IME using the appropriate level and site-specific consultation code appended with modifier 32 to indicate a mandated service, and shall be reimbursed according to the Fee Schedule.

VI. MAXIMUM MEDICAL IMPROVEMENT

- A. When an employee has reached maximum medical improvement (MMI) for the work related injury and/or illness, the physician should promptly, and at least within fourteen (14) days, submit a report to the payer showing the date of maximum medical improvement.
- B. Maximum medical improvement is reached at such time as the patient reaches the maximum benefit from medical treatment or is as far restored as the permanent character of his injuries will permit and/or the current limits of medical science will permit. Maximum medical improvement may be found even though the employee will require further treatment or care.

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VII. OUT-OF-STATE MEDICAL TREATMENT

- A. Each employer shall furnish all reasonable and necessary drugs, supplies, hospital care and services, and medical and surgical treatment for the work-related injury or illness. All such care, services, and treatment shall be performed at facilities within the state when available.
- B. When billing for out-of-state services, supporting documentation is necessary to show that the service being provided cannot be performed within the state, the same quality of care cannot be provided within the state, or more cost-effective care can be provided out-of-state. In determining whether out-of-state treatment is more cost effective, this question must be viewed from both the payer and patient's perspective. As stated in General Rule 9, treatment should be provided in an area reasonably convenient to the place of the injury or the residence of the injured employee, in addition to being reasonably suited to the nature of the injury.
- C. Reimbursement for out-of-state services shall be based on one of the following, in order of preference: (1) the workers' compensation fee schedule for the state in which services are rendered, or (2) in cases where there is no applicable fee schedule for the state in which services are rendered, or the fee schedule in said state excludes or otherwise does not provide reimbursement allowances for the services rendered, reimbursement should be paid at the usual and customary rate for the geographical area in which the services are rendered, or (3) reimbursement for out-of-state services may be based on the mutual agreement of the parties.
- D. Prior authorization must be obtained from the payer for referral to out-of-state providers. The documentation must include the following:
1. Name and location of the out-of-state provider.
 2. Justification for an out-of-state provider, including qualifications of the provider and description of services being requested.

VIII. AUTHORIZATION FOR TREATMENT

- A. Prior Authorization: Providers must request authorization from the payer before service is rendered for the services and supplies listed below.
1. Non-emergency elective inpatient hospitalization
 2. Non-emergency elective inpatient surgery
 3. Non-emergency elective outpatient surgery
 4. Physical medicine treatments after 15 visits or 30 days, whichever comes first
 5. Rental or purchase of supplies or equipment over the amount of \$50.00 per item
 6. Rental or purchase of TENS
 7. Home health services
 8. Pain clinic/therapy programs, including interdisciplinary pain rehabilitation programs.
 9. External spinal stimulators
 10. Pain control programs
 11. Work hardening programs, back schools, functional capacity testing, ISO kinetic testing
 12. Referral for orthotics or prosthetics
 13. Referral for acupuncture

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14. Referral for biofeedback
 15. Referral to psychological testing/counseling
 16. Referral to substance abuse program
 17. Referral to weight reduction program
 18. Referral to any non-emergency medical service outside the State of Mississippi
 19. Repeat MRI (more than one per injury)
 20. Repeat CT Scan (more than one per injury)
 21. Intraoperative neurophysiologic monitoring (e.g., SSEP, VEP, DEP, BAEP, MEP)
- B. **Response Time.** The payer must respond within two (2) business days to a request of prior authorization for non-emergency services.
- C. **Federal Facilities.** Treatment provided in federal facilities requires authorization from the payer. However, federal facilities are exempt from the billing requirements and reimbursement policies in this manual.
- D. **Pre-certification for Non-emergency Surgery.** Providers must pre-certify all non-emergency surgery. However, certain catastrophic cases require frequent returns to the operating room (O.R.) (e.g., burns may require daily surgical debridement). In such cases, it is appropriate for the provider to obtain certification of the treatment plan to include multiple surgical procedures. The provider's treatment plan must be specific and agreement must be mutual between the provider and the payer regarding the number and frequency of procedures certified.
- E. **Retrospective Review.** Failure to obtain pre-certification as required by this Fee Schedule shall not, in and of itself, result in a denial of payment for the services provided. Instead, the payer, if requested to do so by the provider within one (1) year of the date of service or discharge, shall conduct a retrospective review of the services, and if the payer determines that the services provided would have been pre-certified, in whole or in part, if pre-certification had been timely sought by the provider, then the payer shall reimburse the provider for the approved services according to the Fee Schedule, or, if applicable, according to the separate fee agreement between the payer and provider, less a ten percent (10%) penalty for the provider's failure to obtain pre-certification as required by this Fee Schedule. This penalty shall be computed as ten percent (10%) of the total allowed reimbursement. If, upon retrospective review, the payer determines that pre-certification would not have been given, or would not have been given as to part of the requested services, then the payer shall dispute the bill and proceed in accordance with the Billing and Payment Rules as hereafter provided.
- F. **Authorization Provided by Employer or Payer.** When authorization for treatment is sought and obtained from the employer, or payer, whether verbally or in writing, and medical treatment is rendered in good faith reliance on this authorization, the provider is entitled to payment from the employer or payer for the initial visit or evaluation, or in emergency cases, for treatment which is medically necessary to stabilize the patient. Reimbursement is not dependent on, and payment is due regardless of, the outcome of medically necessary services which are provided in good faith reliance upon authorization given by the employer or payer.

IX. RETURN TO WORK

If an employee is capable of some form of gainful employment, it is advisable for the physician to release the employee to light work and make a specific report to the payer as to the date of such release and setting out any restrictions on such light work. It can be to the employee's economic advantage to be released to light or alternative work, since he/she can receive compensation based on sixty-six and two-thirds percent (66 2/3%) of the difference between the employee's earnings in such work and the employee's pre-injury average weekly wage. The physician's judgment in such matters is extremely

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important, particularly as to whether the patient is medically capable of returning to work in some capacity

Return to work decisions should be based on objective findings, and the physician's return to work assessment should identify, if possible, any alternative duty employment to which the patient may return if return to full duty is not medically advisable.

X. SELECTION OF PROVIDERS

The selection of appropriate providers for diagnostic testing or analysis, including but not limited to CAT scans, MRI, x-ray, and laboratory, shall be at the direction of the treating or prescribing physician. In the absence of specific direction from the treating or prescribing physician, the selection shall be made by the payer, in consultation with the treating or prescribing physician.

Physical or occupational therapy, including work hardening, functional capacity evaluations, back schools, chronic pain programs, or massage therapy shall be provided upon referral from a physician. In the absence of specific direction from the treating or prescribing physician, the selection of a provider for these services shall be made by the payer in consultation with the treating or prescribing physician.

Referral for an electromyogram and/or a nerve conduction study shall be at the discretion and direction of the physician in charge of care, and neither the payer nor the payer's agent may unilaterally or arbitrarily redirect the patient to another provider for these tests. The payer or the payer's agent may, however, discuss with the physician in charge of care appropriate providers for the conduct of these tests in an effort to reach an agreement with the physician in charge as to who will conduct an electromyogram and/or nerve conduction study in any given case.

The selection of providers for the purchase or rental of durable medical equipment shall be at the direction of the payer.

The selection of providers for medical treatment or service, other than as above provided, shall be in accordance with the provisions of MCA section 71-3-15 (Rev. 2000).

XI. DRUG SCREENING

Only one (1) drug screen or drug test result shall be eligible for reimbursement for each drug test conducted on the same patient on the same day, except and unless the initial screening results are deemed by the prescribing provider to be inconsistent or inherently unreliable. In that event, a confirmation screening may be ordered by the prescribing provider and shall be paid for by the payer. In addition, treatment may not be discontinued based on the results of a drug test absent a confirmation test, which shall be reimbursed in addition to the initial screening test. Merely duplicate screenings or tests which are rerun to confirm initial results are not otherwise eligible for reimbursement.

XII. MILEAGE REIMBURSEMENT

The payer shall reimburse each claimant for all travel to obtain medical treatment which is being obtained under the provisions of the Mississippi Workers' Compensation Law, including travel to a pharmacy to obtain medication or supplies necessary for treatment of a compensable injury, regardless of the number of miles traveled. There is no minimum distance of travel required for reimbursement, and reimbursement shall be made for each mile of round trip travel necessitated by the compensable injury, at the rate

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adopted by the Commission and in effect at the time of the travel. Only reasonable and necessary miles traveled are subject to reimbursement.

Billing and Reimbursement Rules

I. GENERAL PROVISIONS

- A. **Maximum Reimbursement Allowance (MRA).** Unless the payer and provider have a separate fee contract which provides for a different level of reimbursement, the maximum reimbursement allowance for health care services shall be the lesser of (a) the provider's total billed charge, or (b) the maximum specific fee established by the Fee Schedule. Items or services or procedures which do not have a maximum specific fee established by this Fee Schedule shall be reimbursed at the usual and customary fee as defined in this Fee Schedule, and in such cases, the maximum reimbursement allowance shall be the lesser of (1) the provider's total billed charge, or (2) the usual and customary fee as defined by this Fee Schedule.

If this Fee Schedule does not establish a maximum specific fee for a particular service or procedure, and a usual and customary rate cannot be determined because the Ingenix MDR Charge Payment System database does not contain a fee for same, then the maximum reimbursement allowance shall be equal to the national Medicare allowance plus thirty percent (30%). In the absence of an established Medicare value, and assuming none of the above provisions apply, the maximum reimbursement allowance shall be the provider's total billed charge.

- B. **Separate Fee Contract.** An employer/payer may enter into a separate contractual agreement with a medical provider regarding reimbursement for services provided under the provisions of the Mississippi Workers' Compensation Law, and if an employer/payer has such a contractual agreement with a provider designed to reduce the cost of workers' compensation health care services, the contractual agreement shall control as to the amount of reimbursement and shall not be subject to the maximum reimbursement allowance otherwise established by the Fee Schedule. However, all other rules, guidelines and policies as provided in this Fee Schedule shall apply and shall be considered to be automatically incorporated into such agreement.
1. **Repricing Agreements.** Payers and providers may voluntarily enter into repricing agreements designed to contain the cost of workers' compensation health care after the medical care or service has been provided, and in such case, the reimbursement voluntarily agreed to by the parties shall control to the exclusion of the Fee Schedule. However, the time spent by the payer and provider attempting to negotiate a post-care repricing agreement does not extend the time elsewhere provided in this Fee Schedule for billing claims, paying claims, requesting correction of an incorrect payment, requesting reconsideration, seeking dispute resolution, or reviewing and responding to requests for correction or reconsideration or dispute resolution. In addition,

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applicable interest and penalties related to late billing and/or late payment shall continue to accrue as otherwise provided. Efforts to negotiate a post-care repricing agreement do not justify late billing or payment, and either party may seek further relief in accordance with the rules provided herein should billing or payment not be made within the time otherwise due under these rules. No party shall be obligated to negotiate or enter into a repricing agreement of any kind whatsoever.

No party, in attempting to negotiate a repricing or other post treatment price reduction agreement, shall state or imply that consent to such an agreement is mandatory, or that the failure to enter into any such agreement may result in audit, delay of payment, or other adverse consequence. If the Commission determines that any party, or other person in privity therewith, has made such false or misleading statements in an effort to coerce another party's consent to a repricing or other price reduction agreement outside the Fee Schedule, the Commission may refer the matter to the appropriate authorities to consider whether such conduct warrants criminal prosecution under section 71-3-69 of the Law. This statute declares that any false or misleading statement or representation made for the purpose of wrongfully withholding any benefit or payment otherwise due under the terms of the Workers' Compensation Law shall be considered a felony. In addition, the Commission may levy a civil penalty in an amount not to exceed ten thousand dollars (\$10,000.00) if it finds that payment of a just claim has been delayed without reasonable grounds, as provided in section 71-3-59(2) of the Law.

- C. **Billing Forms.** Billing for provider services shall be standardized and submitted on the following forms: Providers must bill outpatient professional services on the most recently authorized paper or electronic version, 837p, of the CMS-1500 form, regardless of the site of service. Health care facilities must bill on the most recently authorized uniform billing form. The electronic version, 837i, of the UB-04 (CMS-1450) is required beginning May 23, 2007. Billing must be submitted using the most current paper or electronic forms which are authorized by CMS.
- D. **Identification Number.** All professional reimbursement submissions by Covered Healthcare Providers as defined under CMS rules for the implementation of the National Provider Identifier (NPI) must include the National Provider Identifier (NPI) field so as to enable the specific identification of individual providers without the need for other unique provider identification numbers. Providers who do not yet have an NPI should continue to use their legacy identifiers until such time as an NPI is obtained. Providers are required to obtain an NPI within the dates specified by CMS in its implementation rules.
- E. **Physician Specialty.** The rules and reimbursement allowances in the *Mississippi Workers' Compensation Medical Fee Schedule* do not address physician specialization within a specialty. Payment is not based on the fact that a physician has elected to treat patients with a particular/specific problem. Reimbursement to qualified physicians is the same amount regardless of specialty.
- F. **"No Show" Appointments.** When an appointment is made for a physician visit by the employer or payer, and the claimant/patient does not show, the provider is entitled to payment at the rate allowed for a minimal office visit.
- G. **"After Hours" and Other Adjunct Service Codes.** When an office service occurs after a provider's normal business hours, procedure code 99050 may be billed. Other adjunct service codes (99051-99060) may be billed as appropriate. Typically, only a single adjunct service code is reported per encounter. However, there may be circumstances in which reporting multiple adjunct codes per patient encounter may be appropriate.
- H. **Portable Services.** When procedures are performed using portable equipment, bill the appropriate procedure code. The charge for the procedure includes the cost of the portable equipment.

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- i. Injections
 1. Reimbursement for injections includes charges for the administration of the drug and the cost of the supplies to administer the drug. Medications are charged separately.
 2. The description must include the name of the medication, strength, and dose injected.
 3. When multiple drugs are administered from the same syringe, reimbursement will be for a single injection.
 4. Reimbursement for anesthetic agents such as Xylocaine and Carbocaine, when used for infiltration, is included in the reimbursement for the procedure performed and will not be separately reimbursed.
 5. Reimbursement for intra-articular and intra-bursal injections (steroids and anesthetic agents) may be separately billed. The description must include the name of the medication, strength, and volume given.
- j. Supplies. Use CPT code 99070 or specific HCPCS Level II codes to report supplies over and above those usually included with the office visit or service rendered. Do not bill for supplies that are currently included in surgical packages, such as gauze, sponges, and Steri-Strips®. Supplies and materials provided by the physician over and above those usually included with the office visit (drugs, splints, sutures, etc.) may be charged separately and reimbursed at a reasonable rate.

II. INSTRUCTIONS TO PROVIDERS

- A. All bills for service must be coded with the appropriate CPT, ASA, or HCPCS Level II code.
- B. The medical provider must file the appropriate billing form and necessary documentation within thirty (30) days of rendering services on a newly diagnosed work-related injury or illness. Subsequent billings must be submitted at least every thirty (30) days, or within thirty (30) days of each treatment or visit, whichever last occurs, with the appropriate medical records to substantiate the medical necessity for continued services. Late billings will be subject to discounts, not to exceed one and one-half percent (1.5%) per month of the bill or part thereof which was not timely billed, from the date the billing or part thereof is first due until received by the payer. Any bill or part thereof not submitted to the payer within sixty (60) days after the due date under this rule shall be subject to an additional discount penalty equal to ten percent (10%) of the total bill or part thereof. Any bill for services rendered which is not submitted to the payer within one (1) year after the date of service, or date of discharge for inpatient care, will not be eligible or considered for reimbursement under this Fee Schedule, unless otherwise ordered by the Commission or its Cost Containment Division.
- C. Fees in excess of the maximum reimbursement allowance (MRA) must not be billed to the employee, employer, or payer. The provider cannot collect any non-allowed amount.
- D. If it is medically necessary to exceed the Fee Schedule limitations and/or exclusions, substantiating documentation must be submitted by the provider to the payer with the claim form.
- E. If a provider believes an incorrect payment was made for services rendered, or disagrees for any reason with the payment and explanation of review tendered by the payer, then the provider may request reconsideration pursuant to the rules set forth herein.
- F. If, after the resolution of a reconsideration request or a formal dispute resolution request, or otherwise, the provider is determined to owe a refund to the payer, the amount refunded shall bear interest at the rate of one and one-half percent (1.5%) per month from the date the refunded amount was first received by the provider, until refunded to the payer.

III. INSTRUCTIONS TO PAYERS

- A. An employer's/payer's payment shall reflect any adjustments in the bill made through the employer's/payer's bill review program. The employer/payer must provide an explanation of review (EOR) to a health care provider whenever reimbursement differs from the amount billed by the provider. This must be done individually for each bill.
- B. In a case where documentation does not indicate the service was performed, the charge for the service may be denied. The explanation of review (EOR) must clearly and specifically indicate the reason for the denial.
- C. (1) When a billed service is documented, but the code selected by the provider is not, in the payer's/reviewer's estimation, the most accurate code available to describe the service, the reviewer must not deny payment, but shall reimburse based on the revised code. The explanation of review (EOR) must clearly and specifically detail the reason(s) for recoding the service or otherwise altering the claim. No claim shall be recoded or otherwise revised or altered without the payer having actually reviewed the medical records associated with the claim which document the service(s) provided.
- (2) As an alternative to recoding or altering a claim, the payer may treat the matter under rule E(1) and (2) below by paying any undisputed portion of the bill, and notifying the provider by explanation of review (EOR) that the remaining parts of the bill are denied or disputed.
- (3) Recoding cannot be used solely for cost containment. Recoding may only be used for the correction of miscoded services. Whenever there is any dispute concerning coding, the provider must be notified immediately and given the opportunity to furnish additional information, although nothing herein suspends the time periods for making payment or giving notice of dispute. Any recoding or so-called "down coding," which is found by the Commission or its Cost Containment Division to be solely for the purpose of cost containment, will subject the party engaging in such conduct to additional penalties as allowed by law.
- D. Properly submitted bills must be paid within thirty (30) days of receipt by the payer. Properly submitted bills not fully paid within thirty (30) days of receipt by the payer shall automatically include interest on the unpaid balance at the rate of one and one-half percent (1.5%) per month from the due date of any unpaid remaining balance until such time as the claim is fully paid and satisfied. Properly submitted bills not fully paid within sixty (60) days of receipt will be subject to an additional penalty equal to ten percent (10%) of the unpaid remaining balance, including interest as herein provided.
- E. (1) When an employer/payer disputes or otherwise adjusts a bill or portion thereof, the employer/payer shall pay the undisputed or unadjusted portion of the bill within thirty (30) days of receipt of the bill. Failure to pay the undisputed portion when due shall subject the payer to interest and penalty as above provided on the undisputed portion of the bill. If the dispute is ultimately resolved in the provider's favor, interest and penalty on the disputed amounts will apply from the original due date of the bill.
- (2) When a payer disputes a bill or portion thereof, the payer shall notify the provider within thirty (30) days of the receipt of the bill of the reasons for disputing the bill or portion thereof, and shall notify the provider of its right to provide additional information and to request reconsideration of the payer's action. The payer shall set forth the clear and specific reasons for disputing a bill or portion thereof on the explanation of review (EOR), and shall provide additional documentation if necessary to provide an adequate explanation of the dispute.
- F. Reimbursement determinations shall be based on medical necessity of services to either establish a diagnosis or treat an injury/illness. Thus, where service is provided in good faith reliance on authorization given by the employer or payer, reimbursement shall not be dependent on the outcome of medically necessary diagnostic services or treatment.

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IV. FACILITY FEE RULES

Please refer to the Pain Management section for the State-specific facility reimbursement rules to be used for outpatient pain management procedures.

Please refer to the Surgery section for the State-specific facility reimbursement rules to be used for ambulatory surgery center (ASC) procedures.

A. Prepayment Review for Facilities. The payer must perform a prepayment review on inpatient hospital bills and outpatient surgery bills in order to verify the charges submitted.

1. At a minimum, the pre-payment review should:
 - a. Validate that prior authorization was approved according to Fee Schedule guidelines;
 - b. Validate that the length of stay and the level of service was appropriate for the diagnosis;
 - c. Review the bill for possible overcharges or billing errors;
 - d. Determine if an on-site audit is appropriate;
 - e. Identify over utilization of services;
 - f. Identify those bills and case records that shall be subject to professional review by a physician or appropriate peer.
2. The payer must reimburse the hospital within thirty (30) days of receipt of a valid claim form if prepayment review criteria are met. An exception to the thirty (30) day payment time will be made if additional documentation is requested for prepayment review, and in such cases, payment should be made within thirty (30) days following receipt of this additional documentation if prepayment review criteria are met. If a full audit is scheduled, fifty percent (50%) of the total bill must be paid prior to the audit, and in such event, the payer shall not be liable for interest and penalty as above provided on any additional sums which may be due following completion of the audit. Failure to pay fifty percent (50%) of the total bill prior to the audit shall result in interest and penalty as above provided being added to the total amount determined to be due, from the original due date until paid.
3. If the hospital does not forward copies of requested medical records to the payer after two (2) consecutive written requests following the initial request, or if it fails to submit necessary or adequate documentation to support the hospital services rendered, the payer should perform a charge audit.

B. Charge Audit. All charge audits must be performed on-site unless otherwise agreed to by the provider and payer.

1. The following information must be provided to the hospital by the payer/auditor when scheduling an audit:
 - a. Patient name
 - b. Account number
 - c. Date(s) of service
 - d. Diagnosis(es)
 - e. Total amount of bill
 - f. Insurance company

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- g. Name of audit requester
 - h. Telephone number and address of requester
2. A hospital must schedule a charge audit within thirty (30) days of a request by a payer/auditor.
 3. Hospitals shall be reimbursed an audit fee of \$50.00 for associated audit costs.
 4. When a charge audit is necessary, the auditor must identify additional charges for medically necessary hospital services that were ordered by the authorized physician and were provided, but were not included, on the initial bill.
 5. The auditor must review and verify the audit findings with a hospital representative at the conclusion of the audit. The hospital may waive its right to the exit conference.
 6. The auditor must provide written explanation of the final reimbursement determination based on the audit findings, whether or not an exit conference is held with the hospital. This written explanation must be provided within thirty (30) days following the conclusion of the audit.
- C. When any hospital bill that has been prescreened and found to be correct, or when corrections have been made to the bill as required, or when a hospital bill has been audited and verified as correct, it must be paid within thirty (30) days thereafter.
- D. Any hospital bill not paid when due under these rules shall automatically include interest at the rate of one and one-half percent (1.5%) per month from the due date of such bill until paid. Any such bill not paid within sixty (60) days after it is due under these rules will be subject to an additional penalty equal to ten percent (10%) of the total amount due, including interest as herein provided.
- E. Implantables. An implantable is an item that is implanted into the body for the purpose of permanent placement, and remains in the body as a fixture. Absorbable items, temporary items, or other items used to help place the implant, are not within the definition of "implantable" and are not reimbursed as such.
- Implantables are included in the applicable DRG reimbursement for inpatient treatment, and, therefore, the provider of inpatient services is not required to furnish the payer with an invoice for implantables. For implantables used in the outpatient setting, reimbursement shall be made separately from the facility fee and all other charges; the provider shall furnish a suitable invoice evidencing the cost of the implantable to the payer within sixty (60) days from the date of service. Upon receipt of this invoice, the payer shall pay the amount due within thirty (30) days thereafter. Implantables shall be reimbursed at cost plus ten percent (10%).
- A "suitable invoice" is an acquisition invoice from the manufacturer ~~or supplier~~ that contains pricing information showing the actual cost of the implant(s) being billed, or as in situations such as a bulk purchase containing information from which the actual cost of the implant(s) can be readily determined. The invoice must be on company letterhead from the implant supplier or manufacturer, not the hospital/facility, unless otherwise agreed to by the payer. Reimbursement is limited to 110% of the original manufacturer's invoice price.

V. EXPLANATION OF REVIEW (EOR)

- A. Payers must provide an explanation of review (EOR) to health care providers for each bill whenever the payer's reimbursement differs from the amount billed by the provider, or when an original claim is altered or adjusted by the payer. The EOR must be provided within thirty (30) days of receipt of the bill, and must accompany any payment that is being made.
- B. A payer may use the listed EOR codes and descriptors or may develop codes of their own to explain why a provider's charge has been reduced or disallowed, or why a claim has been altered or adjusted in some other way. In all cases, the payer must clearly and specifically detail the reasons for adjusting or altering a bill, including references to the applicable provisions of the Fee Schedule or GPT book, or other source(s) used as the basis for the EOR. Should the EOR include an alteration in the codes

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submitted on the original claim, it must be based on a review of the medical records documenting the service.

- C. The EOR must contain appropriate identifying information to enable the provider to relate a specific reimbursement to the applicable claimant, the procedure billed, and the date of service.
- D. Acceptable EORs may include manually produced or computerized forms that contain the EOR codes, written explanations, and the appropriate identifying information.
- E. The following EOR codes may be used by the payer to explain to the provider why a procedure or service is not reimbursed as billed, provided clear and specific detail is included, along with references to the applicable provisions of the Fee Schedule or CPT book, or other source(s) used as the basis for the EOR:
 - 001 These services are not reimbursable under the Workers' Compensation Law for the following reason(s): [Provide specific reason(s) why services are not reimbursable under the Workers' Compensation Law]
 - 002 Charges exceed maximum reimbursement allowance [Specify]
 - 003 Charge is included in the basic surgical allowance [Specify]
 - 004 Surgical assistant is not routinely allowed for this procedure. Documentation of medical necessity required [Specify]
 - 005 This procedure is included in the basic allowance of another procedure [Specify the other procedure]
 - 006 This procedure is not appropriate to the diagnosis [Specify]
 - 007 This procedure is not within the scope of the license of the billing provider [Specify]
 - 008 Equipment or services are not prescribed by a physician [Specify]
 - 009 This service exceeds reimbursement limitations [Specify]
 - 010 This service is not reimbursable unless billed by a physician [Specify]
 - 011 Incorrect billing form [Specify]
 - 012 Incorrect or incomplete identification number of billing provider [Specify]
 - 013 Medical report required for payment [Specify]
 - 014 Documentation does not justify level of service billed [Specify]
 - 015 Place of service is inconsistent with procedure billed [Specify]
 - 016 Invalid procedure code [Specify]
 - 017 Prior authorization was not obtained [Specify]

VI. REQUEST FOR RECONSIDERATION

- A. When, after examination of the explanation of review (EOR) and other documentation, a health care provider is dissatisfied with a payer's payment or dispute of a bill for medical services, reconsideration may be requested by the provider. Any other matter in dispute between the provider and payer may be subject to reconsideration as herein provided at the request of either party, including, but not limited to, a request by the payer for refund of an alleged over-payment. Alleged over-payments should be addressed through the dispute resolution process, if necessary, and not by way of unilateral recoupment initiated by the payer on subsequent billings.

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- B. A provider or payer must make a written request for reconsideration within thirty (30) days from the receipt of the explanation of review (EOR) or other written documentation evidencing the basis for the dispute. A request for reconsideration must be accompanied by a copy of the bill in question, the payers' explanation of review (EOR), and/or any additional documentation to support the request for reconsideration.
- C. The payer or provider, upon receipt of a request for reconsideration, must review and re-evaluate the original bill and accompanying documentation, and, must notify the requesting party within twenty (20) days thereafter of the results of the reconsideration. The response must adequately explain the reason(s) for the decision, and cite the specific basis upon which the final determination was made. If the payer finds the provider's request for reconsideration is meritorious, and that additional payment(s) should be made, or if the provider finds the payer's request for refund or other payment is meritorious, the additional payment should be made within the above twenty (20) day period. Any additional payment(s) made in response to a provider's or payer's request for reconsideration shall include interest from the original due date of the bill or payment, and an additional ten percent (10%) penalty if applicable.
- D. If the dispute is not resolved within the above time after a proper request for reconsideration has been served by the provider or payer, then either party may request further review by the Commission pursuant to the Dispute Resolution Rules set forth hereafter.
- E. Failure to seek reconsideration within the time above provided shall bar and prohibit any further reconsideration or review of the bill or other issue in question unless, for good cause shown, the Commission or its representative extends the time for seeking reconsideration or review under these rules. In no event shall the time for seeking reconsideration hereunder be extended by more than an additional thirty (30) days, and any such request for additional time in which to seek reconsideration or further review must be made in writing to the Commission within the initial thirty (30) day period set forth in paragraph B. above.
- F. Requests by either provider or payer for refunds, or for additional payment, or other requests related to the billing or payment of a claim, must be sought in accordance with the specific rules set forth herein. No retrospective audits or dispute requests shall be allowed beyond the time otherwise provided herein for seeking reconsideration and/or review.

Medical Records Rules

I. MEDICAL RECORDS

- A. The medical record, which documents the patient's course of treatment, is the responsibility of the provider and is the basis for determining medical necessity and for substantiating the service(s) rendered; therefore, failure to submit necessary or adequate documentation to support the services rendered may result in the services being disallowed.
- B. A medical provider may not charge any fee for completing a medical report or form required by the Workers' Compensation Commission which is part of the required supporting documentation which accompanies a request for payment. The supporting documentation that is required to substantiate the medical treatment is included in the fee for service and does not warrant a separate fee as it is incidental to providing medical care. CPT code 99080 is appropriate for billing special reports beyond those required by this Fee Schedule and requested by the payer or their representatives.
- C. Medical records must be legible and include, as applicable:
 - 1. Initial office visit notes which document a history and physical examination appropriate to the level of service indicated by the presenting injury/illness or treatment of the ongoing injury/illness;
 - 2. Progress notes which reflect patient complaints, objective findings, assessment of the problem, and plan of care or treatment;
 - 3. Copies of lab, x-ray, or other diagnostic tests that reflect current progress of the patient and/or response to therapy or treatment;
 - 4. Physical medicine/occupational therapy progress notes that reflect the patient's response to treatment/therapy;
 - 5. Operative reports, consultation notes with report, and/or dictated report; and
 - 6. Impairment rating (projected and actual) and anticipated MMI date.
- D. A plan of care should be included in the medical record and should address, as applicable, the following:
 - 1. The disability;
 - 2. Degree of restoration anticipated;
 - 3. Measurable goals;
 - 4. Specific therapies to be used;
 - 5. Frequency and duration of treatments to be provided;
 - 6. Anticipated return to work date;
 - 7. Projected impairment.

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- E. Health care providers must submit copies of records and reports to payers upon request. Providers can facilitate the timely processing of claims and payment for services by submitting appropriate documentation to the payer when requested. Only those records for a specific date of injury are considered non-privileged as it relates to a workers' compensation injury. The employer/payer is not privileged to non-work related medical information.
- F. Providers must submit documentation for the following
 - 1. The initial office visit;
 - 2. A progress report if still treating after thirty (30) days;
 - 3. Evaluation for physical medicine treatment (P.T., O.T., C.M.T., O.M.T.);
 - 4. A progress report every thirty (30) days for physical medicine services;
 - 5. An operative report or office note (if done in the office) for a surgical procedure;
 - 6. A consultation;
 - 7. The anesthesia record for anesthesia services;
 - 8. A functional capacity or work hardening evaluation;
 - 9. When billing a by-report (BR) service, a description of the service is required;
 - 10. Whenever a modifier is used to describe an unusual circumstance;
 - 11. Whenever the procedure code descriptors include a written report.
- G. Hospitals and other inpatient facilities must submit required documentation with the appropriate billing forms as follows:
 - 1. Admission history and physical;
 - 2. Discharge summary;
 - 3. Operative reports;
 - 4. Pathology reports;
 - 5. Radiology reports;
 - 6. Consultations;
 - 7. Other dictated reports;
 - 8. Emergency room records.

II. COPIES OF RECORDS

- A. Outpatient Records. The payer may request additional records or reports from the provider concerning service or treatment provided to a patient other than on an inpatient basis. These additional records and reports will be reimbursed as follows.

1-5 pages — \$15.00

6+ pages — \$.50 per page in addition to the above fee

This applies to copies of microfiche and other electronic media or storage systems.

As provided by MCA section 11-1-52(1) (Supp. 2006), as amended, the provider may add ten percent (10%) of the total charge to cover the cost of postage and handling, and may charge an additional fifteen dollars (\$15.00) for retrieving records stored off the premises where the provider's facility or office is located.

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- B. Inpatient Records. The payer may request additional records or reports from a facility concerning inpatient service or treatment provided to a patient. Such reports or records requested by the payer will be reimbursed as follows:
- 1-5 pages — \$15.00/per admission
 - 6+ pages — \$.50 per page/per admission in addition to the above fee
- This applies to copies of microfiche and other electronic media or storage systems.
- There is a maximum reimbursement allowance of fifty dollars (\$50.00) for a particular inpatient medical record, exclusive of postage, handling and retrieval charges as set forth below. This is per admission.
- As provided by MCA section 11-1-52(1) (Supp. 2006), as amended, the provider may add ten percent (10%) of the total charge to cover the cost of postage and handling, and may charge an additional fifteen dollars (\$15.00) for retrieving records stored off the premises where the provider's facility or office is located.
- C. Copies of records requested by the patient and/or the patient's attorney or legal representative will be reimbursed by the requesting party according to the provisions of this section on additional reports and records.
- D. Documentation submitted by the provider which has not been specifically requested will not be subject to reimbursement.
- E. Health care providers may charge up to ten dollars (\$10.00) per film for copying x-rays or for providing copies of x-rays via electronic or other magnetic media. (Copies of film do not have to be returned to the provider.)
- F. Payers, their representatives, and other parties requesting records and reports must be specific in their requests so as not to place undue demands on provider time for copying records.
- G. Providers should respond promptly (within fourteen (14) working days) to requests for additional records and reports.
- H. Records requested by the Mississippi Workers' Compensation Commission will be furnished by the provider without charge to the Commission.
- I. Any additional reimbursement, including copy service vendors, other than is specifically set forth above, is not required, and providers or their vendors will not be paid any additional amounts.

Dispute Resolution Rules

I. GENERAL PROVISIONS

- A. Unresolved disputes may be appealed to and resolved by the Mississippi Workers' Compensation Commission.
- B. Reconsideration must be sought by the provider or payer prior to a request for resolution of a dispute being sent to the Commission. This provides the payer and provider an opportunity to resolve most concerns in a timely manner.
- C. All communication between parties in dispute will be handled by the Mississippi Worker's Compensation Commission, Cost Containment Division. In addition, there will be no communication between the parties in dispute and any Peer Reviewer who might be called upon to assist the Commission in the resolution of a dispute.

II. FORMS AND DOCUMENTATION

- A. Valid requests for resolution of a dispute must be submitted on the 'Request for Resolution of Dispute' form (in the Forms section) along with the following:
 - 1. Copies of the original and resubmitted bills in dispute that include dates of service, procedure codes, charges for services rendered and any payment received, and an explanation of any unusual services or circumstances;
 - 2. EOR including the specific reimbursement;
 - 3. Supporting documentation and correspondence;
 - 4. Specific information regarding contact with the payer; and
 - 5. Any other information deemed relevant by the applicant for dispute resolution.
- B. A request for Resolution of Dispute must be submitted to:

Mississippi Workers' Compensation Commission
Cost Containment Division
1428 Lakeland Drive
P.O. Box 5300
Jackson, MS 39296-5300

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III. TIME FOR FILING

A Request for Resolution of Dispute must be filed with the Commission within twenty (20) days following the payer's or provider's response to a request for reconsideration of any matter in dispute, or, in cases where the payer or provider fails to respond to a request for reconsideration, within twenty (20) days of the expiration of the time in which said response should have been provided. Failure to file a Request for Resolution of Dispute within this time shall bar any further action on the disputed issue(s) unless, for good cause shown, the Commission or its Cost Containment Director extends the time for filing said request. In no event will the time for filing a Request for Resolution of Dispute be extended more than once or more than an additional twenty (20) days from the time said request was first due to be filed, provided the request for additional time in which to file a Request for Resolution of Dispute is filed within the initial twenty (20) day period provided herein and absent compelling circumstances, a dispute resolution request will not be considered by the Cost Containment Division if submitted more than one (1) year after the date of service. The decision to extend the time for filing a Request for Resolution of Dispute based on 'good cause' shall be entirely at the discretion of the Commission or its Cost Containment Director. Mere neglect will not constitute 'good cause.'

IV. PROCEDURE BY COST CONTAINMENT DIVISION

- A. Requests for dispute resolution will be reviewed and decided by the Cost Containment Division of the Commission within thirty (30) days of receipt of the request, unless additional time is required to accommodate a Peer Review. The payer and/or provider may be contacted by telephone or other means for additional information if necessary; however, both parties to a dispute may submit in writing any information or argument they deem relevant to the issue in dispute, if not already submitted with the request for dispute resolution, and this information shall be considered by the Cost Containment Division when rendering a decision. Any written information or argument submitted for consideration by a party to a dispute, without a request from the Commission, must be received by the Cost Containment Division within ten (10) days after filing the request for dispute resolution in order to merit consideration.
- B. Every effort will be made to resolve disputes by telephone or in writing. The payer and provider may be requested to attend an informal hearing conducted by a Commission representative. Failure to appear at an informal hearing may result in dismissal of the request for dispute resolution.
- C. Following review of all documentation submitted for dispute resolution and/or following contact with the payer and/or provider for additional information and/or negotiation, the Cost Containment Division shall render an administrative decision on the request for dispute resolution.
- D. Cases involving medical care determination may be referred for Peer Review, but only on request of the Commission. The peer review consultant will render an opinion and submit same to the Commission representative within the time set by the Cost Containment Division. The Commission representative will notify the parties in dispute if a Peer Review has been requested, and of the peer consultant's determination.

V. COMMISSION REVIEW OF A DISPUTE

- A. Any party aggrieved by the decision of the Cost Containment Division shall have twenty (20) days from the date of said decision to request review by the Commission. Failure to file a written request for review with the Commission within this twenty (20) day period shall bar any further review or action with regard to the issue(s) presented. No extension of time within which to file for Commission review of a dispute under these Rules shall be allowed. In the event a request for review is not filed with the Commission within twenty (20) days or within allowed by any extension which has been granted, the parties to the dispute shall have fourteen (14) days thereafter in which to comply with the final decision of the Cost Containment Division.

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1. A party to a dispute may, when a written request for review has not been timely filed with the Commission, file with the Commission a written request to compel compliance with the final administrative decision of the Cost Containment Division. The Commission may consider such a request with or without a hearing. A request to compel compliance with the final decision of the Cost Containment Division may be filed at any time following fourteen (14) days after the decision of the Cost Containment Division becomes final.
- B. The request for review by the Commission shall be filed with the Cost Containment Division of the Mississippi Workers' Compensation Commission, and shall be in writing and shall state the grounds on which the requesting party relies. All documentation submitted to and considered by the Cost Containment Division, including the Request for Resolution of Dispute form, along with a copy of the decision of the Cost Containment Division, shall be attached to the request for review which is filed with the Commission.
- C. The Commission shall review the issue(s) solely on the basis of the documentation submitted to the Cost Containment Division. No additional documentation not presented to and considered by the Cost Containment Division shall be considered by the Commission on review, unless specifically requested by the Commission, and no hearing or oral argument shall be allowed.
- D. The Commission shall consider the request for review and issue a decision thereon within thirty (30) days after said request is filed, unless otherwise provided by the Commission.
- E. Following the decision of the Commission, or following the conclusion of the dispute resolution process at any stage without an appeal to the Commission, no further audit, adjustment, refund, review, consideration, reconsideration or appeal with respect to the claim in question may be sought by either party.
- F. The costs incurred in seeking Commission review or in seeking compliance with an Administrative Decision rendered by the Cost Containment Director, including reasonable attorney fees, if any, shall be assessed to the party who requested review if that party's position is not sustained by the Commission, and to the party who has failed to comply with a prior decision if compliance therewith is ordered by the Commission. Otherwise, each party shall bear their own costs, including attorney's fees.
- G. If the Commission determines that a dispute is based on or arises from a billing error, a payment adjustment or error, including but not limited to improper bundling of service codes, unbundling, downcoding, code shifting, or other action by either party to the dispute, or if the Commission determines that a provider or payer has unreasonably refused to comply with the Law, the Rules of the Commission, including this Fee Schedule, or with any decision of the Commission or its representatives, and that this causes proceedings with respect to the billing and/or payment for covered medical services to be instituted or continued or delayed without reasonable grounds, then the Commission may require the responsible party or parties to pay the reasonable expenses, including attorney's fees, if any, to the opposing party, and, in addition, the Commission may levy against the responsible party or parties a civil penalty not to exceed the sum of ten thousand dollars (\$10,000.00), payable to the Commission, as provided in section 71-3-59(2) of the Law. The award of costs and penalties as herein provided shall be in addition to interest and penalty charges which may apply under other provisions of this Fee Schedule.

Utilization Review Rules

The Mississippi Workers' Compensation Commission requires mandatory utilization review of certain medical services and charges associated with the provision of medical treatment covered under the Act and subject to the Fee Schedule. These rules are set forth to encourage consistency in the procedures for interaction between workers' compensation utilization review agents, representatives or organizations, providers, and payers. The provisions herein set forth regarding utilization review are in addition subject to the requirements of MCA section 41-83-1 et seq. (Rev. 2005), as amended, and any regulations adopted pursuant thereto by the State Department of Health or the State Board of Medical Licensure, and in the event of conflict between this Fee Schedule, and the requirements of the above statute, and any implementing regulations, the provisions of this Fee Schedule or other applicable rules of the Mississippi Workers' Compensation Commission shall govern.

I. SERVICES REQUIRING UTILIZATION REVIEW

Mandatory Utilization review is required for the following

- A. All admissions to inpatient facilities of any type
- B. All surgical procedures, inpatient and outpatient
- C. Repeat MRI (more than one per injury)
- D. Repeat CT Scan (more than one per injury)
- E. Work hardening programs, pain management programs, back schools, massage, therapy, acupuncture, biofeedback
- F. External spinal stimulators
- ~~G. FCE and isokinetic testing~~
- G. Physical medicine treatments, after fifteen (15) visits or thirty (30) days, whichever comes first.
- H. Home health
- J. Psychiatric treatment

II. DEFINITIONS

Case Management. The clinical and administrative process in which timely, individualized, and cost effective medical rehabilitation services are implemented, coordinated, and evaluated by a nurse or other case manager employed by the payer, on an ongoing basis for patients who have sustained an injury or illness. Use of case management is optional in Mississippi.

Certification. A determination by a utilization review organization or agent that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the requirements of the workers' compensation program.

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Clinical Peer. A health professional that holds unrestricted license and is qualified to practice in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession (i.e., the same licensure category as the ordering provider).

Clinical Rationale. A statement that provides additional clarification of the clinical basis for a non-certification determination. The clinical rationale should relate the non-certification determination to the worker's condition or treatment plan, and should supply a sufficient basis for a decision to pursue an appeal.

Clinical Review Criteria. The written screens, decision rules, medical protocols, or guidelines used by the payer's Utilization Management Program as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services.

Concurrent Review. Utilization management conducted during a worker's hospital stay or course of treatment, sometimes called continued stay review.

Discharge Planning. The process of assessing a patient's need for medically appropriate treatment after hospitalization and affecting an appropriate and timely discharge.

Expedited Appeal. An expedited appeal is a request for additional review of a determination not to certify imminent or ongoing services, an admission, an extension of stay, or other medical services of an imminent or ongoing nature. Also sometimes referred to as a reconsideration request.

First Level Clinical Review. Review conducted by registered nurses and other appropriate licensed or certified health professionals. First level clinical review staff may approve requests for admissions, procedures, and services that meet clinical review criteria, but must refer requests that do not meet clinical review criteria to second level clinical peer reviewers for approval or denial.

Notification. Correspondence transmitted by mail, telephone, facsimile, email and/or electronic data interchange (EDI).

Pre-certification. The review and assessment of medical necessity and appropriateness of services before they occur. The appropriateness of the site or level of care is assessed along with the duration and timing of the proposed services.

Provider. A licensed health care facility, program, agency, or health professional that delivers health care services.

Retrospective Review. Utilization review conducted after services have been provided to the worker.

Second Level Clinical Review. Clinical review conducted by appropriate clinical peers when a request for an admission, procedure, or service does not meet clinical review criteria.

Standard Appeal. A request to review a determination not to certify an admission, extension of stay, or other health care service.

Third Level Clinical Review. Clinical review conducted by appropriate clinical peers who were not involved in second level review when a decision not to certify a requested admission, procedure, or service has been appealed. The third level peer reviewer must be in the same or like specialty as the requesting provider.

Utilization Review. Evaluation of the necessity, appropriateness, and efficiency for the use of health care services. It includes both prospective and concurrent review, and may include retrospective review under certain circumstances.

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Utilization Reviewer. An entity, organization, or representative thereof, or other person performing utilization review activities or services on behalf of an employer, payer or third-party claims administrator.

Variance. A deviation from a specific standard.

III. STANDARDS

Utilization review organizations or programs are required to meet the following standards:

- A. The payer's utilization reviewer must comply with the requirements of MCA section 41-83-1 et seq. (Rev. 2005), as amended, and any regulations adopted pursuant thereto by the State Department of Health or the State Board of Medical Licensure, and shall have utilization review agents or representatives who are properly qualified, trained, supervised, and supported by explicit clinical review criteria and review procedures.
- B. The first level review is performed by individuals who are health care professionals, who possess a current and valid professional license, and who have been trained in the principles and procedures of utilization review.
- C. The first level reviewers are required to be supported by a doctor of medicine who has an unrestricted license to practice medicine.
- D. The second level review is performed by clinical peers who hold a current, unrestricted license and are oriented in the principles and procedures of utilization review. The second level review shall be conducted for all cases where clinical determination to certify cannot be made by first level clinical reviewers. Second level clinical reviewers shall be available within one (1) business day by telephone or other electronic means to discuss the determination with the attending physicians or other ordering providers. In the event more information is required before a determination can be rendered by a second level reviewer, the attending/ordering provider must be notified of the delay and given a specific time frame for determination.
- E. The payer's utilization reviewer shall conduct third level reviews by requiring peers who serve in this capacity to hold a current, unrestricted license and be board certified in a specialty board approved by the American Board of Medical Specialties. Board certification requirement is not applicable to reviewers who are not doctors of medicine. Third level clinical reviewers shall be in the same profession or similar specialty as typically manages the medical condition, procedure, or treatment under review.
- F. The payer's utilization reviewer shall maintain written policies and procedures for the effective management of its utilization review activities, which shall be made available to the provider, or the Commission, upon request.
- G. The payer maintains the responsibility for the oversight of the delegated functions if the payer delegates utilization review responsibility to a vendor. The vendor or organization to which the function is being delegated must be currently certified by the Mississippi Board of Health, Division of Licensure and Certification to perform utilization management in the State of Mississippi. A copy of the license or certification held by the utilization review agent shall be furnished to the provider, or to the Commission, upon request. The payer who has another entity perform utilization review functions or activities on its behalf maintains full responsibility for compliance with the rules.
- H. The payer's utilization reviewer shall maintain a telephone review service that provides access to its review staff at a toll free number from at least 9:00 a.m. to 5:00 p.m. CST each normal business day. There should be an established procedure for receiving or redirecting calls after hours or receiving faxed requests. Reviews should be conducted during hospitals' and health professionals' reasonable and normal business hours.

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- I. The payer's utilization reviewer shall collect only the information necessary to certify the admission procedure or treatment, length of stay, frequency, and duration of services. The utilization reviewer should have a process to share all clinical and demographic information on individual workers among its various clinical and administrative departments to avoid duplicate requests to providers. (Providers may use the Mississippi Workers' Compensation Commission Utilization Review Request Form.)

IV. PROCEDURES FOR REVIEW DETERMINATIONS

The following procedures are required for effective review determination.

- A. Review determinations must be made within two (2) business days of receipt of the necessary information on a proposed non-emergency admission or service requiring a review determination. The Mississippi Workers' Compensation Utilization Review Request Form may be used to request pre-certification.
- B. When an initial determination is made to certify, notification shall be provided promptly, at least within one (1) business day or before the service is scheduled, whichever first occurs, either by telephone or by written or electronic notification to the provider or facility rendering the service. If an initial determination to certify is provided by telephone, a written notification of the determination shall be provided within two (2) business days thereafter. The written notification shall include the number of days approved, the new total number of days or services approved, and the date of admission or onset of services.
- C. When a determination is made not to certify, notify the attending or ordering provider or facility by telephone within one (1) business day and send a written notification within one (1) business day thereafter. The written notification must include the principal reason/clinical rationale for the determination not to certify and instructions for initiating an appeal. Reasons for a determination not to certify may include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the attending physician.
- D. The payer's utilization reviewer shall inform the attending physician and/or other ordering provider of their right to initiate an expedited appeal or standard appeal of a determination not to certify, and the procedure to do so.
 1. Expedited appeal—When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review, and the attending physician believes that the determination warrants immediate appeal, the attending physician shall have an opportunity to appeal that determination over the telephone or by electronic mail or facsimile on an expedited basis within one (1) business day.
 - a. Each private review agent shall provide for reasonable access to its consulting physician(s) for such appeals.
 - b. Both providers of care and private review agents should attempt to share the maximum information by phone, fax, or otherwise to resolve the expedited appeal (sometimes called a reconsideration request) satisfactorily.
 - c. Expedited appeals, which do not resolve a difference of opinion, may be resubmitted through the standard appeal process.
 2. Standard appeal—A standard appeal will be considered, and notification of the appeal decision given to the provider, not later than ~~thirty (30)~~ twenty (20) days after receiving the required documentation for the appeal.
 - a. An attending physician who has been unsuccessful in an attempt to reverse a determination not to certify should be provided the clinical rationale for the determination upon request.

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3. Retrospective review—For retrospective review, the review determination shall be based on the medical information available to the attending or ordering provider at the time the medical care was provided, and on any other relevant information regardless of whether the information was available to or considered by the provider at the time the care or service was provided.
 - a. When there is retrospective determination not to certify an admission, stay, or other service, the attending physician or other ordering provider and hospital or facility shall receive written notification, or notification by facsimile or electronic mail, within twenty (20) days after receiving the request for retrospective review and all necessary and supporting documentation.
 - b. Notification should include the principal reason for the determination and a statement of method for standard appeal.
4. Emergency admissions or surgical procedures—Emergency admissions or surgical procedures must be reported to the payer by the end of the next business day. Post review activities will be performed following emergency admissions, and a continued stay review will be initiated.
 - a. If a licensed physician certifies in writing to the payer or its agent or representative within seventy-two (72) hours of an admission that the injured worker admitted was in need of emergency admission to hospital care, such shall constitute a prima facie case for the medical necessity of the admission. An admission qualifies as an emergency admission if it results from a sudden onset of illness or injury which is manifested by acute symptoms of sufficient severity that the failure to admit to hospital care could reasonably result in (1) serious impairment of bodily function(s), (2) serious or permanent dysfunction of any bodily organ or part or system, (3) permanently placing the person's health in jeopardy, or (4) other serious medical consequence.
 - b. To overcome a prima facie case for emergency admission as established above, the utilization reviewer must demonstrate by clear and convincing evidence that the patient was not in need of an emergency admission.
- E. Failure of the health care provider to provide necessary information for review, after being requested to do so by the payer or its review agent, may result in denial of certification.
- F. When a payer and provider have completed the utilization review appeals process and cannot agree on a resolution to a dispute, either party, or the patient, can appeal to the Cost Containment Division of the Mississippi Workers' Compensation Commission, and should submit this request on the Request for Dispute Resolution Form adopted by the Commission. A request for resolution of a utilization review dispute should be filed with the Commission within twenty (20) days following the conclusion of the underlying appeal process provided by the utilization reviewer. The Commission shall consider and decide a request for resolution of a utilization review dispute in accordance with the Dispute Resolution Rules provided elsewhere in this Fee Schedule.
- G. Failure of by the utilization reviewer to timely notify the provider of a decision whether to certify or approve an admission, procedure, service or other treatment shall be deemed to constitute approval by the payer of the requested treatment, and shall obligate the payer to reimburse the provider in accordance with other applicable provisions of this Schedule. Timely notification means notification by mail, facsimile, electronic mail, or telephone, followed by written notification, to the provider within the applicable time periods set forth in these Utilization Review Rules.
- H. Upon request of the provider, or the Commission, a utilization reviewer must furnish a copy of the license or certification obtained from the State Department of Health which authorizes the reviewer to engage in utilization review activities in the State of Mississippi.

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Upon a finding by the Commission that a payer or the payer's utilization reviewer has failed without reasonable grounds to comply with the time requirements of these rules, penalties pursuant to Miss. Code Ann. Section 71-3-59 (Rev. 2000) may be assessed against the payer.

Rules for Modifiers and Code Exceptions

Please see the modifier rules in each section of the *Mississippi Workers' Compensation Medical Fee Schedule* for a complete listing of appropriate modifiers for each area.

- A. Modifier codes must be used by providers to identify procedures or services that are modified due to specific circumstances.
- B. When modifier 22 is used to report an increased service, a report explaining the medical necessity of the situation must be submitted with the claim to the payer. It is not appropriate to use modifier 22 for routine billing.
- C. The use of modifiers does not imply or guarantee that a provider will receive reimbursement as billed. Reimbursement for a modified service or procedure is based on documentation of medical necessity and determined on a case-by-case basis.
- D. Modifiers allow health care providers to indicate that a service was altered in some way from the stated description without actually changing the definition of the service.

I. MODIFIERS FOR CPT (HCPCS LEVEL I) CODES

This section contains a list of modifiers used with CPT codes. Also consult each practice-area section of the Fee Schedule for additional modifiers.

21 Prolonged Evaluation and Management Services

When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category, it may be identified by adding modifier 21 to the evaluation and management code number. A report may also be appropriate.

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.

23 Unusual Anesthesia

Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

24 Unrelated Evaluation and Management Services by the Same Physician During a Postoperative Period

The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See Evaluation and Management Services Guidelines for instructions on determining level of E/M service.) The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

26 Professional Component

Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component (HCPCS Level II Modifier)

Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

Mississippi's note: The technical component is calculated by subtracting the professional component amount from the total amount for the reimbursement.

32 Mandated Services

Services related to mandated consultation and/or related services (e.g., third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

47 Anesthesia by Surgeon

Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) Note: Modifier 47 would not be used as a modifier for the anesthesia procedures 00100-01999.

Mississippi's note: Reimbursement is made for base units only.

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Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five-digit code.

51 Multiple Procedures

When multiple procedures, other than E/M Services, physical medicine and rehabilitation services, or provision of supplies (e.g., vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated 'add-on' codes (see the applicable CPT book appendix).

Mississippi's note: This modifier should not be appended to designated "modifier 51 exempt" codes as specified in the applicable CPT book.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 Discontinued Procedure

Under certain circumstances the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

54 Surgical Care Only

When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

55 Postoperative Management Only

When one physician performed the postoperative management and another physician performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

Medical Fee Schedule**56 Preoperative Management Only**

When one physician performed the preoperative care and evaluation and another physician performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

57 Decision for Surgery

An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. Note: For treatment of a problem that requires a return to the operating or procedure room, see modifier 78.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures or services other than E/M services that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

62 Two Surgeons

When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If an additional procedure(s) (including an add-on procedure(s)) is performed during the same surgical session, a separate code(s) may be reported with modifier 62 added. Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those service(s) may be reported using a separate procedure code(s) with modifier 80 or modifier 62 added, as appropriate.

66 Surgical Team

Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of modifier 66 to the basic procedure number used for reporting services.

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76 Repeat Procedure by Same Physician

It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

77 Repeat Procedure by Another Physician

The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.

78 Return to the Operating Room for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period

The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

80 Assistant Surgeon

Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

Mississippi's note: Reimbursement is twenty percent (20%) of the maximum reimbursement allowance.

81 Minimum Assistant Surgeon

Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.

Mississippi's note: Physician reimbursement is ten percent (10%) of the allowable.

82 Assistant Surgeon (when qualified resident surgeon not available)

The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).

90 Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.

91 Repeat Clinical Diagnostic Laboratory Test

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describes a series of test results (e.g.,

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glucose tolerance tests, evocative/suppression testing). This modifier may only be used for a laboratory test(s) performed more than once on the same day on the same patient.

92 Alternative Laboratory Platform Testing

When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701-86703). The test does not require permanent dedicated space; hence by its design it may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.

99 Multiple Modifiers

Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

AA Anesthesiologist Services Performed Personally by an Anesthesiologist

Report modifier AA when the anesthesia services are personally performed by an anesthesiologist.

AD Medical Supervision by a Physician: More Than Four Concurrent Anesthesia Procedures

Report modifier AD when the anesthesiologist supervises more than four concurrent anesthesia procedures.

AS Assistant at Surgery Services Provided by Registered Nurse First Assistant, Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist (Mississippi Modifier)

Assistant at surgery services provided by a registered nurse first assistant or other qualified individual (excluding assistant at surgery services provided by a physician) are identified by adding modifier AS to the listed applicable surgical procedures. The use of the AS modifier is appropriate for any code that otherwise is reimbursable for a physician assisting a surgeon in the operating room.

Mississippi's note: AS reimbursement is ten percent (10%) of the allowable. For assistant at surgery services provided by a physician, see modifiers 80, 81, and 82.

NP Nurse Practitioner (Mississippi Modifier)

This modifier should be added to the appropriate CPT code to indicate that the services being billed were rendered or provided by a nurse practitioner.

PA Physician Assistant (Mississippi Modifier)

This modifier should be added to the appropriate CPT code to indicate that the services being billed were rendered or provided by a physician assistant.

PT – Physical or Occupational Therapist Assistant (Mississippi Modifier)

This modifier should be added to the appropriate CPT code to indicate that the services being billed were rendered or provided by either a Physical Therapist Assistant or an Occupational Therapist Assistant.

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CA – CARF Accredited

This modifier should be used in conjunction with CPT code 97799 ('unlisted physical medicine/rehabilitation service or procedure') to indicate chronic pain treatment being administered by a CARF accredited provider as part of a pre-approved interdisciplinary pain rehabilitation program.

CP – Chronic Pain Treatment

This modifier should be used only in conjunction with CPT Code 97799 ('unlisted physical medicine/rehabilitation service or procedure') to indicate chronic pain treatment being administered as part of a pre-approved interdisciplinary pain rehabilitation program.

QK Medical Direction of Two, Three, or Four Concurrent Anesthesia Procedures Involving Qualified Individuals (CRNA) by an Anesthesiologist

Report modifier QK when the anesthesiologist supervises two, three, or four concurrent anesthesia procedures involving qualified individuals (CRNA or AA).

QX CRNA Service: With Medical Direction by an Anesthesiologist

Regional or general anesthesia provided by the CRNA or AA with medical direction by a physician may be reported by adding modifier QX.

QY Medical Direction of One Certified Registered Nurse Anesthetist (CRNA) by an Anesthesiologist

Report modifier QY when the anesthesiologist supervises one CRNA or AA.

QZ CRNA Service: Without Medical Direction by an Anesthesiologist

Regional or general anesthesia provided by the CRNA or AA without medical direction by a physician may be reported by adding modifier QZ.

II. MODIFIERS APPROVED FOR AMBULATORY SURGERY CENTER (ASC) HOSPITAL OUTPATIENT USE

This section contains a list of modifiers used with ambulatory surgery center and hospital-based outpatient services. Also consult each practice-area section of the Fee Schedule for additional modifiers.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or

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substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

27 Multiple Outpatient Hospital E/M Encounters on the Same Date

For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (e.g., hospital emergency department, clinic). Note: This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient evaluation and management services provided by the same physician on the same date and performed in multiple outpatient setting(s) (e.g., hospital emergency department, clinic), see Evaluation and Management, Emergency Department, or Preventive Medicine Services codes.

50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five digit code.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.

58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. Note: For treatment of a problem that requires a return to the operating or procedure room, see modifier 78.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures or services other than E/M services that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the

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same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

73 Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of modifier 73. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

74 Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of modifier 74. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

76 Repeat Procedure by Same Physician

It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

77 Repeat Procedure by Another Physician

The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.

78 Return to the Operating Room for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period

The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

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91 Repeat Clinical Diagnostic Laboratory Test

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results, due to testing problems with specimens or equipment, or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

III. MODIFIERS FOR HCPCS LEVEL II CODES

This section contains a list of commonly used modifiers with HCPCS Level II DME codes. Other HCPCS Level II modifiers, including those which can be used with CPT codes, are acceptable modifiers.

AU Item furnished in conjunction with a urological, ostomy, or tracheostomy supply

AV Item furnished in conjunction with a prosthetic device, prosthetic, or orthotic

AW Item furnished in conjunction with a surgical dressing

KC Replacement of special power wheelchair interface

NU Purchased new equipment

RR Rental equipment (listed amount is the per-month allowance)

UE Purchased used equipment

IV. CODE EXCEPTIONS

- A. Unlisted Procedure Codes. If a procedure is performed that is not listed in the Medical Fee Schedule, the provider must bill with the appropriate "Unlisted Procedure" code and submit a narrative report to the payer explaining why it was medically necessary to use an unlisted procedure code.

The CPT book contains codes for unlisted procedures. Use these codes only when there is no procedure code that accurately describes the service rendered. A report is required as these services are reimbursed by report (see below).

- B. By Report (BR) Codes. By report (BR) codes are used by payers to determine the reimbursement for a service or procedure performed by the provider that does not have an established maximum reimbursement allowance (MRA).
1. Reimbursement for procedure codes listed as "BR" must be determined by the payer based on documentation submitted by the provider in a special report attached to the claim form. The required documentation to substantiate the medical necessity of a procedure does not warrant a separate fee. Information in this report must include, as appropriate:

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- a. A complete description of the actual procedure or service performed;
 - b. The amount of time necessary to complete the procedure or service performed;
 - c. Accompanying documentation that describes the expertise and/or equipment required to complete the service or procedure.
2. Reimbursement of "BR" procedures should be based on the usual and customary rate.
- C. **Category II Codes.** This Fee Schedule does not include Category II codes as published in *CPT 2008*. Category II codes are supplemental tracking codes that can be used for performance measurements. These codes describe clinical components that are typically included and reimbursed in other services such as evaluation and management (E/M) or laboratory services. These codes do not have an associated relative value or fee.
- D. **Category III Codes.** This Fee Schedule does not include Category III codes published in *CPT 2008*. If a provider bills a Category III code, payment may be denied.
- E. **Add-On Codes.** Some of the listed procedures are commonly carried out in addition to the primary procedure performed. These additional or supplemental procedures are designated as add-on codes with a + symbol, and are listed in the applicable CPT book. Add-on codes can be readily identified by specific descriptor nomenclature which includes phrases such as "each additional" or "(List separately in addition to code for primary procedure)."
- The "add-on" code concept in the CPT book applies only to add-on procedures/services performed by the same physician. Add-on codes describe additional intra-service work associated with the primary procedure (e.g., additional digit(s), lesion(s), neurothaphy(s), vertebral segment(s), tendon(s), joint(s)).
- Add-on codes are always performed in addition to the primary service/procedure, and must never be reported as a stand-alone code. All add-on codes found in the CPT book are exempt from the multiple procedure concept (see modifier 51 definition in this section). Add-on codes are reimbursed at one hundred percent (100%) of the maximum reimbursement allowance.
- Refer to the most current version of the CPT book for a complete list of add-on codes.
- F. **Codes Exempt From Modifier 51.** Certain codes are exempt from the use of modifier 51 but have not been designated as CPT add-on procedures/services. Please consult the most current CPT book for the list of codes that are exempt from modifier 51. Codes designated as exempt from modifier 51 are identified with a @ symbol, and are listed in the most current CPT book.
- All codes exempt from modifier 51 found in the CPT book are exempt from the multiple procedure concept (see modifier 51 definition in this section). Codes exempt from modifier 51 are reimbursed at one hundred percent (100%) of the maximum reimbursement allowance or the provider's usual charge whichever is less.
- G. **Moderate (Conscious) Sedation.** To report moderate (conscious) sedation provided by the physician also performing the diagnostic or therapeutic service for which conscious sedation is being provided, see codes 99143–99145. It is not appropriate for the physician performing the sedation and the service for which the conscious sedation is being provided to report the sedation separately when the code is listed with the conscious sedation symbol K. The conscious sedation symbol identifies services that include moderate (conscious) sedation. A list of codes for services that include moderate (conscious) sedation is also included in the most current CPT book.
- For procedures listed with K, when a second physician other than the health care professional performing the diagnostic or therapeutic services provides moderate (conscious) sedation in the facility setting (e.g., hospital, outpatient hospital/ambulatory surgery center, skilled nursing facility), the second physician reports the associated moderate sedation procedure/service using codes 99148–99150. Moderate (conscious) sedation services are not reported additionally when performed by the second physician in the non-facility setting (e.g., physician office, freestanding imaging center).

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Moderate sedation codes are not used to report minimal sedation (anxiolysis), deep sedation, or monitored anesthesia care.

Nurse Practitioner, and Physician Assistant and Physical or Occupational Therapist Assistant Rules

- I. Modifier NP should be attached to the appropriate CPT code when billing services rendered by the nurse practitioner. The nurse practitioner must use his/her unique identifier to bill for all services. Nurse practitioners must comply with the requirements for a National Provider Identifier (NPI) as specified in the Billing and Reimbursement Rules of this Fee Schedule.
- II. The nurse practitioner is reimbursed at eighty-five percent (85%) of the maximum allowable for the procedure.
- III. There is only one fee allowed for each CPT code. It is the decision of the physician or the nurse practitioner as to who will bill for a service when both have shared in the provision of the service. Incorrect billing of the service may cause a delay or improper payment by the payer. The payer will reimburse the bill which is received first.

The medical doctor (MD) must be on-site on the date of service in order for physician reimbursement to apply.
- IV. The physician assistant shall be reimbursed at the same rate as for the nurse practitioner, and the same rules as apply to the nurse practitioners with regard to billing and reimbursement, shall apply to the physician assistant.
- V. Modifier PA should be attached to the appropriate CPT code when billing services rendered by the physician assistant.
- VI. The Physical Therapist Assistant or Occupational Therapist Assistant shall be reimbursed at eighty-five percent (85%) of the maximum allowable for the procedure. Modifier "PT" should be attached to the appropriate CPT code(s) when billing services rendered by a Physical Therapist Assistant or an Occupational Therapist Assistant.

Pharmacy Rules

I. SCOPE

This section provides specific rules for the dispensing of and payment for medications and other pharmacy services prescribed to treat work-related injury/illness under the terms of the Act.

II. DEFINITIONS

- A. Medications are defined as drugs prescribed by a licensed health care provider and include name brand and generic drugs as well as patented or over-the-counter drugs, compound drugs and physician-dispensed or repackaged drugs.
- B. Average Wholesale Price means the AWP based on the most current edition of the *Drug Topics Red Book* in effect at the time the medication is dispensed.

III. RULES

- A. Generic Equivalent Drug Products: Unless otherwise specified by the ordering physician, all prescriptions will be filled under the generic name.

When the physician writes "brand medically necessary" on the prescription, the pharmacist will fill the order with the brand name. When taking telephone orders, the pharmacist will assume the generic brand is to be used unless "brand medically necessary" is specifically ordered by the treating physician. Without exception, the treating physician has the authority to order a brand name medication if he/she feels the trademark drug is substantially more effective.
- B. A payer or provider may not prohibit or limit any person from selecting a pharmacy or pharmacist of his/her choice, and may not require any person to purchase pharmacy services, including prescription drugs, exclusively through a mail-order pharmacy or program, or to obtain medication dispensed by the physician or in the physician's office, provided the pharmacy or pharmacist selected by the claimant has agreed to be bound by the terms of the Workers' Compensation Law and this Fee Schedule with regard to the provision of services and the billing and payment therefor.
- C. Dietary supplements, including but not limited to minerals, vitamins, and amino acids are not reimbursable unless a specific compensable dietary deficiency has been clinically established.
- D. Not more than one dispensing fee shall be paid per drug within a ten (10) day period.

IV. REIMBURSEMENT

- A. Reimbursement for pharmaceuticals ordered for the treatment of work-related injury/illness is as follows:
 - 1. Brand/Trade Name Medications: Average Wholesale Price (AWP) plus a five dollar (\$5.00) dispensing fee.

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2. Generic Medications: Average Wholesale Price (AWP) plus a five dollar (\$5.00) dispensing fee.
 3. Over-the-counter medications are reimbursed at usual and customary rates.
 4. Dispensing fees are payable only if the prescription is filled under the direct supervision of a registered pharmacist. If a physician dispenses medications from his/her office, a dispensing fee is not allowed.
 5. Repackaged and/or Physician Dispensed Medication. If the National Drug Code ("NDC") for the drug product as dispensed is a repackaged drug, the maximum allowable fee shall be the lesser of AWP using a) the NDC for the underlying drug product from the original labeler, or b) the therapeutic equivalent drug product from the original labeler NDC.
For purposes of this provision, "therapeutically equivalent drugs" means drugs that have been assigned the same Therapeutic Equivalent Code starting with the letter "A" in the Food and Drug Administration's publication "Approved Drug Products with Therapeutic Equivalence Evaluations" ("Orange Book"). The Orange Book may be accessed through the Food and Drug Administration website at <http://www.accessdata.fda.gov/scripts/cder/ob/default.cfm>.
National Drug Code "for the underlying drug product from the original labeler" means the NDC of the drug product actually utilized by the repackager in producing the repackaged product.
 6. Compound Medications. Compound drugs or medications shall be billed by listing each drug and its NDC number included in the compound and calculating the charge for each drug separately. Payment shall be based on the sum of the fee for each ingredient, plus a single dispensing fee of five dollars (\$5.00). If the NDC for any ingredient is a repackaged drug, reimbursement for the repackaged ingredient(s) shall be as above provided.
 7. If information pertaining to the original labeler of the underlying drug product used in repackaged or compound medications is not provided or is otherwise unknown or unavailable, the payer shall reimburse using the lowest priced generic therapeutic equivalent drug product.
- B. Supplies and equipment used in conjunction with medication administration should be billed with the appropriate HCPCS codes and shall be reimbursed according to the Fee Schedule. Supplies and equipment not listed in the Fee Schedule will be reimbursed at the usual and customary rate.
- C. Mail-order pharmaceutical services are subject to the rules and reimbursement limitations of this Fee Schedule when supplying medications to Mississippi Workers' Compensation claimants.

Home Health Rules

I. SCOPE

This section of the Fee Schedule pertains to home health services provided to patients who have a work-related injury/illness.

- A. The determination that the injury/illness or condition is work related must be made by the payer and home health services shall be pre-certified as medically necessary by the payer's Utilization Management Program.
- B. All nursing services and personal care services shall have prior authorization by the payer.
- C. A description of needed nursing or other attendant care must accompany the request for authorization.

II. REIMBURSEMENT

- A. If a payer and provider have a mutually agreed upon contractual arrangement governing the payment for home health services to injured/ill employees, the payer shall reimburse under the contractual agreement and not according to the Fee Schedule.
- B. In the absence of a mutually agreed upon contractual arrangement governing payment for home health service, reimbursement shall be made as in other cases (see Billing and Reimbursement Rules) in an amount equal to the maximum reimbursement allowance (MRA).
Billing for home health services is appropriate using the applicable billing form for other institutional providers or facilities.
- C. A visit made simultaneously by two or more workers from a home health agency to provide a single covered service for which one supervises or instructs the other shall be counted as one visit.
- D. A visit is defined as time up to and including the first two hours.
- E. The maximum reimbursement rates listed herein are inclusive of mileage and other incidental travel expenses, unless otherwise agreed to by the payer and provider.
- F. The hourly rates set forth in this section of the Schedule apply to all hours worked. No additional reimbursement is allowed for overtime hours, unless otherwise agreed to by the parties in a separate fee contract.

III. RATES

- A. The following rates and codes apply to services provided by or through a home health agency:

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Service	Fee Per Visit	Billing Code
Skilled Nursing Care	\$110.00	G0154
Physical Therapy	\$120.00	G0151
Speech Therapy	\$125.00	G0153
Occupational Therapy	\$125.00	G0152
Medical Social Services	\$125.00	G0155
Home Health Aid	\$60.00	G0156

For services that exceed two hours, reimbursement for time in excess of the first two hours shall be pro-rated and based on an hourly rate equal to fifty percent (50%) of the above visit fee. For home health services rendered in two (2) hours or less, reimbursement shall be made for a visit as above provided.

NOTE: in addition to the Skilled Nursing Care fees above, an additional sum of \$7.16 per visit shall be added to cover the cost of medical supplies, provided the billing form adequately specifies what supplies were utilized.

B. The following Private Duty Rates shall apply:

Skilled Nursing Care – R.N.	\$44.00 per hour
Skilled Nursing Care – L.P.N.	\$37.00 per hour
Certified Nurse Assistant	\$20.00 per hour
Sitter	\$13.00 per hour

C. Any reimbursement to persons not working under a professional license, such as a spouse or relative, will be at the rate of \$8.00 per hour unless otherwise negotiated by the payer and caregiver or provider.

D. Professional providers not assigned a maximum allowable rate for home health services and who have not negotiated their rates with the payer prior to provision of home health care, shall be reimbursed at the usual and customary rate, or the total billed charge, whichever is less.

Skilled Nursing Facility Rules

- I. The maximum reimbursement amount for medical care provided within the confines of a freestanding skilled nursing facility, a hospital based skilled nursing facility, or a swing bed facility, shall be three hundred dollars (\$300.00) per day. This rate covers and includes all routine and ancillary health care services provided to a claimant during each day of a covered skilled nursing facility stay.

- II. The following services are excluded from the daily skilled nursing facility rate, and shall be reimbursed separately and in addition to the above daily rate: cardiac catheterization; angiography; magnetic resonance imaging (MRI) and computerized axial tomography (CT) scans; radiation therapy and chemotherapy; emergency services, which are defined as an admission or services necessitated by a sudden onset of illness or injury which is manifested by acute symptoms of sufficient severity that the failure to provide services could reasonably result in (a) serious impairment of bodily function(s), (b) serious or permanent dysfunction of any bodily organ or part or system, (c) permanently placing the person's health in jeopardy, or (d) other serious medical consequence; outpatient services when provided in a hospital or other free standing outpatient facility separate from the skilled nursing facility; customized prosthetic services; ambulance transportation related to any of the above services; and services provided independent of the facility by physicians, and other medical practitioners (e.g., NP, PA, CRNA, psychologist).

- III. As in other cases, the above provisions shall not apply to any mutual agreement or contract entered into by the payer and provider which sets forth the terms for the provision of skilled nursing facility services and reimbursement therefor.

Evaluation and Management

This section contains rules and codes used to report evaluation and management services.

Note: Rules used by all physicians in reporting their services are presented in the General Rules section.

I. DEFINITIONS AND RULES

Definitions and rules pertaining to evaluation and management services are as follows:

- A. **Consultations:** The CPT book defines a consultation as "a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source." (This includes referrals for a second opinion.) Consultations are reimbursable only to physicians with the appropriate specialty for the services provided.

In order to qualify as a consultation the following criteria must be met:

- The verbal or written request for a consult must be documented in the patient's medical record.
- The consultant's opinion and any services ordered or performed must be documented by the consulting physician in the patient's medical record.
- The consulting physician must provide a written report to the requesting physician or other appropriate source.

A payer/employer may request a second opinion examination or evaluation for the purpose of evaluating temporary or permanent disability or medical treatment being rendered, as provided in MCA §71-3-15(1) (Rev. 2000). This examination is considered a confirmatory consultation. The confirmatory consultation is billed using the appropriate level and site specific consultation code, 99241–99245 for office or other outpatient consultations and 99251–99255 for inpatient consultations, with modifier 32 appended to indicate a mandated service.

- B. **Referral:** Subject to the definition of "consultation" provided in this Fee Schedule, a referral is the transfer of the total or specific care of a patient from one physician to another and does not constitute a consultation. (Initial evaluations and subsequent services are designated as listed in E/M services).
- C. **New and Established Patient Service:** Several code subcategories in the Evaluation and Management section are based on the patient's status as new or established. The new versus established patient guidelines also clarify the situation in which a physician is on call or covering for another physician. In this instance, classify the patient encounter the same as if it were for the physician who is unavailable.

- *New Patient.* A new patient is one who has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, for this same injury or within the past three years.
 - *Established Patient.* An established patient is a patient who has been treated for the same injury by any physician, of the same specialty, who belongs to the same group practice.
- D. E/M Service Components. The first three components of history, examination, and medical decision-making are the keys to selecting the correct level of E/M codes, and all three components must be met or exceeded in the documentation of an initial evaluation. However, in established, subsequent, and follow-up categories, only two of the three must be met or exceeded for a given code.
1. The history component is categorized by four levels
 - a. *Problem Focused.* Chief complaint; brief history of present illness or problem.
 - b. *Expanded Problem Focused.* Chief complaint; brief history of present illness; problem-pertinent system review.
 - c. *Detailed.* Chief complaint, extended history of present illness; problem-pertinent system review extended to include a review of limited number of additional systems; pertinent past, family medical and/or social history directly related to the patient's problems.
 - d. *Comprehensive.* Chief complaint, extended history of present illness; review of systems that are directly related to the problems identified in the history of the present illness, plus a review of all additional body systems; complete past, family, and social history.
 2. The physical exam component is similarly divided into four levels of complexity:
 - a. *Problem Focused.* An exam limited to the affected body area or organ system.
 - b. *Expanded Problem Focused.* A limited examination of the affected body area or organ system and other symptomatic or related organ systems.
 - c. *Detailed.* An extended examination of the affected body areas and other symptomatic or related organ systems.
 - d. *Comprehensive.* A general multi-system examination or a complete examination of a single organ system.

The CPT book identifies the following body areas:

- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back
- Each extremity

The CPT book identifies the following organ systems:

- Constitutional symptoms (fevers, weight loss, etc.)
- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal

- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic

3. Medical decision-making is the final piece of the E/M coding process. Medical decision making refers to the complexity of establishing a diagnosis or selecting a management option that can be measured by the following:
- a. The number of diagnoses and/or the number of management options to be considered.
 - b. The amount and/or complexity of medical records, diagnostic tests, and other information that must be retrieved, reviewed, and analyzed.
 - c. The risk of significant complications, morbidity, mortality, as well as co-morbidities associated with the patient's presenting problems, the diagnostic procedures, and/or the possible management options.

E. Contributory Components.

1. Counseling, coordination of care, and the nature of the presenting problem are not major considerations in most encounters, so they generally provide contributory information to the code selection process. The exception arises when counseling or coordination of care dominates the encounter (more than fifty percent (50%) of the time spent). Document the exact amount of time spent to substantiate the selected code and what was clearly discussed during the encounter. Counseling is defined in the CPT book as a discussion with a patient and/or family concerning one or more of the following areas:
 - a. Diagnostic results, impressions, and/or recommended diagnostic studies;
 - b. Prognosis;
 - c. Risks and benefits of management (treatment) options;
 - d. Instructions for management (treatment) and/or follow-up;
 - e. Importance of compliance with chosen management (treatment) options;
 - f. Risk factor reduction;
 - g. Patient and family education.
2. E/M codes are designed to report actual work performed, not time spent. But when counseling or coordination of care dominates the encounter, time overrides the other factors and determines the proper code. For office encounters, count only the time spent face-to-face with the patient and/or family. For hospital or other inpatient encounters, count the time spent rendering services for that patient while on the patient's unit, on the patient's floor, or at the patient's bedside.

F. Interpretation of Diagnostic Studies in the Emergency Room

1. Only one fee for the interpretation of an x-ray or EKG procedure will be reimbursed per procedure.
2. The payer is to provide reimbursement to the provider that directly contributed to the diagnosis and treatment of the individual patient.
3. It is necessary to provide a signed report in order to bill the professional component of a diagnostic procedure. The payer may require the report before payment is rendered.
4. If more than one bill is received, physician specialty should not be the deciding factor in determining which physician to reimburse.

Example: In many EDs, an emergency room (ER) physician orders the x-ray on a particular patient. If the ER physician interprets the x-ray making a notation as to the findings in the chart and then treats the patient according to these radiological findings, the ER physician should be paid for the interpretation and report. There may be a radiologist on staff at the particular facility with quality control responsibilities at that particular facility. However, the fact that the radiologist reads all x-rays taken in the ED for quality control purposes is not sufficient to command a separate or additional reimbursement from the payer.

5. A review alone of an x-ray or EKG does not meet the conditions for separate payment of a service, as it is already included in the ED visit.

II. GENERAL GUIDELINES

The E/M code section is divided into subsections by type and place of service. Keep the following in mind when coding each service setting:

- A patient is considered an outpatient at a health care facility until formal inpatient admission occurs.
- All physicians use codes 99281–99285 for reporting emergency department services, regardless of hospital-based or non-hospital-based status.
- Admission to a hospital or nursing facility includes E/M services provided elsewhere on the same day.

III. OFFICE OR OTHER OUTPATIENT SERVICES (99201–99215)

Use the Office or Other Outpatient Services codes to report the services for most patient encounters. Multiple office or outpatient visits provided on the same calendar date are billable if medically necessary and include documentation to support medical necessity.

IV. HOSPITAL OBSERVATION SERVICES (99217–99220)

CPT codes 99217 through 99220 report E/M services provided to patients designated or admitted as "observation status" in a hospital. It is not necessary that the patient be located in an observation area designated by the hospital to use these codes; however, whenever a patient is placed in a separately designated observation area of the hospital or emergency department, these codes should be used.

The instructional notes for Initial Hospital Observation Care include the following:

- A. Use these codes to report the encounters by the supervising physician when the patient is designated as "observation status."
- B. These codes include initiation of "observation status," supervision of the health care plan for observation, and performance of periodic reassessments.
- C. When a patient is admitted to observation status in the course of an encounter in another site of service (e.g., hospital emergency department, physician's office, nursing facility), all E/M services provided by that physician on the same day are included in the admission for hospital observation. Only one physician can report initial observation services. Do not use these observation codes for post-recovery of a procedure that is considered a global surgical service.
- D. Observation services are included in the inpatient admission service when provided on the same date. Use Initial Hospital Care codes for services provided to a patient who, after receiving

observation services, is admitted to the hospital on the same date. The observation service is not reported separately.

- E. Admission to a hospital or nursing facility includes evaluation and management services provided elsewhere (office or emergency department) by the admitting physician on the same day.
 - F. For a patient admitted to the hospital on a date subsequent to the date of observation status, the hospital admission would be reported separately with the appropriate Initial Hospital Care code 99221–99223.
 - G. For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes 99234–99236.
- See Office and Other Outpatient Consultation codes to report observation encounters by other physicians.

V. OBSERVATION CARE DISCHARGE SERVICES (99217)

- A. CPT code 99217 is used only if discharge from observation status occurs on a date other than the initial date of observation. The code includes final examination of the patient, discussion of the hospital stay, instructions for continuing care, and preparation of discharge records.
- B. If a patient is admitted to and subsequently discharged from observation status on the same date, see codes 99234–99236.
- C. Do not report observation discharge 99217 in conjunction with a hospital admission.

VI. HOSPITAL INPATIENT SERVICES (99221–99239)

The codes for hospital inpatient services report admission to a hospital setting, follow-up care provided in a hospital setting, and hospital discharge day management. For inpatient care, the time component includes not only face-to-face time with the patient but also the physician's time spent in the patient's unit or on the patient's floor. This time may include family counseling or discussing the patient's condition with the family; establishing and reviewing the patient's record; documenting within the chart; and communicating with other health care professionals, such as other physicians, nursing staff, respiratory therapists, etc.

- A. If the patient is admitted to a facility on the same day as any related outpatient encounter (office, emergency department, nursing facility, etc.), report the total care as one service with the appropriate Initial Hospital Care code.
- B. For initial hospital care of a patient admitted on one date and discharged a subsequent day, report 99221–99223 for the initial inpatient care, 99231–99233 for the subsequent hospital care excluding the discharge day.
- C. For a patient admitted and discharged for inpatient services or observation status on the same date, report the service with CPT codes 99234–99236.
- D. Code 99238 or 99239 reports hospital discharge day management, but excludes discharge of a patient from observation status and inpatients admitted and discharged on the same date. When concurrent care is provided on the day of discharge by a physician other than the attending physician, report these services using Subsequent Hospital Care codes.

VII. MULTIPLE HOSPITAL VISITS

Not more than one hospital visit per day shall be payable except when documentation describes the medical necessity of more than one visit by a particular practitioner. Hospital visit codes shall be combined into the single code that best describes the service rendered.

VIII. CONSULTATIONS (99241–99255)

Consultations in CPT 2008 fall under two subcategories: Office or Other Outpatient Consultations, and Inpatient Consultations. If counseling dominates the encounter, time determines the correct code.

Most requests for a consultation come from the attending physician, the employer, an attorney, or other appropriate source. Include the name of the requesting physician or other source on the claim form or electronic billing. Confirmatory consultations may be requested by the patient and/or family or may result from a second (or third) opinion. When requested by the patient and/or family the service is not reported with consultation codes, but may be reported using the office, home service, or domiciliary/rest home care codes. When required by the attending physician or other appropriate source, report the service with a consultation code for the appropriate site of service, 99241–99245 for office or other outpatient consultation or 99251–99255 for inpatient consultation.

The consultant may initiate diagnostic and/or therapeutic services, such as writing orders or prescriptions and initiating treatment plans.

The opinion rendered and services ordered or performed must be documented in the patient's medical record and a report of this information communicated to the requesting entity.

Report separately any identifiable procedure or service performed on, or subsequent to, the date of the initial consultation.

When the consultant assumes responsibility for the management of any or all of the patient's care subsequent to the consultation encounter, consult codes are no longer appropriate. Depending on the location, identify the correct subsequent or established patient codes.

IX. EMERGENCY DEPARTMENT SERVICES (99281–99288)

Emergency department (ED) service codes do not differentiate between new and established patients and are used by hospital-based and non-hospital-based physicians. The notes in the CPT book clearly define an emergency department as "an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day." This guideline indicates that care provided in the ED setting for convenience should not be coded as an ED service. Also note that more than one ED service can be reported per calendar day if medically necessary.

Codes 99281–99288 are used to report services provided in a medical emergency. If, however, the physician sees the patient in the emergency room out of convenience for either the patient or physician, the appropriate office visit code should be reported (99201–99215) and reimbursement will be made accordingly.

X. CRITICAL CARE SERVICES (99291–99300)

Critical care is the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition. Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure. Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life threatening situations when these elements are not

present. Critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the patient, provided that the patient's condition continues to require the level of physician attention described above.

Providing medical care to a critically ill, injured, or postoperative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility.

Critical care services provided to infants 29 days through 24 months of age are reported with pediatric critical care codes 99293 and 99294. Critical care services provided to infants older than one month of age at the time of admission to an intensive care unit are reported with critical care codes 99291 and 99292. Critical care services provided to neonates (28 days of age or less at the time of admission to an intensive care unit) are reported with the neonatal critical care codes 99295, 99296, 99298, 99299, and 99300. The neonatal critical care codes are reported as long as the neonate qualifies for critical care services during the hospital stay. The reporting of pediatric and neonatal critical care services is not based on time, the type of unit (e.g., pediatric or neonatal critical care unit) or the type of provider delivering the care. For additional instructions on reporting these services, see the Inpatient Neonatal and Pediatric Critical Care section of the CPT book and codes 99293–99300.

Services for a patient who is not critically ill but happens to be in a critical care unit are reported using other appropriate E/M codes.

Critical care and other E/M services may be provided to the same patient on the same date by the same physician.

The following services are included in reporting critical care when performed during the critical period by the physician(s) providing critical care: the interpretation of cardiac output measurements (93561, 93562), chest x-rays (71010, 71015, 71020), pulse oximetry (94760, 94761, 94762), blood gases, and information data stored in computers (e.g., ECGs, blood pressures, Hematologic data (99090)); gastric intubation (43752, 91105); temporary transcutaneous pacing (92953); ventilatory management (94002–94004, 94660, 94662); and vascular access procedures (36000, 36410, 36415, 36591). Any services performed which are not listed above should be reported separately when performed in conjunction with critical care services reported with code 99291–99292. When reporting inpatient neonatal and pediatric critical care services 99293–99300, consult the CPT book for additional procedures that are bundled into codes 99293–99300.

Codes 99291–99292 should not be reported for the physician's attendance during the transport of critically ill or injured patients to or from a facility or hospital. Physician transport services of the critically ill or injured pediatric patient (24 months of age or less) are separately reportable, see 99289, 99290.

The critical care codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured patient, even if the time spent by the physician on that date is not continuous. For any given period of time spent providing critical care services, the physician must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time.

XI. NURSING FACILITY SERVICES (99304–99318)

Nursing facility E/M services have been grouped into four subcategories: Initial Nursing Facility Care, Subsequent Nursing Facility Care, Nursing Facility Discharge Services, and Other Nursing Facility Services. Included in these codes are E/M services provided to patients in nursing facilities (formerly called skilled nursing facilities (SNFs)), intermediate care facilities (ICFs), long-term care facilities

(LTCFs), and psychiatric residential treatment centers. Psychiatric residential treatment centers must provide a "24 hour therapeutically planned and professionally staffed group living and learning environment." Report other services, such as medical psychotherapy, separately when provided in addition to E/M services.

XII. DOMICILIARY, REST HOME (E.G., BOARDING HOME), OR CUSTODIAL CARE SERVICES (99324–99340)

The evaluation and management codes are used to report care given to patients residing in a facility that provides room and board and other personal assistance services. The facility is generally a long-term facility. The facility's services do not include a medical component. Typical times have not been established for this code group.

XIII. HOME SERVICES (99341–99350)

Services and care provided at the patient's home are coded from this subcategory. Typical times have not been established for this code group.

XIV. PROLONGED SERVICES (99354–99359)

A. *Prolonged Physician Service with Direct Patient Contact (99354–99357).* Prolonged physician services are reportable in addition to other physician services, including any level of E/M service. The codes report the total duration of face-to-face time spent by the physician on a given date, even if the time is not continuous.

Codes 99354 or 99356 report the first hour of prolonged service on a given date, depending on the place of service. Code 99355 or 99357 is used to report each additional 30 minutes beyond the first hour. Services lasting less than 30 minutes are not reportable in this category, and the services must extend 15 minutes or more into the next time period to be reportable. For example, services lasting one hour and twelve minutes are reported by code 99354 or code 99356 alone. Services lasting one hour and seventeen minutes are reported using the code for the first hour plus the code for an additional 30 minutes.

Prolonged physician services should be reported only once per date of service, even if the time spent is not continuous. Please refer to the most current CPT book for a more complete explanation of prolonged physician care.

B. *Prolonged Physician Service without Direct Patient Contact.* Use code 99358 to report the first hour and 99359 for each additional 30 minutes. All aspects of time reporting are the same as explained above for direct patient contact services.

Prolonged physician services without direct patient contact may include review of extensive records and tests, and communication (other than telephone calls, 99441–99443) with other professionals and/or the patient and family. These are beyond the usual services and include both inpatient and outpatient settings. Report these services in addition to other services provided, including any level of E/M service.

XV. PHYSICIAN STANDBY SERVICES (99360)

Code 99360 is used to report physician standby service that is requested by another physician and that involves prolonged physician attendance without direct (face-to-face) patient contact. The physician may

not be providing care or services to other patients during this period. This code is not used to report time spent proctoring another physician. It is also not used if the period of standby ends with the performance of a procedure subject to a "surgical" package by the physician who was on standby.

Code 99360 is used to report the total duration of time spent by a physician on a given date on standby. Standby service of less than 30 minutes total duration on a given date is not reported separately.

Second and subsequent periods of standby beyond the first 30 minutes may be reported only if a full 30 minutes of standby was provided for each unit of service reported.

XVI. CASE MANAGEMENT SERVICES (99363–99368)

Physician case management is a process in which a physician is responsible for direct care of a patient, and for coordinating and controlling access to or initiating and/or supervising other health care services needed by the patient.

XVII. CARE PLAN OVERSIGHT SERVICES (99339–99340, 99374–99380)

Care plan oversight services are reported separately from codes for office/outpatient, hospital, home, nursing facility, or domiciliary services. The complexity and the approximate physician time spent in care plan oversight services provided within a thirty (30) day period determines the code to be billed.

Only one physician may report care plan oversight services during a given period of time, reflecting the physician's sole or predominant supervisory role with the patient. These codes should not be used for supervision of a patient in a nursing facility or under the care of a home health agency unless they require recurrent supervision of therapy. Care plan oversight services are considered part of the patient evaluation and management services when less than fifteen (15) minutes are provided during a thirty (30) day period.

XVIII. SPECIAL EVALUATION AND MANAGEMENT SERVICES (99450–99456)

This series of codes was introduced in *CPT 1995* to report physician evaluations in order to establish baseline information for insurance certification and/or work-related or medical disability.

XIX. OTHER EVALUATION AND MANAGEMENT SERVICES (99499)

This is an unlisted code to report E/M services not specifically defined in the CPT book.

XX. MODIFIERS

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code, a two-digit number placed after the usual procedure code, separated by a hyphen. If more than one modifier is needed, place the multiple modifiers code 99 after the procedure code to indicate that two or more modifiers will follow. Modifiers commonly used with E/M procedures are as follows:

21 Prolonged Evaluation and Management Services

When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category, it may be identified by adding modifier 21 to the evaluation and management code number. A report may also be appropriate.

24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period

The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57.

For significant, separately identifiable non-E/M services, see modifier 59.

32 Mandated Services

Services related to mandated consultation and/or related services (eg, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

57 Decision for Surgery

An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

Anesthesia

I. INTRODUCTION

The base units in this section have been determined on an entirely different basis from the relative values in other sections. A conversion factor applicable to this section is not applicable to any other section.

The American Society of Anesthesiologists' (ASA) *Relative Value Guide™ 2008-2010* is recognized as an appropriate assessment of current relative values for specific anesthesiology procedures. It is the basis for the assigned base units for CPT codes in the Anesthesia section of the Fee Schedule.

The conversion factor for anesthesia services has been designated at \$42-45.00 per unit.

Total anesthesia value is defined in the following formula:

$$(\text{Base units} + \text{time units} + \text{modifying units}) \times \text{conversion factor} = \text{reimbursement}$$

II. BASE UNITS

Base units are listed for most procedures. This value is determined by the complexity of the service and includes all usual anesthesia services except the time actively spent in anesthesia care and the modifying factors. The base units include preoperative and postoperative visits, the administration of fluids and/or blood incident to the anesthesia care, and interpretation of noninvasive monitoring (ECG, temperature, blood pressure, oximetry, and other usual monitoring procedures). The basic anesthesia unit includes the routine follow-up care and observation (including recovery room observation and monitoring). When multiple surgical procedures are performed during the same period of anesthesia, only the highest base unit allowance of the various surgical procedures will be used.

III. TIME UNITS

Time begins when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or in an equivalent area. Time ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision. The anesthesia time units will be calculated in 15-minute intervals, or portions thereof, equaling one (1) time unit. No additional time units are allowed for recovery room time and monitoring.

IV. SPECIAL CIRCUMSTANCES

A. Physical Status Modifiers

Physical status modifiers are represented by the initial letter P followed by a single digit from one (1) to six (6) defined below:

Status	Description	Base Units
P1	A normal healthy patient.	0
P2	A patient with mild systemic disease	0
P3	A patient with severe systemic disease	1
P4	A patient with severe systemic disease that is a constant threat to life	2
P5	A moribund patient who is not expected to survive without the operation	3
P6	A patient declared brain-dead whose organs are being removed for donor purposes	0

The above six levels are consistent with the American Society of Anesthesiologists' (ASA) ranking of patient physical status. Physical status is included in the CPT book to distinguish between various levels of complexity of the anesthesia service provided.

B. Qualifying Circumstances

1. Qualifying circumstances warrant additional value due to unusual events. The following list of CPT codes and the corresponding anesthesia unit values may be listed if appropriate. The unit value listed is added to the existing anesthesia base units.

CPT	Description	Units
99100	Anesthesia for patient of extreme age, younger than one year and older than seventy (List separately in addition to code for primary anesthesia procedure)	1
99110	Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure)	5
99135	Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure)	5

89140	Anesthesia complicated by emergency conditions (specify conditions) (List separately in addition to code for primary anesthesia procedure) (An emergency is defined as existing when delay in treatment of a patient would lead to a significant increase in the threat to life or body part.)	2
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2. Payers must utilize their medical consultants when there is a question regarding modifiers and/or special circumstances for anesthesia charges.

V. MONITORED ANESTHESIA CARE

Monitored anesthesia care occurs when the attending physician requests that an anesthesiologist be present during a procedure. This may be to insure compliance with accepted procedures of the facility. Monitored anesthesia care includes pre-anesthesia exam and evaluation of the patient. The anesthesiologist must participate or provide medical direction for the plan of care. The anesthesiologist, resident, or nurse anesthetist must be in continuous physical presence and provide diagnosis and treatment of emergencies. This will also include noninvasive monitoring of cardiocirculatory and respiratory systems with administration of oxygen and/or intravenous administration of medications. Reimbursement will be the same as if general anesthesia had been administered (time units + base units).

VI. REIMBURSEMENT FOR ANESTHESIA SERVICES

A. Criteria for Reimbursement

Anesthesia services may be billed for any one of the three following circumstances:

1. An anesthesiologist provides total and individual anesthesia service.
2. An anesthesiologist directs a CRNA or AA
3. Anesthesia provided by a CRNA or AA working independent of an anesthesiologist's supervision is covered under the following conditions:
 - a. The service falls within the CRNA's or AA's scope of practice and scope of license as defined by law.
 - b. The service is supervised by a licensed health care provider who has prescriptive authority in accordance with the clinical privileges individually granted by the hospital or other health care organization.

B. Reimbursement

1. The maximum reimbursement allowance for anesthesia is calculated by adding the base unit value, the number of time units, any applicable modifier and/or unusual circumstances units, and multiplying the sum by a dollar amount (conversion factor) allowed per unit.
2. Reimbursement includes the usual pre- and postoperative visits, the care by the anesthesiologist during surgery, the administration of fluids and/or blood, and the usual monitoring services. Unusual forms of monitoring, such as central venous, intra-arterial, and Swan-Ganz monitoring, may be reimbursed separately.
3. When an unlisted service or procedure is provided, the value should be substantiated with a report. Unlisted services are identified in this Fee Schedule as by report (BR).

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4. When it is necessary to have a second anesthesiologist, the necessity should be substantiated BR. The second anesthesiologist will receive five base units + time units (calculation of total anesthesia value).
5. Payment for covered anesthesia services is as follows:
 - a. When the anesthesiologist provides an anesthesia service directly, payment will be made in accordance with the Billing and Reimbursement Rules of this Fee Schedule.
 - b. When an anesthesiologist provides medical direction to the CRNA or AA providing the anesthesia service, then the reimbursement will be divided between the two of them at fifty percent (50%).
 - c. When the CRNA or AA provides the anesthesia service directly, then payment will be the lesser of the billed charge or eighty percent (80%) of the maximum allowable listed in the Fee Schedule for that procedure.
6. Anesthesiologists, CRNAs, and AAs must bill their services with the appropriate modifiers to indicate which one provided the service. Bills NOT properly coded may cause a delay or error in reimbursement by the payer. Application of the appropriate modifier to the bill for service is the responsibility of the provider, regardless of the place of service. Modifiers are as follows:
 - AA Anesthesiologist services performed personally by an anesthesiologist.
 - AD Medical supervision by a physician: more than four concurrent anesthesia procedures
 - QK Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals (CRNA or AA) by an anesthesiologist
 - QX CRNA or AA service: with medical direction by an anesthesiologist
 - QY Medical direction of one certified registered nurse anesthetist (CRNA or AA) by an anesthesiologist
 - QZ CRNA service: without medical direction by an anesthesiologist

VII. ANESTHESIA MODIFIERS

All anesthesia services are reported by using the anesthesia five-digit procedure codes. The basic value for most procedures may be modified under certain circumstances as listed below. When applicable, the modifying circumstances should be identified by the addition of the appropriate modifier (including the hyphen) after the usual anesthesia code. Certain modifiers require a special report for clarification of services provided.

Modifiers commonly used in anesthesia are as follows:

22. Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.

Mississippi's note: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement.

23 Unusual Anesthesia

Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

32 Mandated Services

Services related to mandated consultation and/or related services (e.g., third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

53 Discontinued Procedure

Under certain circumstances the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.

59 Distinct Procedural Service

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

AA Anesthesia Services Performed Personally by the Anesthesiologist:

Report modifier AA when the anesthesia services are personally performed by an anesthesiologist.

AD Medical Supervision by a Physician; More Than Four Concurrent Anesthesia Procedures:

Report modifier AD when the anesthesiologist supervises more than four concurrent anesthesia procedures.

QK Medical Direction of Two, Three, or Four Concurrent Anesthesia Procedures Involving Qualified Individuals:

Report modifier QK when the anesthesiologist supervises two, three, or four concurrent anesthesia procedures.

QX CRNA or AA Service with Medical Direction by a Physician:

Regional or general anesthesia provided by the CRNA or AA with medical direction by a physician may be reported by adding modifier QX.

QY Medical Supervision by Physician of One CRNA or AA:

Report modifier QY when the anesthesiologist supervises one CRNA or AA.

QZ CRNA or AA Service without Medical Direction by a Physician:

Regional or general anesthesia provided by the CRNA or AA without medical direction by a physician may be reported by adding modifier QZ.

Pain Management

In addition to the General Rules, this section provides specific rules for Pain Management services.

I. REIMBURSEMENT FOR PAIN MANAGEMENT SERVICES

A. Reimbursement for pain management services is based on the Resource Based Relative Value Scale (RBRVS).

Pain Management Base Units for Professional Services

Base units for professional services in the Pain Management section are state specific and have been authorized by the Mississippi Workers' Compensation Commission for the professional reimbursement of procedures in Pain Management. Reimbursement is for base units only. Time units will not be considered for reimbursement purposes.

The conversion factor for Pain Management is forty-two dollars (\$42.00) per unit. The formula for calculating professional reimbursement is:

— Base unit x conversion factor (\$42.00) = professional reimbursement

B. Facility Fees

Pain management facility fees are state specific and are based upon the intensity of the procedure and the amount of resources required in completing the procedure. The facility fee is paid for the use of personnel, materials, drugs, equipment and space. The facility reimbursement is all inclusive and will not be unbundled.

C. Use of Fluoroscopy

The reimbursement for the use of fluoroscopy (CPT codes 77002 and 77003) is based on the RBRVS, to be one hundred dollars (\$100.00), regardless of the number of procedures performed, and may only be billed once per date of service.

CPT code 77002 is to be used for fluoroscopic guidance for needle placement for CPT code 64510 Cervical (stellate ganglion) sympathetic block, or CPT code 64520 Thoracic or lumbar blocks.

CPT code 77003 is to be used for fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (i.e., epidural, transforaminal epidural, paravertebral facet joint or facet joint nerve, or sacroiliac joint), and including facet nerve neurolytic agent destruction.

The facility reimbursement amount for pain management services is listed in the Facility Fee column. This amount is specific to the Pain Management section and the facility and not to be used for any other section or physician services. Reimbursement for multiple pain procedures performed in a facility shall be:

- — One hundred percent (100%) for the primary procedure
- — Fifty percent (50%) for the second and any subsequent procedures

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C. Reimbursement for Injection/Destruction Procedures

1. The current CPT codes for Pain Management typically have separate codes for injections that may involve additional levels (e.g., ~~64470~~ 64490 is for injection of cervical facet single or first level, and ~~64472~~ 64491 and 64492 are used for additional levels).
2. Facet injections, medial branch blocks and nerve destruction procedures are reimbursed at a maximum of three (3) total anatomic joint levels. Additional level or bilateral modifiers may be used to allow up to a maximum of two (2) additional service levels (but not more) for facet or medial branch blocks in the cervical/thoracic (~~64472~~ 64491 and 64492) or lumbar (~~64476~~ 64494 and 64495) for a maximum of three (3) procedure levels reimbursed per treatment session or day. Additional injected site levels, beyond the first three (3), will not be reimbursed. These procedures are unilateral by definition. Bilateral modifiers may be used when nerves are treated bilaterally. Reimbursement of the bilateral modifier is fifty percent (50%) of the base amount for the second or contralateral side.
3. Reimbursement for injection/destruction procedure codes is made on the basis of nerves treated (e.g., destruction by neurolytic agent of the L4-L5 facets counts as two (2) levels/nerves and should be billed as 64622 (first level/nerve) and 64623 (each additional level)). There are two nerves supplying each joint and reimbursement is based upon nerve(s) treated, not the joint levels treated. This applies to CPT codes 64622, 64623 (lumbar), and 64626, 64627 (cervical/thoracic). These procedures are unilateral by definition. Additionally, bilateral modifiers may be used when nerves are treated bilaterally. Reimbursement of the bilateral modifier is fifty percent (50%) of the base amount for the second or contralateral side.
4. Multiple Epidural Injections in a Single Treatment Day/Session. In order to obtain reimbursement for more than one epidural injection in a single treatment day/session (either multiple levels or bilateral injections) there must be appropriate documentation in the medical records of a medical condition for which multiple injections would be appropriate. For bilateral injections, this includes the presence of significant bilateral radiating/radicular pain. For multiple level injections, this includes conditions for which an additional injected level could be anticipated to result in improved clinical outcomes. These conditions would include:
 - Disc pathology (e.g., protrusion) at one level with a dermatomal pain distribution of an adjacent level (e.g., disc affects the traversing nerve root, such as an L4/5 disc herniation affecting the traversing L5 nerve root).
 - Multiple dermatomal nerve root involvement.A maximum of two (2) levels of transforaminal epidural steroid injections are reimbursable for a given date of service. This applies to codes 64479, 64480, 64483, and 64484.
Reimbursement is still limited to two epidural procedures (either two levels, or one level bilaterally) per date of service.
5. A maximum of one (1) interlaminar epidural steroid injection is reimbursable for a given date of service. This applies to codes 62310 and 62311.
6. A maximum of three (3) facet level procedures are reimbursable for a given date of service. This maximum applies to facet joint injections and nerve blocks, codes ~~64470-64476~~ 64490-64495. Nerve destruction procedures, codes 64622-64627, are limited to two (2) facet levels (three (3) nerve branches), unilateral and bilateral, per given date of service.

D. Multiple Procedure Reimbursement

Reimbursement for multiple pain procedures shall be:

- One hundred percent (100%) for the primary procedure
- Fifty percent (50%) for the second and any subsequent procedures

For purposes of reimbursement, each injection is considered a separate procedure and will be reimbursed according to the multiple procedure rule. Multiple level injection codes reported with add-on codes (e.g., 64480, 64484, 64627) shall be reimbursed as additional procedures under applicable multiple injection rules as explained in this section. The reimbursement rate for these add-on procedure codes is fifty percent (50%) of the rate for the primary (base) procedure. Because these are add-on codes, the listed amount for the procedure is fifty percent (50%) of the primary (base) procedure and the add-on code will be reimbursed at the full amount listed in the Fee Schedule.

No more than two (2) types of pain management procedures can be performed on a given day unless otherwise approved by the payer.

Only one (1) type of pain management procedure is reimbursable on a given date of service, unless otherwise approved by the payer. This rule does NOT include multiple level injections or bilateral procedures of the same type, with appropriate modifiers. This also does not include separate procedures performed as part of a single primary service, such as implantation of a spinal cord stimulator, for example.

"Type" is defined as any procedure code involving an anatomically different structure (e.g., spinal nerve, facet joint, sacroiliac joint, trigger point, etc.). Joints and nerves in different anatomical regions (cervical, thoracic, lumbar, sacral) are considered to be different "types" and are limited to two (2) procedures per given day. Additional level or bilateral injections of a single procedure in the same area are not considered different "types," and for the purpose of this rule, are considered to be the same "type." However, the multiple level restrictions, as detailed herein, still apply.

Example: A three-level lumbar facet injection would be billed as 64476 64493 for the first level and 64476 64494 and 64495 for each additional level.

Reimbursement is as follows:

Level	Code	Base Units	Reimbursement
First	64476	10	\$420 -00
Second	64476	5	\$210 -00
Third	64476	5	\$210 -00
Total Reimbursement			\$840.00

Note: The reimbursement for each of the additional levels is fifty percent (50%) of the reimbursement amount for the first level. However, because these are add-on codes, the reduction in reimbursement is a function of the reduction in the base units. The base units for the second and additional levels already reflect the fifty percent (50%) reduction, so an additional reduction would not be applied when adjudicating the claim. Add-on codes are reimbursed at one hundred percent (100%) of the allowable.

II. REIMBURSEMENT FOR REFILL OF PAIN PUMPS

- A. Code 95990. This CPT code, which applies to refilling and maintenance of an implantable pump or reservoir for drug delivery spinal (intrathecal, epidural) or brain (intraventricular), is reimbursed at the specified MRA listed in the Medicine section of the Fee Schedule.

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- B. Evaluation and Management Services. Refilling and maintenance of implantable pump or reservoir for pain management drug delivery is a global service. An evaluation and management service is not paid additionally unless significant additional or other cognitive services are provided and documented. To report a significant, separately identifiable evaluation and management service, append modifier 25 to the appropriate evaluation and management code. Documentation is required and payment will be allowed if supported by the documentation.
- C. Drugs. Those drugs used in the refill of the pain pump shall be reimbursed in accordance with the Pharmacy Rules contained in the Pharmacy Rules section of this Fee Schedule.
- D. Compounding Fee. If the drugs used in the refill of the pain pump must be compounded, the compounding service shall be reimbursed at \$157.44 per individual refill. Report the compounding service with code S9430, Pharmacy compounding and dispensing services.

III. "DIAGNOSTIC ONLY" INJECTIONS AND PROCEDURES

- A. Valid "diagnostic only" injections require a reasonably alert patient capable of adequately determining the amount or level of pain relieved or produced by the procedure. This requires judicious use of sedatives in the performance of such procedures. Clearly, analgesic medications such as intravenous narcotics are to be avoided during the procedure and evaluation phase of testing, as these medications can affect the validity of such diagnostic tests. The results of the tests and drugs used during the injection or procedure must be part of the medical records, and available for review by the payer. Failure to document the patient's response to a diagnostic procedure or injection, and the level of alertness following the procedure or injection, could result in denial of reimbursement.
- B. Discography requires a reasonably alert patient capable of discriminating the quality and quantity of discomfort during the performance of the procedure in order to provide valid information on concordant or non-concordant pain. The results of the tests and drugs used during the procedure must be part of the medical records, and available for review by the payer. Failure to document the patient's response to the procedure, and level of alertness during discography could result in denial of reimbursement.
- C. Medial branch (facet nerve) or diagnostic intra-articular facet injections require an alert patient, free from undue influence of intravenous narcotics in order to more reliably determine the analgesic response to the procedure. Failure to document the patient's response to the procedure or injection, and level of alertness after the procedure for diagnostic facet nerve or facet intra-articular injections could result in denial of reimbursement.
- D. Diagnostic injections with local anesthetics require documentation of analgesic response through any validated pain measurement test (e.g., numerical pain scale, visual analogue scale). This should be performed after the procedure during the time that there would be an expected analgesic response (every thirty (30) minutes for at least one (1) hour). This must be documented and the documentation must be available to the payer for review. The documentation must also include the drugs used during the procedure, and comments on the patient's level of alertness at each time period when the pain or response is evaluated. If the patient's pre-procedure pain was determined by provocative exam tests or maneuvers, these should be repeated during the evaluation period following the procedure, to differentiate analgesia related to the procedure from positional analgesia, such as, for example, that which may be provided by lying in a recovery bed.
- E. Intravenous narcotic pain medications are typically to be avoided for diagnostic analgesic injections, such as facet joint or nerve blocks, as they would be expected to provide an analgesic benefit completely independent of the injection itself. Sedatives such as midazolam or propofol can be used judiciously, if necessary, avoiding excessive post-procedure sedation, depending on the experience level of the practitioner ordering or administering the medication. Proper documentation of a lack of

undue influence of sedation and analgesics must be provided to support a request for reimbursement for diagnostic procedures.

- F. Other injections with both therapeutic and potentially diagnostic benefit, such as selective nerve root or peripheral nerve blocks or therapeutic facet injections (see T modifiers), would ideally be performed with minimal sedation and avoidance of intravenous narcotics. However, as these injections also have potential therapeutic benefit, this is NOT a requirement for reimbursement.

IV. PHYSICAL THERAPY

In the pain management setting, no more than two (2) modalities and/or procedures may be used on a date of service (e.g., heat/cold, ultrasound, diathermy, iontophoresis, TENS, electrical stimulation, muscle stimulation, etc.). Multiple modalities should be performed sequentially. Only one (1) modality can be reported for concurrently performed procedures.

V. GENERAL RULES

- A. Reimbursement for an approved epidural series is limited to two (2) injections. This Fee Schedule does not recognize a "series" of epidural injections, regardless of number. A trial of epidural injections is permitted provided there is appropriate documentation of a recognized indication for this procedure. Only a single injection can be approved unless there is documentation of analgesic response consistent with a response to the injection. Further injections require a positive analgesic response for approval. For the first injection, the initial analgesic response may be temporary. However, after the second injection, there must be a residual and progressive analgesic benefit in order to perform a third injection. Documentation of a positive patient response will be required to continue epidural treatment. If there is no documented residual pain relief after two (2) injections, no further injections will be considered medically necessary.
1. There is no recognized "series" of epidural injections, and repeat injections are contingent upon proper documentation of clinical responses as stated above. Repeat injections (up to two additional injections, for a total of three (3) per twelve (12) month period), however, do NOT require prior approval as long as the appropriate responses are properly documented. Specifically, the first injection must provide at least a temporary analgesic response. Subsequent epidural injections must provide progressive and durable relief of the targeted pain. Utilization management or review decisions shall not be based solely on the application of clinical guidelines, but must include review of clinical information submitted by the provider and represent an individualized determination based on the worker's current condition and the concept of medical necessity predicated on objective or appropriate subjective improvements in the patient's clinical status.
- B. Reimbursement will be limited to three (3) epidural pain injections in a twelve (12) month period unless the payer gives prior approval for more than three (3) such injections. Separate billing for the drug injected is not appropriate and will not be reimbursed.
- C. Modifiers

PM Pain Management

Modifier PM, which is a Mississippi-specific pain management code modifier, is no longer required, and will not be recognized for reimbursement for dates of service beginning August 1, 2007.

Modifiers T and D (Mississippi State Modifiers)

Facet joint/nerve injections can be used for diagnostic or therapeutic indications, or both. These injections should be used with modifier D to indicate a diagnostic intention of the injection, or with modifier T to indicate a therapeutic intention of the injection.

Intra-articular joint injections (cervical, thoracic, lumbar), which can have both diagnostic and therapeutic indications, should always be considered primarily therapeutic and should be billed using modifier T.

The number of facet injections subject to reimbursement is limited to four (4) dates of service with a maximum of two (2) therapeutic and two (2) diagnostic injections for the initial twelve (12) month period of treatment per anatomical region. This allows for a total of four (4) dates of service, regardless of the number of levels treated, which levels are treated, or which side (left or right or bilateral) is treated, in the same anatomical region. For coding purposes, the spine is divided into three (3) anatomical regions, cervical, thoracic, and lumbar/sacral. If treatment for facet related pain continues past twelve (12) months, further injections are limited to a total of ~~three (3)~~ two (2) dates of service per twelve (12) month period. This limit applies to both therapeutic and diagnostic injections combined, and reimbursement beyond the initial twelve (12) month period is further limited to no more than two (2) injections of either type, as determined by modifiers T or D, per twelve (12) month period. Failure to designate injections with the appropriate T or D modifier will limit reimbursement to no more than two (2) facet joint/nerve injections per twelve (12) month period. This rule applies to cervical, thoracic, and lumbar facet joint and facet joint nerve injections. Facet injections in different anatomical areas are not subject to the above limits, as each different anatomical area would be subject to its own separate limit as described above. Nerve-destructive procedures (e.g. radiofrequency facet nerve neurotomy, codes 64622, 64623, 64626, 64627) do NOT count as an additional therapeutic procedure for the purpose of this rule.

A "different anatomical area" refers to the lumbar, thoracic, and cervical areas. Injections within the lumbar spine, for example, are considered to be within the same anatomical area regardless of the actual lumbar joint/nerve level, or which side (right or left), is treated, and all limits would apply in this anatomical area. The same rule applies to the thoracic and cervical anatomical areas, regardless of the level or laterality treated within the same anatomical area.

Facet nerve (medial branch ablation) for cervical, thoracic or lumbar nerves will only be reimbursed once per nine (9) month period.

In order to perform a repeat therapeutic facet joint injection (cervical, thoracic, or lumbar, codes 64490 – 64495), there must be documentation of a significant analgesic response that persists for at least four (4) weeks. This relief must be at least fifty percent (50%) of the pain in the specific anatomical area targeted by the injection, or there must be documentation of a durable (also four (4) weeks) measurable improvement in the range of motion of the involved joint area being treated.

- D. In order to be eligible for reimbursement under this Fee Schedule, pain management procedures or services which are specifically governed by the rules in this Pain Management section of the Fee Schedule must be performed by a licensed physician holding either an M.D. or D.O. degree. Pain management procedures specifically governed herein which are performed by any other person, such as a Certified Registered Nurse Anesthetist (CRNA), shall not be reimbursed under this Fee Schedule.
- E. Trigger point injection is considered one (1) procedure and is reimbursed as such regardless of the number of injection sites. Billing for multiple injections, and multiple regions, falls under the same one-procedure rule. Two codes are available for reporting trigger point injections: use 20552 for injection(s) of single or multiple trigger point(s) in one or two muscles, or 20553 when three or more muscles are involved. When billing for multiple injections, and multiple regions, only code 20552 OR 20553 is allowed per date of service.
- F. Sacroiliac arthroscopy (CPT code 73542) assumes the use of a fluoroscope and is considered an integral part of the procedure(s). Therefore, an additional fee for the fluoroscopy (CPT code 77002)

is not warranted and will not be reimbursed. This code may only be used once per twelve (12) month period.

- G. Epidurography (CPT code 72275), a/k/a "epidural myelogram" or "epidural without dural puncture," is the proper code to use for contrast material injected into the epidural space. The epidurography code involves the inherent use of a fluoroscope, and, therefore, an additional fluoroscopy fee for procedure code 77003 is not reimbursable. This code may only be used once per twelve (12) month period.
- H. CPT code 62318 includes needle placement, catheter infusion and subsequent injections. Code 62318 should be used for multiple solutions injected by way of the same catheter, or multiple bolus injections during the initial procedure. The epidural needle or catheter placement is inherent to the procedure, and, therefore, no additional charge for needle or catheter placement is allowed.
- I. Investigational Procedures. The following procedures are considered investigational, and, therefore, do not presently qualify for reimbursement under the *Mississippi Workers' Compensation Medical Fee Schedule*:
1. Intradiscal electrothermal therapy (IDET) (22526, 22527) and intradiscal annuloplasty by other method (0062T, 0063T).
 2. Intraventricular administration of Morphine.
 3. Pulse radiofrequency, regardless of procedure involved or indication (e.g., medial branch radiofrequency, dorsal root radiofrequency, etc.). If pulsed radiofrequency is used, but not specifically recorded as such in the medical records, the payer may retroactively deny payment for the service and request for reimbursement from the provider.
 4. Intradiscal therapies used in discography, such as percutaneous disc decompression (Dekompressor), fluoroscopic, laser, radiofrequency, and thermal disc therapies.
 5. Percutaneous disc nucleoplasty.
 6. Epidural adhesiolysis, also known as Racz procedure or lysis of epidural adhesions.
- J. The following procedures must be performed fluoroscopically in order to qualify for reimbursement:
1. Facet injections (64470-64472-64475-64476-64490-64495)
 2. Sacroiliac (SI) injections (27096)
 3. Transforaminal epidural steroid injections (64479, 64480, 64483, 64484)
 4. Cervical translaminar/interlaminar epidural injections (62310)
- K. Any analgesia/sedation used in the performance of the procedures in this section is considered integral to the procedure, and will not be separately reimbursed. This rule applies whether or not the person administering the analgesia/sedation is the physician who is performing the pain management injection. Administration of analgesia/sedation by a different person from the physician performing the injection, including an RN, PA, CRNA, or MD/DO, DOES NOT allow for separate billing of analgesia/sedation.
- L. Anatomical descriptions of the procedures performed must accompany the bill for service in order for reimbursement to be made. These descriptions must include landmarks used in determining needle positioning, needles used, and the type and quantity of drugs injected. Tolerance to the procedure, and side effects or lack thereof should be included in this documentation.
- M. Discography. Discography is a diagnostic test to identify (or rule out) painful intervertebral discs. Discography is appropriate only in patients for whom no other treatment options remain except for possible surgical stabilization (spinal fusion). A discography is then used on these patients to determine which discs, if any, are painful and abnormal, so that a surgical correction (fusion) can be performed. If a patient is not considered to be a candidate for surgery (fusion), then a discogram is not considered medically necessary. Investigational intradiscal therapies such as percutaneous disc

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decompression (Diskompressor), fluoroscopic, laser, radiofrequency, and thermal disc therapies are not an indication for a discography.

Reimbursement of discography:

~~62290 — 10 units; additional levels denoted with modifier 54 or 59 are reimbursed at five (5) units per level.~~

~~62291 — 12 units; additional levels denoted with modifier 51 or 59 are reimbursed at six (6) units per level.~~

~~72285-72295 — 8 units~~

The radiographic interpretation codes 72285 and 72295 can only be used ONCE per treatment session and additional level modifiers are not allowed.

When reporting the radiological supervision and interpretation professional components for discography (72285, 72295), the anatomical localization for needle placement is inclusive with the procedure and code 77003 should NOT be additionally reported.

Radiographic interpretation codes 72285 and 72295 must include a thorough description of radiographic findings available in a separate report with hard copy radiographs or other media, such as digital, that will allow review of images (AP and lateral at a minimum).

- N. BOTOX. BOTOX is not indicated for the relief of musculoskeletal pain, and its use as such is not covered by the Fee Schedule. An exception is made when BOTOX treatment is indicated for spasticity or other indications and requires prior approval.
- O. Use of Opioids or Other Controlled Substances for Management of Chronic (Non-Terminal) Pain. It is recognized that optimal or effective treatment for chronic pain may require the use of opioids or other controlled substances. The proper and effective use of opioids or other controlled substances has been specifically addressed by the Mississippi Board of Medical Licensure. Unless otherwise directed by the Commission, reimbursement for prescriptions for opioids or other controlled substances used for the management or treatment of chronic, non-terminal pain shall not be provided under this Fee Schedule unless treatment is sufficiently documented and complies with the following Rules and Regulations, as promulgated by the Mississippi State Board of Medical Licensure, and supplemented by the Commission accordingly:
1. DEFINITIONS: For the purpose of this provision, the following terms have the meanings indicated:
 - a. "Chronic Pain" is a pain state in which the cause of the pain cannot be removed or otherwise treated and which in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, evaluation by the attending physician and one or more physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain. Further, if a patient is receiving controlled substances for the treatment of pain for a prolonged period of time (more than six (6) months), then they will be considered for the purposes of this regulation to have "de facto" chronic pain and subject to the same requirements of this regulation. "Terminal Disease Pain" should not be confused with "Chronic Pain." For the purpose of this section, "Terminal Disease Pain" is pain arising from a medical condition for which there is no possible cure and the patient is expected to live no more than six (6) months.
 - b. "Acute Pain" is the normal, predicted physiological response to an adverse chemical, thermal, or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time limited and is responsive to therapies, including controlled substances as defined by the U.S. Drug Enforcement Administration, Title 21 CFR Part 1301 Food and Drugs.

- c. "Addiction" is a neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.
- d. "Physical Dependence" is a physiological state of neuroadaptation to a substance which is characterized by the emergence of a withdrawal syndrome if the use of the substance is stopped or decreased abruptly, or if an antagonist is administered. Withdrawal may be relieved by re-administration of the substance. Physical dependence is a normal physiological consequence of extended opioid therapy for pain and should not be considered addiction.
- e. "Substance Abuse" is the use of any substance(s) for non-therapeutic purposes, or use of medication for purposes other than those for which it is prescribed.
- f. "Tolerance" is a physiological state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect or a reduced effect is observed with a constant dose. Tolerance occurs to different degrees for various drug effects, including sedation, analgesia and constipation. Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Such tolerance may or may not be evident during treatment and does not equate with addiction.
2. Notwithstanding any other provisions of these rules and regulations, a physician may prescribe, administer, or dispense controlled substances in Schedules II, IIN, III, IIIN, IV and V, or other drugs having addiction-forming and addiction-sustaining liability to a person in the usual course of treatment of that person for a diagnosed condition causing chronic pain.
3. Notwithstanding any other provisions of these rules and regulations, as to the prescribing, administration, or dispensation of controlled substances in Schedules II, IIN, III, IIIN, IV and V, or other drugs having addiction-forming and addiction-sustaining liability, use of said medications in the treatment of chronic pain should be done with caution. A physician may administer, dispense or prescribe said medications for the purpose of relieving chronic pain, provided that the following conditions are met:
- a. Before initiating treatment utilizing a Schedules II, IIN, III, IIIN, IV or V controlled substance, or any other drug having addiction-forming and addiction-sustaining liability, the physician shall conduct an appropriate risk/benefit analysis by reviewing his own records of prior treatment, or review the records of prior treatment which another treating physician has provided to the physician, that there is an indicated need for long term controlled substance therapy. Such a determination shall take into account the specifics of each patient's diagnosis, past treatments and suitability for long term controlled substance use either alone or in combination with other indicated modalities for the treatment of chronic pain. This shall be clearly entered into the patient medical record, and shall include consultation/referral reports to determine the underlying pathology or cause of the chronic pain.
- b. Documentation in the patient record shall include a complete medical history and physical examination that indicates the presence of one or more recognized medical indications for the use of controlled substances.
- c. Documentation of a written treatment plan which shall contain stated objectives as a measure of successful treatment and planned diagnostic evaluations, e.g., psychiatric evaluation or other treatments. The plan should also contain an informed consent agreement for treatment that details relative risks and benefits of the treatment course. This should also include specific requirements of the patient, such as using one physician and pharmacy if possible, and urine/serum medication level monitoring when requested, but no less than once every twelve (12) months.

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- d. Periodic review and documentation of the treatment course is conducted at reasonable intervals (no less than every six months) with modification of therapy dependent on the physician's evaluation of progress toward the stated treatment objectives. This should include referrals and consultations as necessary to achieve those objectives.
4. No physician shall administer, dispense or prescribe a controlled substance or other drug having addiction-forming and addiction-sustaining liability that is non-therapeutic in nature or non-therapeutic in the manner the controlled substance or other drug is administered, dispensed or prescribed.
 5. No physician shall administer, dispense or prescribe a controlled substance for treatment of chronic pain to any patient who has consumed or disposed of any controlled substance or other drug having addiction-forming and addiction-sustaining liability other than in strict compliance with the treating physician's directions. These circumstances include those patients obtaining controlled substances or other abusable drugs from more than one physician and those patients who have obtained or attempted to obtain new prescriptions for controlled substances or other abusable drugs before a prior prescription should have been consumed according to the treating physician's directions. This requirement will not be enforced in cases where a patient has legitimately temporarily escalated a dose of their pain medication due to an acute exacerbation of their condition but have maintained a therapeutic dose level, however, it will be required of the treating physician to document in the patient record that such increase in dose level was due to a recognized indication and was within appropriate therapeutic dose ranges. Repetitive or continuing escalations should be a reason for concern and a re-evaluation of the present treatment plan shall be undertaken by the physician.
 6. No physician shall prescribe any controlled substance or other drug having addiction-forming or addiction-sustaining liability to a patient who is a drug addict for the purpose of "detoxification treatment," or "maintenance treatment," and no physician shall administer or dispense any narcotic controlled substance for the purpose of "detoxification treatment" or "maintenance treatment" unless they are properly registered in accordance with MCA section 303(g) 21 U.S.C. 823(g). Nothing in this paragraph shall prohibit a physician from administering narcotic drugs to a person for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are being made for referral for treatment. Not more than one (1) day's medication may be administered to the person or for the person's use at one time. Such emergency treatment may be carried out for not more than three (3) days. Nothing in this paragraph shall prohibit a physician from administering or dispensing narcotic controlled substances in a hospital to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction.
 7. In addition to the specific Rules and Regulations promulgated by the Mississippi State Board of Medical Licensure as set forth above and incorporated herein, the payer may, as in other cases, obtain a second opinion from an appropriate and qualified physician to determine the appropriateness of the treatment being rendered, including but not limited to the appropriateness of the continuing use of opioids or other controlled substances for treatment of the patient's chronic pain. However, any such second opinion shall not be used as the basis for abrupt withdrawal of medication or payment therefor. Nothing in this paragraph shall prohibit a physician from administering narcotic drugs to a person for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are being made for referral or discontinuance of treatment, and the payer shall provide reimbursement in accordance with this Fee Schedule, as follows: not more than one (1) day's medication may be administered to the person or for the person's use at one time. Such emergency treatment may be carried out for not more than three (3) days. Discontinuance of treatment or reimbursement of prescriptions based on a second opinion obtained hereunder shall be subject to review by the Commission pursuant to the Dispute Resolution Rules set forth in the Dispute Resolution Rules section in this Fee Schedule.

P. Radiographic Codes in Pain Management. In the 2007 CPT book, code 76003 was replaced by code 77002, and code 76005 (fluoroscopy for injection) is replaced by code 77003. Description of service and reimbursement will remain the same.

Codes 72000–72220 which apply to radiographic examination of the spine are not reimbursed concurrent with the pain management procedures in this section or with fluoroscopy services.

Code 73542 is not separately reimbursed with facet or sacroiliac joint injections.

Q. Soft Tissue Injections. 'Myofascial, myoneural, and trigger point injections' are synonymous and are to be reimbursed with the 20552 and/or 20553 codes. Modifiers for additional injections are not allowed with these codes. Reimbursement for codes 20552 and 20553 will be identical, and not additive.

Codes 20550 and 20551 are used for the injections of tendon origins and are NOT to be used for 'myofascial, myoneural or trigger point' injections. Failure to observe this rule could result in denial of service on retrospective review and/or request for reimbursement.

Code 20612 is to be used for the aspirations/injection of a ganglion cyst and NOT for 'myofascial, myoneural, or trigger point' injections. Failure to observe this rule could result in denial of service on retrospective review and/or request for reimbursement.

R. Implantation of spinal cord stimulators. The following conditions must be met for consideration of spinal cord stimulators.

- Patient must have a medical condition for which spinal cord stimulation (SCS) is a recognized and accepted form of treatment.
- There must be a trial stimulation that includes a minimum seven (7) day home trial with the temporary stimulating electrode.
- During the trial stimulation, the patient must report at least fifty percent (50%) pain reduction during the last four (4) days of the stimulation trial.
- Psychological screening must be used to determine if the patient is free from
 - Substance abuse issues
 - Untreated psychiatric conditions
 - Major psychiatric illness that could impair the patient's ability to respond appropriately to the trial stimulation

S. Sacroiliac joint injections (code 27096) require documentation of at least a four (4) week durable analgesic benefits or at least fifty percent (50%) pain relief in the anatomical area being targeted by the injection. A maximum of two (2) therapeutic sacroiliac joint injections are allowed per twelve (12) month period. This rule is limited only to the joint injected, and not the contralateral joint (i.e., right or left sided joint).

Surgery

I. GENERAL GUIDELINES

A. Global Reimbursement:

The reimbursement allowances for surgical procedures are based on a global reimbursement concept that covers performing the basic service and the normal range of care required after surgery.

Global reimbursement includes:

1. The operation per se
2. Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
3. Subsequent to the decision and/or authorization for surgery, one related E/M encounter on the date immediately prior to or on the date of the procedure (including history and physical) but does not include the initial consultation
4. Immediate postoperative care, including dictating operative notes, talking with the family and other physicians
5. Writing orders
6. Evaluating the patient in the post-anesthesia recovery area
7. Normal, uncomplicated follow-up (FU) care for the time periods indicated in the follow-up days (FUD) column to the right of each procedure code. The number in that column establishes the days during which no additional reimbursement is allowed for the usual care provided following surgery, absent complications or unusual circumstances.
8. The maximum reimbursement allowances cover all normal postoperative care, including the removal of sutures by the surgeon or associate. Follow-up days are specified by procedure. Follow-up days listed are for 0, 10, or 90 days and are listed in the Fee Schedule as 000, 010, or 090. Follow-up days may also be listed as MMM indicating that services are for uncomplicated maternity care, XXX indicating that the global surgery concept does not apply, YYY indicating that the follow-up period is to be set by the payer (used primarily with BR procedures), or ZZZ indicating that the code is related to another service and is treated in the global period of the other procedure billed in conjunction with the ZZZ procedure (used primarily with add-on and exempt from modifier 51 codes). The day of surgery is day one when counting follow-up days. Hospital discharge day management is considered to be normal, uncomplicated follow-up care.

B. Follow-up Care for Diagnostic Procedures

Follow-up care for diagnostic procedures (e.g., endoscopy, injection procedures for radiography) includes only the care related to recovery from the diagnostic procedure itself. Care of the condition for which the diagnostic procedure was performed or of other concomitant conditions is not included and may be charged for in accordance with the services rendered.

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- C. Follow-up Care for Therapeutic Surgical Procedures**
Follow-up care for therapeutic surgical procedures includes only care that is usually part of the surgical procedure. Complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring additional services concurrent with the procedure(s) or during the listed period of normal follow-up care may warrant additional charges.
- D. Separate Procedures**
Separate procedures are commonly carried out as an integral part of another procedure. They should not be billed in conjunction with the related procedure. These procedures may be billed when performed independently by adding modifier 59 to the specific "separate procedure" code.
- E. Additional Surgical Procedure(s)**
When an additional surgical procedure(s) is carried out within the listed period of follow-up care for a previous surgery, the follow-up periods will continue concurrently to their normal terminations.
- F. Microsurgery, Operating Microscope, and Use of Code 69990**
The surgical microscope is employed when the surgical services are performed using the technique of microsurgery. Code 69990 should be reported (without modifier 51 appended) in addition to the code for the primary procedure performed. Do not use 69990 for reporting visualization with magnifying loupes or corrected vision. Do not report code 69990 in addition to procedures where the use of the operating microscope is considered an inclusive component. The operating microscope is considered inclusive in the following codes only: 15756–15758; 15842; 19364; 19368; 20955–20962; 20969–20973; 26551–26554; 26556; 31526; 31531; 31536; 31541; 31545; 31546; 31561; 31571; 43116; 43496; 49906; 61548; 63075–63078; 64727; 64820–64823; 65091–68850. For purposes of clarification, if microsurgery technique is employed and the primary procedure code is not contained in the aforementioned list, it is appropriate to report 69990 with the primary procedure performed and reimbursement is required for said services. (For example, code 63030 is not included in the aforementioned list and, as such, it is appropriate for providers to report 69990 along with 63030 to describe microsurgical technique. Reimbursement for 69990 is required provided operative documentation affirms microsurgical technique and not just visualization with magnifying loupes or corrected vision.)
- G. Unique Techniques**
A surgeon is not entitled to an extra fee for a unique technique. It is inappropriate to use modifier 22 unless the procedure is significantly more difficult than indicated by the description of the code.
- H. Surgical Destruction**
Surgical destruction is part of a surgical procedure, and different methods of destruction (e.g., laser surgery) are not ordinarily listed separately unless the technique substantially alters the standard management of a problem or condition. Exceptions under special circumstances are provided for by separate code numbers.
- I. Incidental Procedure(s)**
An additional charge for an incidental procedure (e.g., incidental appendectomy, incidental scar excisions, puncture of ovarian cysts, simple lysis of adhesions, simple repair of hiatal hernia, etc.) is not customary and does not warrant additional reimbursement.
- J. Endoscopic Procedures**
When multiple endoscopic procedures are performed by the same practitioner at a single encounter, the major procedure is reimbursed at one hundred percent (100%). If a secondary procedure is performed through the same opening/orifice, fifty percent (50%) is allowable as a multiple procedure.

However, diagnostic procedures during the same session and entry site are incidental to the major procedure.

K. Biopsy Procedures

A biopsy of the skin and another surgical procedure performed on the same lesion on the same day must be billed as one procedure.

L. Repair of Nerves, Blood Vessels, and Tendons with Wound Repairs

The repair of nerves, blood vessels, and tendons is usually reported under the appropriate system. The repair of associated wounds is included in the primary procedure unless it qualifies as a complex wound, in which case modifier 51 may be applied. Simple exploration of nerves, blood vessels, and tendons exposed in an open wound is also considered part of the essential treatment of the wound closure and is not a separate procedure unless appreciable dissection is required.

M. Suture Removal

Billing for suture removal by the operating surgeon is not appropriate as this is considered part of the global fee.

N. Joint Manipulation Under Anesthesia

There is no charge for manipulation of a joint under anesthesia when it is preceded or followed by a surgical procedure on that same day by that surgeon. However, when manipulation of a joint is the scheduled procedure and it indicates additional procedures are necessary and appropriate, fifty percent (50%) of the manipulation may be allowed.

O. Supplies and Materials

Supplies and materials provided by the physician (e.g., sterile trays/drugs) over and above those usually included with the office visit may be listed separately using CPT code 99070 or specific HCPCS Level II codes.

P. Plastic and Metallic Implants

Plastic and metallic implants or non-autogenous graft materials supplied by the physician are to be reimbursed at cost.

Q. Aspirations and Injections

Puncture of a cavity or joint for aspiration followed by injection of a therapeutic agent is one procedure and should be billed as such.

R. Surgical Assistant

1. Physician surgical assistant — For the purpose of reimbursement, a physician who assists at surgery is reimbursed as a surgical assistant. Assistant surgeons should use modifier 80 and are allowed twenty percent (20%) of the maximum reimbursement allowance (MRA) for the procedure(s).

2. Registered Nurse Surgical Assistant

or Physician Assistant

a. A physician assistant, or registered nurses who have completed an approved first assistant training course, may be allowed a fee when assisting a surgeon in the operating room (O.R.).

b. The maximum reimbursement allowance for the physician assistant or the

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registered nurse first assistant (RNFA) is ten percent (10%) of the surgeon's fee for the procedure(s) performed.

- c. Under no circumstances will a fee be allowed for an assistant surgeon and a physician assistant or

RNFA at the same surgical encounter.

- d. Registered nurses on staff in the O.R. of a hospital, clinic, or outpatient surgery center do not qualify for reimbursement as an RNFA.

- e. CPT codes with modifier AS should be used to bill for physician assistant or RNFA services on a CMS-1500 form and should be submitted with the charge for the surgeon's services.

S. Operative Reports

An operative report must be submitted to the payer before reimbursement can be made for the surgeon's or assistant surgeon's services.

T. Needle Procedures

Needle procedures (lumbar puncture, thoracentesis, jugular or femoral taps, etc.) should be billed in addition to the medical care on the same day.

U. Therapeutic Procedures

Therapeutic procedures (injecting into cavities, nerve blocks, etc.) (CPT codes 20526-20610, 64400, 64450) may be billed in addition to the medical care for a new patient. (Use appropriate level of service plus injection.)

In follow-up cases for additional therapeutic injections and/or aspirations, an office visit is only indicated if it is necessary to re-evaluate the patient. In this case, a minimal visit may be listed in addition to the injection. Documentation supporting the office visit charge must be submitted with the bill to the payer. Reimbursement for therapeutic injections will be made according to the multiple procedure rules.

Trigger point injection is considered one procedure and reimbursed as such regardless of the number of injection sites. Two codes are available for reporting trigger point injections. Use 20552 for injection(s) of single or multiple trigger point(s) in one or two muscles or 20553 when three or more muscles are involved.

V. Anesthesia by Surgeon

In certain circumstances it may be appropriate for the attending surgeon to provide regional or general anesthesia. Anesthesia by the surgeon is considered to be more than local or digital anesthesia. Identify this service by adding modifier 47 to the surgical code. Only base anesthesia units are allowed. See the Anesthesia section.

W. Therapeutic/Diagnostic Injections

Injections are considered incidental to the procedure when performed with a related invasive procedure.

X. Intervertebral Biomechanical Device(s) and Use of Code 2285

Code 22851 describes the application of an intervertebral biomechanical device to a vertebral defect or interspace. Code 22851 should be listed in conjunction with a primary procedure without the use of modifier 51. The use of 22851 is limited to one instance per single interspace or single vertebral defect regardless of the number of devices applied and infers additional qualifying training.

experience, sizing, and/or use of special surgical appliances to insert the biomechanical device. Qualifying devices include manufactured synthetic or allograft biomechanical devices, or methyl methacrylate constructs, and are not dependant on a specific manufacturer, shape, or material of which it is constructed. Qualifying devices are machine cut to specific dimensions for precise application to an intervertebral defect. (For example, the use of code 22851 would be appropriate during a cervical arthrodesis (22554) when applying a synthetic alloy cage, a threaded bone dowel, or a machine cut hexahedron cortical, cancellous, or corticocancellous allograft biomechanical device. Surgeons utilizing generic non-machined bony allografts or autografts are referred to code sets 20930–20931, 20936–20938 respectively.)

Y. Intra-operative neurophysiologic monitoring (e.g. SSEP, MEP, BAEP, TES, DEP, VEP). All intra-operative neurophysiologic monitoring requires pre-authorization. Reimbursement for intra-operative neurophysiologic monitoring will not be allowed in the following cases, unless mutually agreed to by the payer and the provider:

1. neuromuscular junction testing of each nerve during intraoperative monitoring;
2. intraoperative monitoring during peripheral nerve entrapment releases, such as carpal release, ulnar nerve transposition at the elbow, and tarsal tunnel release;
3. during decompression of cervical nerve roots without myelopathy;
4. during placement of cervical instrumentation absent evidence of myelopathy;
5. during lumbar discectomy for radiculopathy; or
6. during lumbar decompression for treatment of stenosis without the need for instrumentation.

II. AMBULATORY SURGERY CENTERS

A. Definition

For purposes of this section of the Fee Schedule, "ambulatory surgery center" means an establishment with an organized medical staff of physicians; with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; with continuous physicians and registered nurses on site or on call, which provides services and accommodations for patients to recover for a period not to exceed twenty-three (23) hours after surgery. An ambulatory surgery center may be a freestanding facility or may be attached to a hospital facility. For purposes of Workers' Compensation reimbursement to ASCs, the facility must be an approved Medicare ASC.

B. Coding and Billing Rules

1. Facility fees for ambulatory surgery must be billed on the UB-04 form.
2. The CPT/HCPCS code(s) of the procedure(s) performed determines the reimbursement for the facility fee. Report all procedures performed.
3. If more than one surgical procedure is furnished in a single operative encounter, the multiple procedure rule applies. The primary procedure is reimbursed at one hundred percent (100%) of the maximum reimbursable allowance (MRA), the second and subsequent procedures are reimbursed at fifty percent (50%) of the MRA.
4. If the billed total for an outpatient surgical encounter is less than the ASC MRA, the lesser of the charges is paid to the facility.
5. The payment rate for an ASC surgical procedure includes all facility services directly related to the procedure performed on the day of surgery. Facility services include:
 - Nursing and technician services

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- Use of the facility
 - Drugs, biologicals, surgical dressings, splints, casts and equipment directly related to the provision of the surgical procedure
 - Materials for anesthesia
 - Administration, record keeping and housekeeping items and services
6. Separate payment is not made for the following services that are directly related to the surgery
- Pharmacy
 - Medical/surgical supplies
 - Sterile supplies
 - Operating room services
 - Anesthesia
 - Ambulatory surgical care
 - Recovery room
 - Treatment or Observation room
7. Facility fees do not include physician services, x-rays, diagnostic procedures, laboratory procedures, CRNA or anesthesia physician services, prosthetic devices, ambulance services, braces, artificial limbs or DME for use in the patient's home. These items will be reimbursed according to Fee Schedule MRA or HCPCS MRA, whichever is appropriate
- C. Facility Fee Reimbursement for ASCs
1. The Mississippi Worker's Compensation Commission has adopted the Medicare ASC Payment Groups for classifying payment of facility fees for ambulatory surgery. The specific rates and groupings are more fully explained in the section on inpatient and Outpatient Care Rules.
 2. The ASC payment rate has been added to the CPT code listing of fees in the Surgery section of the Fee Schedule. The column lists the total approved facility fee for that particular CPT code.
 3. The facility fees will be paid for medically necessary services only. All ambulatory elective procedures must be precertified according to the rules and guidelines of the Fee Schedule.
 4. Procedures not assigned an ASC facility fee will be reimbursed according to the lesser of total billed charges or usual and customary rates

III. MULTIPLE PROCEDURES

A. Multiple Procedure Reimbursement Rule

Multiple procedures performed during the same operative session at the same operative site are reimbursed as follows:

- One hundred percent (100%) of the allowable fee for the primary procedure
- Fifty percent (50%) of the allowable fee for the second and subsequent procedures

B. Bilateral Procedure Reimbursement Rule

Physicians and staff are sometimes confused by the definition of bilateral. Bilateral procedures are identical procedures (i.e., use the same CPT code) performed on the same anatomic site but on opposite sides of the body. Furthermore, each procedure should be performed through its own separate incision to qualify as bilateral. For example, open reductions of bilateral fractures of the mandible treated through a common incision would not qualify under the definition of bilateral and

would be reimbursed according to the multiple procedure rule. Medicare's accepted method of billing bilateral services is to list the procedure once and add modifier 50. Mississippi is adopting this same policy. Refer to the example below:

69300 50 Otoplasty, protruding ear

Place a "2" in the UNITS column of the CMS-1500 claim form so that payers are aware that two procedures were performed. List the charge as one hundred fifty percent (150%) of your normal charge. Reimbursement shall be at one hundred fifty percent (150%) of the amount allowed for a unilateral procedure(s). For example, if the allowable for a unilateral surgery is one hundred dollars (\$100.00) and it is performed bilaterally, reimbursement shall be one hundred fifty dollars (\$150.00). However, if the procedure description states "bilateral," reimbursement shall be as listed in the Fee Schedule since the fee was calculated for provision of the procedure bilaterally.

C. Multiple Procedures—Different Areas Rule

When multiple surgical procedures are performed in different areas of the body during the same operative sessions and the procedures are unrelated (e.g., abdominal hernia repair and a knee arthroscopy), the multiple procedure reimbursement rule will apply independently to each area. Modifier 51 must be added.

D. Multiple Procedure Billing Rules

1. The primary procedure, which is defined as the procedure with the highest RVU, must be billed with the applicable CPT code.
2. The second or lesser or additional procedure(s) must be billed by adding modifier 51 to the codes, unless the procedure(s) is exempt from modifier 51 or qualifies as an add-on code.

IV. REPAIR OF WOUNDS

A. Definitions

Wound repairs are classified as simple, intermediate, or complex.

1. **Simple repair.** Simple repair is repair of superficial wounds involving primarily epidermis and dermis or subcutaneous tissues without significant involvement of deeper structures and simple one layer closure/suturing. This includes local anesthesia and chemical or electrocauterization of wounds not closed.
2. **Intermediate repair.** Intermediate repair is repair of wounds that requires layered closure of one or more of the subcutaneous tissues and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure. Single-layer closure of heavily contaminated wounds that require extensive cleaning or removal of particulate matter also constitutes intermediate repair.
3. **Complex repair.** Complex repair is repair of wounds requiring more than layered closure, scar revision, debridement (e.g., traumatic lacerations or avulsions), extensive undermining, stents or retention sutures. It may include creation of the defect and necessary preparation for repairs or the debridement and repair of complicated lacerations or avulsions.

B. Reporting

The following instructions are for reporting services at the time of the wound repair:

1. The repaired wound(s) should be measured and recorded in centimeters, whether curved, angular, or stellate.

2. When multiple wounds are repaired, add together the lengths of those in the same classification (see above) and anatomical grouping and report as a single item. When more than one classification of wound is repaired, list the more complicated as the primary procedure and the less complicated as the secondary procedure using modifier 51.
3. Debridement is considered a separate procedure only when gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue are removed, or when debridement is carried out separately without immediate primary closure (extensive debridement of soft tissue and/or bone).
4. Report involvement of nerves, blood vessels, and tendons under the appropriate system (nervous, musculoskeletal, etc.) for repair. The repair of these wounds is included in the fee for the primary procedure unless it qualifies as a complex wound, in which case modifier 51 applies.
5. Simple ligation of vessels in an open wound is considered part of any wound closure, as is simple exploration of nerves, blood vessels, or tendons.
6. Adjacent tissue transfers, flaps and grafts include such procedures as Z-plasty, W-plasty, V-4-plasty or rotation flaps. Reimbursement is based on the size of the defect. Closing the donor site with a skin graft is considered an additional procedure and will be reimbursed in addition to the primary procedure. Excision of a lesion prior to repair by adjacent tissue transfer is considered "bundled" into the tissue transfer procedure and is not reimbursed separately.
7. Wound exploration codes should not be billed with codes that specifically describe a repair to major structure or major vessel. The specific repair code supersedes the use of a wound exploration code.

V. MUSCULOSKELETAL SYSTEM

A. Casting and Strapping

This applies to severe muscle sprains or strains that require casting or strapping.

1. Initial (new patient) treatment for soft tissue injuries must be billed under the appropriate office visit code.
2. When a cast or strapping is applied during an initial visit, supplies and materials (e.g., stockinet, plaster, fiberglass, ace bandages) may be itemized and billed separately using the appropriate HCPCS Level II code.
3. When initial casting and/or strapping is applied for the first time during an established patient visit, reimbursement may be made for the itemized supplies and materials in addition to the appropriate established patient visit.
4. Replacement casts or strapping provided during a follow-up visit (established patient) include reimbursement for the replacement service as well as the removal of casts, splints, or strapping. Follow-up visit charges may be reimbursed in addition to replacement casting and strapping only when additional significantly identifiable medical services are provided. Office notes should substantiate medical necessity of the visit. Cast supplies may be billed using the appropriate HCPCS Level II code and reimbursed separately.

B. Fracture Care

1. Fracture care is a global service. It includes the examination, restoration or stabilization of the fracture, application of the first cast, and cast removal. Casting material is not considered part of the global package and may be reimbursed separately. It is inappropriate to bill an office visit since the reason for the encounter is for fracture care. However, if the patient requires surgical intervention, additional reimbursement can be made for the appropriate E/M code to properly evaluate the patient for surgery. Use modifier 57 with the E/M code.

2. Reimbursement for fracture care includes the application and removal of the first cast or traction device only. Replacement casting during the period of follow-up care is reimbursed separately.
 3. The phrase "with manipulation" describes reduction of a fracture.
 4. Re-reduction of a fracture performed by the primary physician may be identified by the addition of modifier 76 to the usual procedure code to indicate "repeat procedure" by the same physician.
 5. The term "complicated" appears in some musculoskeletal code descriptions. It implies an infection occurred or the surgery took longer than usual. Be sure the medical record documentation supports the "complicated" descriptor to justify reimbursement.
- C. Bone, Cartilage, and Fascia Grafts
1. Reimbursement for obtaining autogenous bone, cartilage or fascia grafts, or other tissue through separate incisions is made only when the graft is not described as part of the basic procedure.
 2. Tissue obtained from a cadaver for grafting must be billed using code 99070 and accompanied by a report in order to ensure an equitable reimbursement by the payer.
- D. Arthroscopy
- Note: Surgical arthroscopy always includes a diagnostic arthroscopy. Only in the most unusual case is an increased fee justified because of increased complexity of the intra-articular surgery performed.
1. Diagnostic arthroscopy should be billed at fifty percent (50%) when followed by open surgery.
 2. Diagnostic arthroscopy is not billed when followed by arthroscopic surgery.
 3. If there are only minor findings that do not confirm a significant preoperative diagnosis, the procedure should be billed as a diagnostic arthroscopy.
- E. Arthrodesis Procedures
- Many revisions have occurred in CPT coding for arthrodesis procedures. References to bone grafting and fixation are now procedures which are listed and reimbursed separately from the arthrodesis codes.
- To help alleviate any misunderstanding about when to code a discectomy in addition to an arthrodesis, the statement "including minimal discectomy" to prepare interspace has been added to the anterior interbody technique. If the disk is removed for decompression of the spinal cord, the decompression should be coded and reimbursed separately.
- F. External Spinal Stimulators Post Fusion
1. The following criteria is established for the medically accepted standard of care when determining applicability for the use of an external spinal stimulator. However, the medical necessity should be determined on a case-by-case basis.
 - a. Patient has had a previously failed spinal fusion, and/or
 - b. Patient is scheduled for revision or repair of pseudoarthrosis, and/or
 - c. The patient smokes greater than a pack of cigarettes per day and is scheduled for spinal fusion.
 2. The external spinal stimulator is not approved by the Mississippi Workers' Compensation Commission for use in primary spinal fusions.
 3. The external spinal stimulator will be reimbursed by report (BR).
 4. Precertification is required for use of the external spinal stimulator.

G. Carpal Tunnel Release

The following intraoperative services are included in the global service package for carpal tunnel release and should not be reported separately and do not warrant additional reimbursement:

- Surgical approach
- Isolation of neurovascular structures
- Video imaging
- Stimulation of nerves for identification
- Application of dressing, splint, or cast
- Tenolysis of flexor tendons
- Flexor tenosynovectomy
- Excision of lipoma of carpal canal
- Exploration of incidental release of ulnar nerve
- Division of transverse carpal ligament
- Use of endoscopic equipment
- Placement and removal of surgical drains or suction device
- Closure of wound

VI. BURNS, LOCAL TREATMENT

A. Degree of Burns

1. Code 16000 must be used when billing for treatment of first degree burns when no more than local treatment of burned surfaces is required.
2. Codes 16020–16030 must be used when billing for treatment of partial-thickness burns only.
3. The claim form must be accompanied by a report substantiating the services performed.
4. Major debridement of foreign bodies, grease, epidermis, or necrotic tissue may be billed separately under codes 11000–11001. Modifier 51 does not apply.

B. Percentage of Total Body Surface Area

The following definitions apply to codes 16020–16030:

1. "Small" means less than five percent (5%) of the total body surface area
2. "Medium" means whole face or whole extremity or five to ten percent (5%–10%) of the total body surface area
3. "Large" means more than one extremity or greater than ten percent (10%) of the total body surface area

C. Reimbursement

1. To identify accurately the proper procedure code and substantiate the descriptor for billing, the exact percentage of the body surface involved and the degree of the burn must be specified on the claim form submitted or by attaching a special report. Claims submitted without this specification will be returned to the physician for this additional information.
2. Hospital visits, emergency room visits, or critical care visits provided by the same physician on the same day as the application of burn dressings will be reimbursed as a single procedure at the highest level of service.

VII. NERVE BLOCKS

A Diagnostic or Therapeutic

1. Please refer to the Pain Management section for guidelines and reimbursement of nerve blocks.
2. Medications such as steroids, pain medication, etc., may be separately billed using the appropriate HCPCS Level II code.
 - a. The name of the medication(s), dosage, and volume must be identified.
 - b. Medication will be reimbursed according to fees listed in the HCPCS section. If not listed in HCPCS, reimbursement will be according to the Pharmacy section in the General Guidelines.

B Anesthetic

When a nerve block for anesthesia is provided by the operating room surgeon, the procedure codes listed in the Anesthesia section must be followed.

VIII. MODIFIERS

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of the appropriate modifier code. The modifier may be reported by a two-digit number placed after the usual procedure number and separated by a hyphen. If more than one modifier is used, place the multiple modifiers code 99 immediately after the procedure code. This indicates that one or more additional modifier codes follow. Modifiers commonly used in surgery are as follows:

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.

Mississippi's note: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement.

26 Professional Component

Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

32 Mandated Services

Services related to mandated consultation and/or related services (e.g., third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

47 Anesthesia by Surgeon

Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) Note: Modifier 47 would not be used as a modifier for the anesthesia procedures 00100–01999.

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Mississippi's note: Reimbursement is made for base units only.

50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed during the same operative session should be identified by adding modifier 50 to the appropriate five-digit code.

51 Multiple Procedures

When multiple procedures, other than E/M services, physical medicine and rehabilitation services, or provision of supplies (e.g., vaccines),

are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes (see the applicable CPT book appendix).

Mississippi's note: This modifier should not be appended to designated "modifier 51 exempt" codes as specified in the most current CPT book.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 Discontinued Procedure

Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.

54 Surgical Care Only

When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

55 Postoperative Management Only

When one physician performed the postoperative management and another physician performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

56 Preoperative Management Only

When one physician performed the preoperative care and evaluation and another physician performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

57 Decision for Surgery

An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. *Note:* For treatment of a problem that requires a return to the operation or procedure room, see modifier 78.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures or services other than E/M services, that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. *Note:* Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

62 Two Surgeons

When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If an additional procedure(s) (including an add-on procedure(s)) is performed during the same surgical session, a separate code(s) may be reported with modifier 62 added. *Note:* If a co-surgeon acts as an assistant in the performance of an additional procedure(s) during the same surgical session, the service(s) may be reported using a separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

66 Surgical Team

Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel and various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of modifier 66 to the basic procedure number used for reporting services.

76 Repeat Procedure by Same Physician

It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

77 Repeat Procedure by Another Physician

The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.

78 Return to the Operating Room for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first and requires the use of the operating room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period

The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

80 Assistant Surgeon

Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

Mississippi's note: Reimbursement is twenty percent (20%) of the maximum reimbursement allowance.

81 Minimum Assistant Surgeon

Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.

Mississippi's note: Physician reimbursement is ten percent (10%) of the allowable.

82 Assistant Surgeon (when qualified resident surgeon not available)

The unavailability of a qualified resident surgeon is prerequisite for use of modifier 82 appended to the unusual procedure code number(s).

90 Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.

99 Multiple Modifiers

Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

AS Assistant At Surgery Services Provided By Registered Nurse First Assistant, Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist

Assistant at surgery services provided by a Registered Nurse First Assistant (RNFA), Physician Assistant, Nurse Practitioner or Clinical Nurse Specialist are identified by adding modifier AS to the listed applicable surgical procedures. The use of the AS modifier is appropriate for any code that otherwise is reimbursable for a physician assisting a surgeon in the operating room.

Mississippi's note: Modifier AS reimbursement is ten percent (10%) of the allowable.

IX. MODIFIERS APPROVED FOR AMBULATORY SURGERY CENTER (ASC) HOSPITAL OUTPATIENT USE**25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service**

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

27 Multiple Outpatient Hospital E/M Encounters on the Same Date

For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (e.g., hospital emergency department, clinic). Note: This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient evaluation and management services provided by the same physician on the same date and performed in multiple outpatient setting(s) (e.g., hospital emergency department, clinic), see Evaluation and Management, Emergency Department, or Preventive Medicine Services codes.

50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five digit code.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. Note: For treatment of a problem that requires a return to the operating or procedure room, see modifier 78.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures or services other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

73 Discontinued Out-Patient Hospital/ Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of modifier 73. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

74 Discontinued Out-Patient Hospital/ Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc). Under these circumstances, the procedure started but terminated can be reported by its usual

procedure number and the addition of modifier 74. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

76 Repeat Procedure by Same Physician

It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

77 Repeat Procedure by Another Physician

The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.

78 Return to the Operating Room for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period

The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

91 Repeat Clinical Diagnostic Laboratory Test

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results, due to testing problems with specimens or equipment, or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

Radiology

I. SCOPE

The following guidelines apply to radiology services provided in offices, clinics, and under some circumstances in hospital x-ray departments. This section also contains guidelines that include nuclear medicine and diagnostic ultrasound.

II. GUIDELINES

A. Total Component

A total fee includes both the professional component for the radiologist and the technical component needed to accomplish the procedure. Explanations of the professional component and the technical component are listed below. The values as listed in the Amount column represent the total reimbursement.

B. Professional Component

The professional component represents the reimbursement allowance of the professional radiological services of the physician and is identified by the use of modifier 26. This includes examination of the patient when indicated, performance or supervision of the procedure, interpretation and written report of the examination, and consultation with the referring physician. In the majority of hospital radiology departments, the radiologist submits a separate statement to the patient for professional services rendered, which are listed as the professional component. Values in the PC Amount column are intended for the services of a radiologist for the professional component only and do not include any other charges. To identify a charge for a professional component only, use the five-digit code followed by modifier 26.

C. Technical Component

The technical component includes charges made by the institution or clinic to cover the services of technologists and other staff members, the film, contrast media, chemicals and other materials, and the use of the space and facilities of the x-ray department. To identify a charge for a technical component only, use the five-digit code followed by HCPCS Level II modifier TC.

D. Review of X-rays

Billing code 76140 is not appropriate in the following circumstances because review of the x-rays is inherent to the evaluation and management code:

- The physician, during the course of an office visit or consultation, reviews an x-ray made elsewhere.
- The treating or consulting physician reviews x-rays at an emergency room or hospital visit.

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- CPT code 76140 Consultation on x-ray examination made elsewhere, written report, will only be paid when there is a documented need for the service and when performed by a radiologist or physician certified to perform radiological services.
- This provision is for payment of a second interpretation under unusual circumstances such as a questionable finding for which the physician performing the initial interpretation requests the expertise of another physician (i.e., expertise of a radiologist). CPT code 76140 is to be used when a second opinion is required for a radiological procedure. Reimbursement is limited to the professional component listed in the Fee Schedule for that procedure.

E. Additional X-rays

No payment shall be made for additional x-rays when recent x-rays are available except when supported by adequate information regarding the need to retake x-rays. The use of photographic or digital media and/or imaging is not reported separately, but is considered to be a component of the basic procedure and shall not merit any additional payment.

F. Contrast Material

1. Complete procedures, interventional radiological procedures, or diagnostic studies involving injection of contrast media include all usual pre-injection and post-injection services (e.g., necessary local anesthesia, placement of needle catheter, injection of contrast media, supervision of the study, and interpretation of results).
2. Low osmolar contrast material and paramagnetic contrast materials shall only be billed when not included in the descriptor of the procedure. When appropriately billed, the contrast media is reimbursed according to the maximum reimbursement allowance rate (MRA) listed in the HCPCS section of the Fee Schedule. Supplies should be billed with the appropriate HCPCS Level II code and will be reimbursed according to the Fee Schedule.
3. When contrast can be administered orally (upper G.I.) or rectally (barium enema), the administration is included as part of the procedure.
4. When an intravenous line is placed simply for access in the event of a problem with a procedure or for administration of contrast, it is considered part of the procedure and does not command a separate fee.

G. Urologic Procedures

In the case of urologic procedures (e.g., CPT codes 74400–74485), insertion of a urethral catheter is part of the procedure and is not separately billed.

H. Separate or Multiple Procedures

1. When multiple procedures are performed on the same day or at the same session, it is appropriate to designate them by separate entries. Surgical procedures performed in conjunction with a radiology procedure will be subject to the rules and regulations of the Surgery section.
2. When x-rays of multiple sections of a body area are billed separately, the total reimbursement must not exceed the maximum reimbursement allowance of the complete body area.

I. Outpatient CT Scans and MRIs

CT scans and MRIs, when performed on an outpatient basis, are subject to the limitations of the fee schedule, regardless of site of service.

J. Unlisted Service or Procedure

A service or procedure may be provided that is not listed in the most recent edition of the CPT book. When reporting such a service, the appropriate unlisted procedure code may be used to indicate the

service, identifying it by special report. The unlisted procedures and accompanying codes are as follows:

76496	Unlisted fluoroscopic procedure (e.g., diagnostic, interventional)
76497	Unlisted computed tomography procedure (e.g., diagnostic, interventional)
76498	Unlisted magnetic resonance procedure (e.g., diagnostic, interventional)
76499	Unlisted diagnostic radiographic procedure
76999	Unlisted diagnostic ultrasound procedure
77299	Unlisted procedure, therapeutic radiology, clinical treatment planning
77399	Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services
77499	Unlisted procedure, therapeutic radiology treatment management
77799	Unlisted procedure, clinical brachytherapy
78099	Unlisted endocrine procedure, diagnostic nuclear medicine
78199	Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine
78299	Unlisted gastrointestinal procedure, diagnostic nuclear medicine
78399	Unlisted musculoskeletal procedure, diagnostic nuclear medicine
78499	Unlisted cardiovascular procedure, diagnostic nuclear medicine
78599	Unlisted respiratory procedure, diagnostic nuclear medicine
78699	Unlisted nervous system procedure, diagnostic nuclear medicine
78799	Unlisted genitourinary procedure, diagnostic nuclear medicine
78999	Unlisted miscellaneous procedure, diagnostic nuclear medicine
79999	Unlisted radiopharmaceutical therapeutic procedure

K. Special Report

A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service. Special reports to justify the necessity of a service do not warrant a separate fee.

L. By Report (BR)

"BR" in the Amount column indicates services that are too new, unusual, or variable in the nature of their performance to permit the assignment of a definable fee. Such services should be substantiated by documentation submitted with the bill. Sufficient information should be included to permit proper identification and a sound evaluation. If the service is justified by the report, the actual charge shall be paid in full, unless the payer has evidence that the actual charge exceeds the usual and customary charge for such service.

M. Radiology Supervision and Interpretation Procedures

There are times when a single physician may perform the procedure and supervise the imaging and interpretation. On other occasions, one physician may perform the procedure, and the imaging supervision with interpretation may be performed by another physician. The appropriate radiology codes are to be used for supervision and interpretation of the imaging. The appropriate surgical codes are to be used for the procedure, including necessary local anesthesia, placement of needle or

catheters, injection of contrast media, etc. The surgical codes are subject to the rules and regulations of the Surgery section, and the radiology codes are subject to this section of radiology rules and regulations.

N. Written Report(s)

A written report, signed by the interpreting physician, should be considered an integral part of a radiological procedure or interpretation.

O. Facility Fee

The Facility Fee is the Amount increased by ten percent (10%).

III. MODIFIERS

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of the appropriate modifier code. The modifier may be reported by a two-digit number placed after the usual procedure number, separated by a hyphen. If more than one modifier is used, place the multiple modifiers code 99 immediately after the procedure code. This indicates that one or more additional modifier codes will follow. Modifiers commonly used in radiology (including nuclear medicine and diagnostic ultrasound) are as follows.

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.

Mississippi's note: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement.

26 Professional Component

Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component (HCPCS Level II Modifier)

Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

Mississippi's note: The technical component is calculated by subtracting the PC Amount from the Amount for the reimbursement.

32 Mandated Service

Services related to mandated consultation and/or related services (e.g., third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

51 Multiple Procedures

When multiple procedures, other than E/M services, physical medicine and rehabilitation services, or provision of supplies (e.g., vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes (see the applicable CPT book).

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 Discontinued Procedure

Under certain circumstances the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

76 Repeat Procedure by Same Physician

It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

77 Repeat Procedure by Another Physician

The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.

99 Multiple Modifiers

Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

Pathology and Laboratory

I. GUIDELINES

A. Pathology Services

Services in pathology and laboratory are provided by the pathologist, or by the technologist, under responsible supervision of a physician.

B. Separate or Multiple Procedures

It is appropriate to designate multiple procedures rendered on the same date by separate entries.

C. Unlisted Service or Procedures

A service or procedure may be provided that is not listed in this fee schedule. When reporting such a service or procedure, the appropriate unlisted procedure code may be used to indicate the service, identifying it by special report as discussed below. The unlisted procedures and accompanying codes for Pathology and Laboratory are as follows:

81099	Unlisted urinalysis procedure
84999	Unlisted chemistry procedure
85999	Unlisted hematology and coagulation procedure
86849	Unlisted immunology procedure
86999	Unlisted transfusion medicine procedure
87999	Unlisted microbiology procedure
88099	Unlisted necropsy (autopsy) procedure
88199	Unlisted cytopathology procedure
88299	Unlisted cytogenetic study
88399	Unlisted surgical pathology procedure
89240	Unlisted miscellaneous pathology test

D. Special Report

A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service. Additional items that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care. This report does not command a separate fee for completion.

Mississippi Workers' Compensation Medical Fee Schedule

E. By Report (BR)

"BR" in the Amount column indicates services that are too new, unusual, or variable in the nature of their performance to permit the assignment of a definable fee. Such services should be substantiated by documentation submitted with the bill. Sufficient information should be included to permit proper identification and a sound evaluation. If the service is justified by the report, the actual charge shall be paid in full, unless the payer has evidence that the actual charge exceeds the usual and customary charge for such service.

F. Facility Fee

The Facility Fee is the Amount increased by ten percent (10%).

II. GENERAL INFORMATION AND INSTRUCTIONS

A. Panel Tests

The billing for panel tests must include documentation listing the tests in the panel. When billing for panel tests (80048-80076), use the code number corresponding to the appropriate panel test. These tests will not be reimbursed separately.

The panel components do not preclude the performance of other tests not listed in the panel. If other laboratory tests are performed in conjunction with a particular panel, the additional tests may be reported separately in addition to the panel.

B. Handling and Collection Process

1. In collecting a specimen, the cost for collection is covered by the technical component when the lab test is conducted at that site. No separate collection or handling fee for this purpose will be reimbursed.
2. When a specimen must be sent to a reference laboratory, the cost of specimen collection is covered in a collection fee. This charge is only allowed when a reference laboratory is used, and modifier 90 must be used.

C. Global, Professional, and Technical Components

Some procedures in the Pathology and Laboratory section are considered global fees and do not qualify for a separate technical (TC) or professional (PC) component. Some procedures are listed with a PC fee in addition to the global fee. For procedures listed with a PC fee, the TC reimbursement rate is calculated by subtracting the PC amount from the total amount.

Whereas these guidelines are written to be all-inclusive, there are instances when the reviewer must make an informed decision regarding the PC/TC reimbursements. Request for PC reimbursement will only be considered if:

- The physician performs the procedure or reviews the results
- A written report, not a computer generated report, is submitted with the request for payment.

III. MODIFIERS

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of the appropriate modifier code. The modifier may be reported by a two-digit number placed after the usual procedure number and separated by a hyphen. If more than one modifier is used, place the multiple modifiers code 99 immediately after the procedure code. This indicates that one or more additional modifier codes will follow. Modifiers commonly used in pathology and laboratory are as follows:

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.

Mississippi's note: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement.

26 Professional Component

Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component (HCPCS Level II Modifier)

Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

Mississippi's note: The technical component is calculated by subtracting the PC Amount from the Amount for the reimbursement.

32 Mandated Services

Services related to mandated consultation and/or related services (e.g., third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 Discontinued Procedure

Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures or services other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

90 Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.

91 Repeat Clinical Diagnostic Laboratory Test

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when another code(s) describes a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for a laboratory test(s) performed more than once on the same day on the same patient.

92 Alternative Laboratory Platform Testing

When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701–86703). The test does not require permanent dedicated space; hence by its design it may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.

99 Multiple Modifiers

Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

Medicine Services

In addition to the general rules, this section applies to unique guidelines for medicine specialties. Physical medicine and rehabilitation guidelines, as well as chiropractic and osteopathic services, are listed in a separate section following Medicine Services.

I. GUIDELINES

A. Unlisted Services or Procedures

When a service or procedure is provided that is not specifically listed in the Fee Schedule, documentation must be submitted to substantiate the charge.

B. Multiple Procedures

It is appropriate to designate multiple procedures rendered on the same date by separate entries.

C. Separate Procedures

Some of the listed procedures are commonly carried out as an integral part of a total service and, as such, do not warrant a separate identification. When, however, such a procedure is performed independently of, and is not immediately related to other services, it may be listed as a "separate procedure." Thus, when a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be reported as a separate procedure.

D. By Report (BR) Procedures

"BR" in the Amount column indicates services that are too new, unusual, or variable in the nature of their performance to permit the assignment of a definable fee. Such services should be substantiated by documentation submitted with the bill. Sufficient information should be included to permit proper identification and a sound evaluation. If the service is justified by the report, the actual charge shall be paid in full, unless the payer has evidence that the actual charge exceeds the usual and customary charge for such service.

E. Special Report

A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service. Additional items that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

F. Materials Supplied by Physician

Supplies and materials provided by the physician over and above those usually included with the office visit should be identified with CPT code 99070 or specific HCPCS Level II code. Reimbursement shall be limited to the Fee Schedule maximum reimbursement allowance (MRA) or the usual and customary rate for items not listed in this Fee Schedule.

G. Audiological Function Tests

The audiometric tests (92551–92596) require use of calibrated electronic equipment. Other hearing tests (e.g., whisper voice or tuning fork) are considered part of the examination and not paid separately. All descriptors refer to testing of both ears.

H. Psychological Services

Payment for a psychiatric diagnostic interview includes history and mental status determination, development of a treatment plan when necessary, and the preparation of a written report that must be submitted with the required billing form.

Psychotherapy codes (90804–90857) must be billed under the CPT code most closely approximating the length of the session. The codes for individual therapy services designate whether the service includes medical evaluation. Only a psychiatrist (M.D. or D.O.) may bill for those codes that include medical evaluation (procedure codes 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829).

A service level adjustment factor is used to determine payment for psychotherapy when a provider other than a psychiatrist provides the service. In those instances, the reimbursement amount for the CPT code is paid at eighty-five percent (85%) of the maximum reimbursement allowance. This applies to psychologists, social workers, and counselors.

I. Electromyography (EMG)

Payment for EMG services includes the initial set of electrodes and all supplies necessary to perform the service. The physician may be paid for a consultation or new patient visit in addition to the EMG performed on the same day. When an EMG is performed on the same day as a follow up visit, payment may be made for the EMG only unless documentation supports the need for a medical service in addition to the EMG.

J. Manipulative Services

Chiropractic manipulative services, which are medicine services, will be discussed in the Physical Medicine section.

II. MODIFIERS

Listed services and procedures may be modified under certain circumstances. When applicable, identify the modifying circumstance by the addition of the appropriate modifier code, which may be reported by a two-digit number placed after the usual procedure number separated by a hyphen. If more than one modifier is used, place the multiple modifiers code 99 immediately after the procedure code. This indicates that one or more additional modifier codes will follow. Modifiers commonly used in Medicine Services are as follows:

22 Increased Procedure Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.

Mississippi's note: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement.

26 Professional Component

Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component (HCPCS Level II Modifier)

Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

Mississippi's note: The technical component is calculated by subtracting the PC Amount from the Amount for the reimbursement.

32 Mandated Services

Services related to mandated consultation and/or related services (e.g., third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

51 Multiple Procedures

When multiple procedures, other than E/M services, physical medicine and rehabilitation services, or provision of supplies (e.g., vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes (see the applicable CPT book).

Mississippi's note: This modifier should not be appended to designated "modifier 51 exempt" codes as specified in the applicable CPT book.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 Discontinued Procedure

Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the wellbeing of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

55 Postoperative Management Only

When one physician performed the postoperative management and another physician performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

56 Preoperative Management Only

When one physician performed the preoperative care and evaluation and another physician performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

57 Decision for Surgery

An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. Note: For the treatment of a problem that requires a return to the operating or procedure room, see modifier 78.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures or services other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

76 Repeat Procedure by Same Physician

It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

77 Repeat Procedure by Another Physician

The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.

78 Return to the Operating Room for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period

The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

90 Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.

99 Multiple Modifiers

Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

Physical Medicine

I. SCOPE

A. Physical Medicine

Physical medicine is an integral part of the healing process for a variety of injured workers. Recognizing this, the Fee Schedule includes codes for physical medicine, modalities, procedures, tests, and measurements in the Physical Medicine section representing specific therapeutic procedures performed by licensed physicians, chiropractors, licensed physical therapists, and licensed occupational therapists.

B. Physical Medical Assessment

1. An assessment must be performed to determine if a patient will benefit from physical medicine therapy.
2. When a physician examines a patient and an assessment for physical medicine is performed, the billing for the office visit includes the physical medicine assessment.
3. Procedure code 97001 is to be used for an initial assessment by physical therapists. Code 97002 is to be used for re-evaluation of a patient by physical therapists. Procedure code 97003 is to be used for an initial assessment by occupational therapists. Code 97004 is to be used for re-evaluation of a patient by occupational therapists.

C. Plan of Care

1. An initial plan of care must be developed and filed with the payer regardless of whether therapy is provided by a physician or practicing therapist. The content of the plan of care, at a minimum, should contain
 - a. The specific therapies to be provided, including the frequency and duration of each
 - b. The estimated duration of the therapeutic regimen
 - c. The potential degree of restoration and measurable goals (e.g., potential restoration is good, poor, low, guarded)
2. The initial plan of care must be signed by the treating physician and submitted to the payer within fourteen (14) days of approval. Physicians are required to sign the plan of care for physical and/or occupational therapy. The physician's signature indicates approval of the therapy the patient is receiving and for the length of time established for the therapy.
3. The physician has the responsibility of providing documentation of medical necessity to the payer whenever there are questions regarding the extent of therapy being provided or the appropriateness of the therapy regimen.
4. A plan of care must be updated at least every thirty (30) days and submitted to the payer.
5. Preparation of a care plan does not warrant a separate fee.

D. Qualifications for Reimbursement

1. The patient's condition must have the potential for restoration of function.
2. The treatment must be prescribed by the authorized attending or treating physician.
3. The treatment must be specific to the injury and have the potential to improve the patient's condition.
4. The physician or therapist must be on-site during the provision of services.

II. REIMBURSEMENT

A. Guidelines

1. Visits for therapy may not exceed one visit per day without prior approval from the payer.
2. Therapy exceeding fifteen (15) visits or thirty (30) days, whichever comes first, must have prior authorization from the payer for continuing care. It must meet the following guidelines:
 - a. The treatment must be medically necessary.
 - b. Prior authorization may be made by telephone. Documentation should be made in the patient's medical record indicating the date and name of the payer representative giving authorization for the continued therapy.
3. Reimbursement is limited to no more than four (4) therapies concurrently at the same visit. In the event of multiple treatment areas, an additional four (4) therapies per treatment day may be allowed at the payer's discretion and with pre-authorization. In the event of multiple treatment areas, the second and subsequent areas are subject to the multiple procedure rule.
[In the pain management setting, no more than two (2) modalities and/or procedures may be used on a given day (e.g., heat/cold, ultrasound, diathermy, iontophoresis, TENS, electrical stimulation, muscle stimulation, etc.). No more than one (1) modality may be used concurrently.]
4. Payment for 97010, which reports application of hot or cold packs, is bundled into payment for other services. Separate reimbursement for hot and cold packs will not be allowed in the treatment of work-related injury/illness.
5. No more than four (4) 15-minute procedures and/or modalities will be reimbursed at each encounter without prior authorization.
6. Only one (1) work hardening or work conditioning program is reimbursed per injury.

B. Treatment Areas

1. Spinal areas are recognized as the following five distinct regions:
 - Cranial
 - Cervical
 - Thoracic
 - Lumbar
 - Sacral

Transitional areas of the spine are not recognized as distinctly different areas (e.g., cervicothoracic, lumbosacral)

2. Pelvis
3. Upper extremity (either left or right) is recognized as the following six distinct regions:

- Shoulder
 - Upper arm
 - Elbow
 - Forearm
 - Wrist
 - Hand
4. Lower extremity (either left or right) is recognized as the following eight distinct regions:
- Hip
 - Thigh
 - Knee
 - Calf
 - Ankle
 - Foot
 - Rib cage
 - Anterior trunk

C. Tests and Measurements

1. When two or more procedures from 95831 through 95852 are performed on the same day, reimbursement may not exceed the maximum reimbursement allowance (MRA) for procedure code 95834 Total evaluation of body, including hands.
2. Functional capacity evaluation (FCE) must have pre-authorization from the payer before scheduling the tests.
3. Reimbursement for extremity testing, muscle testing, and range of motion measurements (95831, 95832, 95833, 95834, 95851, 95852) will not be made more than once in a thirty (30) day period for the same body area. If a physician's order specifically indicates testing in more than one plane of motion, (e.g., flexion/extension and internal/external rotation), then each plane of motion test is reimbursable, but not more than once in a thirty (30) day period for that same body area. The multiple procedure rule would apply.

D. Fabrication of Orthotics

1. Procedure code 97760 must be billed for the professional services of a physician or therapist to fabricate orthotics.
2. Orthotics, prosthetics, and related supplies used may be billed under the appropriate HCPCS code. The maximum reimbursement allowance is listed in the DME and Other HCPCS Codes section of the Fee Schedule. For orthotics and supplies not listed in the DME and Other HCPCS Codes section, use CPT code 99070. Reimbursement may not exceed a twenty percent (20%) mark-up of the provider's cost and an invoice may be required by the payer before reimbursement is made.

E. Follow-up Examination of an Established Patient

A physician, physical therapist, or occupational therapist may charge and be reimbursed for a follow-up examination for physical therapy only if new symptoms present the need for re-examination and evaluation as follows:

1. There is a definitive change in the patient's condition.
2. The patient fails to respond to treatment and there is a need to change the treatment plan.

3. The patient has completed the therapy regimen and is ready to receive discharge instructions.

III. WORK HARDENING RULES

- A. Work hardening programs are interdisciplinary, goal-specific, vocationally-driven treatment programs designed to maximize the likelihood of return to work through functional, behavioral, and vocational management.
- B. Not all claimants require these programs to reach a level of function that will allow successful return to work.
- C. Only those programs that meet all of the specific guidelines will be defined as work hardening programs.
- D. Programs will be reimbursed per the Fee Schedule after meeting all other requirements.
- E. Work hardening will be reimbursed for a maximum of four weeks with prior authorization from the payer. The payer may approve additional two-week increments if the patient demonstrates substantial improvement.
- F. For pre-admission criteria, all claimants must complete a preprogram assessment, including a functional capacity evaluation (FCE). The goal of the program is return to work; therefore, for all anticipated returns to previous employment or placement with a new employer, the following must be provided:
 1. Specific written critical job demands and/or job site analysis
 2. Verified written employment opportunities
- G. For the evaluation process, initial screening evaluation is performed to determine if the injured worker will benefit from a work hardening program. The outcome of this evaluation will be:
 1. Recommendation of release to return to work
 2. Acceptance into the program with an individual written rehabilitation plan stating specific goals and recommended services
 3. Rejection from program for specific reasons
 4. Referral back to the provider for medical evaluation
- H. The individualized work hardening plan must be supervised by a licensed physical or occupational therapist and/or physician within a therapeutic environment. Although some time is spent on a one-to-one basis, more than fifty percent (50%) of the time is self-monitored under the supervision of a physical or occupational therapist and/or physician. Recommended group size is no larger than five-to-one (5 patients to 1 therapist).
- I. Progress should be documented and reviewed to ensure continued progress.
- J. Simultaneous utilization of work conditioning and work hardening is not allowed. Prior authorization is required for either one of these services and requires documentation of specific goals and outcomes.
- K. Discharge criteria must be provided to all claimants in writing prior to initiation of treatment at the time program goals are determined.
- L. Voluntary discharge is achieved by:
 1. Meeting program goals
 2. Early return to work
 3. Acute or worsening medical condition
 4. The claimant declining further treatment
- M. Non-voluntary discharge may be necessary in cases of:

1. Failure to comply with program policies
 2. Absenteeism
 3. Lack of demonstrable benefit from treatment
- N. Non-voluntary discharge requires written documentation of prior and repeated counseling of the claimant, and immediate notification of the employer, insurer, case manager, and treating and attending (if different) provider.
- O. Under all circumstances of voluntary and non-voluntary discharge, the claimant will return to the attending provider for release from the program.
- P. The attending provider must sign a release to return to work when the program goals are achieved.
- Q. The exit/discharge summary should delineate the person's:
1. Present functional status and potential
 2. Functional status related to the targeted job, alternative occupations, or competitive labor market
- R. For program evaluation, programs must provide insurers and referring providers with:
1. Initial interdisciplinary team evaluation report.
 2. Proposed treatment plan
 3. Progress reports at weekly intervals
 4. The opportunity to attend team meetings
 5. Final discharge summary report
- S. Fees for work hardening programs will be paid in accordance with the Fee Schedule, with written prior approval by the payer, utilizing the following guidelines:
1. In all cases, for both voluntary and non-voluntary discharge, payment is for the actual duration of treatment provided.
 2. Non-multi disciplinary work conditioning programs will be reimbursed utilizing existing physical therapy, occupational therapy, and physical medicine codes. CPT code 97545 (initial two hours) and code 97546 (each additional hour) are to be used to bill work hardening. CPT code 97545 is to be billed for the initial two hours of the work hardening program. This is a one-time charge. CPT code 97546 is to be used for billing each additional hour of the work hardening program after the initial two hours (indicated by code 97545).

IV. FUNCTIONAL CAPACITY EVALUATIONS

- A. The functional capacity evaluation (FCE) is utilized for the following purposes:
1. To determine the highest level of safe functionality and of maximal medical improvement.
 2. To provide a pre-vocational baseline of functional capabilities to assist in the vocational rehabilitation process.
 3. To objectively set restrictions and guidelines for return to work.
 4. To determine whether specific job tasks can be safely performed by modification of technique, equipment, or by further training.
 5. To determine whether additional treatment or referral to a work hardening program is indicated.
 6. To assess outcome at the conclusion of a work hardening program.

B. General Requirements

1. The FCE may be prescribed only by a licensed physician, or may be required by the payer when indicated
2. The FCE requires prior authorization by the payer
3. The FCE should be billed using code 97750 Functional capacity evaluation.

V. TENS UNITS

- A. TENS (transcutaneous electrical nerve stimulation) must be provided under the attending or treating physician's prescription
- B. Authorization from the payer must be sought before purchase or rental arrangements are made for a TENS unit. The payer has sole right of selection of vendors for rental or purchase of equipment, supplies, etc.

VI. SUPPLIES, EQUIPMENT, ORTHOTICS, AND PROSTHETICS

- A. Physicians and therapists must obtain authorization from the payer before purchase/rental of supplies, equipment, orthotics, and prosthetics costing more than fifty dollars (\$50.00) per item for workers' compensation patients. When submitting bills, include the appropriate HCPCS Level II code. Or, if there is not an appropriate HCPCS code, use CPT code 99070
- B. The payer has sole right of selection of vendors.

VII. OTHER INSTRUCTIONS

- A. Charges will not be reimbursed for publications, books, or videocassettes unless prior approval of the payer is obtained.
- B. All charges for services must be clearly itemized by CPT code, and the state professional license number must be on the bill.
- C. The treating physician must approve and sign all physical capability/restriction forms for the work-related injury/illness. This form must be submitted to the payer within fourteen (14) working days of the release to work.
- D. Documentation may be required by the payer to substantiate the necessity for treatment rendered. Documentation to substantiate charges and reports of tests and measurements are included in the fee for the service and do not warrant additional reimbursement.
- E. When patients do not show measurable progress, the payer may request the physician discontinue the treatment or provide documentation to substantiate medical necessity.
- F. When physical medicine therapies are provided to more than one body area, modifier 51 must be added to the procedure code or codes billed for the additional body area and will be reimbursed according to the multiple procedure rule.
- G. Non-surgical debridement should be billed as CPT code 97597, 97598, or 97602.

VIII. BACK SCHOOLS

All back school programs shall require prior authorization from the payer. The payer and the back school program may agree upon the daily, weekly, or other time-based payment to be made for services

provided to the injured/ill worker. This agreement shall supersede the use of this Physical Medicine section when calculating reimbursement, but it shall not exceed the usual and customary fee

IX. MESSAGE THERAPY

Massage therapy requires prior authorization of the payer before treatment can be rendered. Medical necessity must be established prior to approval. Reimbursement must be arranged between the payer and provider.

X. CHIROPRACTIC MANIPULATIVE TREATMENT

Codes 98940 through 98943 are used to code chiropractic manipulative treatment. Like any other service, a spinal manipulation includes pre-evaluation and post-evaluation that would make it inappropriate to bill with an E/M service. However, if the patient's condition has deteriorated or an injury to another site has occurred, reimbursement can be made for an E/M service if documentation substantiates the additional service. Modifier 25 is added to an E/M service when a significant, separately identifiable E/M service is provided and documented as medically necessary.

XI. ELECTROMYOGRAM (EMG) AND NERVE CONDUCTION STUDY (NCS)

A. Only a licensed physical medicine doctor or a neurologist is entitled to reimbursement for performing an Electromyogram (EMG) and/or a nerve conduction study (NCS).

B. Reimbursement is not allowed under this Schedule for automated nerve conduction studies.

C. Referral for an electromyogram and/or a nerve conduction study shall be at the discretion and direction of the physician in charge of care, and neither the payer nor the payer's agent may unilaterally or arbitrarily redirect the patient to another provider for these tests. The payer or the payer's agent may, however, discuss with the physician in charge of care appropriate providers for the conduct of these tests in an effort to reach an agreement with the physician in charge as to who will conduct an electromyogram and/or nerve conduction study in any given case.

XII. CHRONIC PAIN – INTER-DISCIPLINARY PAIN REHABILITATION PROGRAM

A. The Inter-Disciplinary Pain Rehabilitation (IDPR) program is based on the biopsychosocial approach to managing chronic pain, and uses both physical medicine treatments as well as psychological treatments and therapy to manage the chronic pain patient. A goal oriented, team approach is used in an effort to reduce pain, improve functioning, and decrease the dependence on the health care system of persons with chronic pain. This is an outpatient program.

B. Pre-authorization is required in order to utilize an inter-disciplinary pain rehabilitation program to treat the chronic pain patient. A specific IDPR program plan must be submitted to the payer as part of the pre-authorization process.

C. The following guidelines shall be used to assist in pre-authorization, and concurrent review:

1. Persons considered suitable candidates for an inter-disciplinary pain rehabilitation program are those:

a. who are likely to benefit from the program design;

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b. whose symptoms are deemed by a pain management provider to constitute chronic pain syndrome, and

c. whose medical, psychological or other conditions do not prohibit participation in this program.

2. Mental Health Evaluation: an initial evaluation to determine the injured worker's readiness or suitability for this type of treatment may be performed prior to initiation of treatment. This evaluation is not considered part of the IDPR program and shall be billed separately.

3. Due to the nature and intensity of the program, both group and individual therapy may be part of the IDPR program. If the program plan for a particular patient includes individual psychotherapy, it shall be billed as part of the program, and not separately. If the program does not include psychotherapy services, such services may be billed separately, if used, subject to applicable pre-authorization requirements.

4. Psychological treatments which are part of the IDPR program may be rendered by a psychiatrist, psychologist, licensed counselor or licensed social worker.

5. The IDPR program shall always include a component designed to reduce the patient's dependence on and/or addiction to pain medications.

6. An individualized plan of treatment shall be supervised by a doctor within a therapeutic environment. Although some time is spent with a doctor on a one-to-one basis, more than 50% of the time may be spent in direct care under the supervision of the physical therapist, occupational therapist, mental health provider, or other licensed member of the IDPR team.

7. Program supervision shall be provided by a doctor who is trained and experienced in the treatment of patients with chronic pain syndrome. The program supervisor shall:

a. provide direct, on-site supervision of the daily pain management activities,

b. participate in the initial and final evaluation of the patient,

c. write the treatment plan for the patient, and write changes to the plan based on the patient's documented response to the treatment, and/or based on documented changes in the patient's condition;

d. direct the members of the IDPR team and review the patient's progress on a regular and consistent basis.

8. Participation in an IDPR program requires a minimum attendance of four (4) hours per day during the first week. The program shall not exceed eight (8) hours per day, except that workers who actually have experience working in a job for more than eight (8) hours per day may be allowed to participate for up to ten (10) hours per day, at the discretion of the program supervisor.

9. Daily treatment and patient response shall be documented and provided to the payer at least every two (2) weeks.

10. Discharge/exit criteria shall include but not be limited to:

a. the appropriate use of medication;

b. decreased intensity of subjective pain;

c. increased ability of the injured worker to manage pain.

- d. reduced health care use related to the chronic pain.
- e. return to work, and/or
- f. non-compliance with the program, or failure to obtain meaningful benefit after a reasonable period of time.

D. Billing. The IDPR program shall be billed using CPT 97799 ("unlisted physical medicine/rehabilitation service or procedure"), and appended with modifier "CP" to indicate chronic pain treatment. The total number of hours shall be indicated in the units column of the bill, or in some other conspicuous place on the bill. CARF accredited providers shall also add "CA" as an additional modifier.

E. Reimbursement. Reimbursement shall be as agreed to by the parties, or a maximum of \$125.00 per hour for CARF accredited providers. Providers without CARF accreditation shall be paid 80% of the maximum allowable fee for CARF accredited providers. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment shall be reimbursed if the time is equal to or greater than 8 minutes and less than 23 minutes.

XIII. Experimental or Investigational Procedures

Certain procedures or treatments are considered investigational or experimental for purposes of this Fee Schedule, and are not approved for reimbursement. These procedures or treatments include:

- A. VAX-D therapy.

Dental

Dental codes (D0120–D9999), also referred to as *D* codes, are a separate category of HCPCS Level II national codes that contain the complete *Current Dental Terminology* (CDT) code set, which is developed, maintained, and copyrighted by the American Dental Association (ADA).

CDT is updated every two years. The current edition is *CDT ~~2007/2008~~ 2010*, which is the edition that has been used in this Fee Schedule.

Decisions regarding the modification, deletion, or addition of CDT codes are made by the ADA and not the national panel responsible for the administration of HCPCS Level II codes. The Department of Health and Human Services has an agreement with the ADA to include *CDT ~~2007/2008~~ 2010* as a set of HCPCS Level II codes used to report dental services.

Durable Medical Equipment (DME), Orthotics, Prosthetics and Other HCPCS Codes

I. DEFINITION

HCPCS is an acronym for CMS's Healthcare Common Procedural Coding System. It is divided into two subsets. HCPCS Level I codes are CPT codes developed and maintained by the AMA. HCPCS Level II codes, with the exception of the dental codes (D0120–D9999), are developed and maintained by CMS and include codes for procedures, equipment, and supplies not found in the CPT book. This section of the Fee Schedule contains HCPCS Level II codes. (See the Dental section for dental codes.) HCPCS Level II codes that are excluded from the Fee Schedule are Physician Voluntary Reporting Program Codes (G8006–G9139), Alcohol/Drug Abuse Treatment Services (H0001–H2037), National Codes for State Medicaid Agencies (T1000–T5999, except T2001–T2007). These three sections are not included because there is no fee associated with the code (G8006–G9139) or the code was created for State Medicaid agencies (H0001–H2037, T1000–T5999) and no fee data is available.

Code categories included in this section are as follows:

Transportation Services including Ambulance	A0021–A0999
Medical/Surgical Supplies	A4206–A8004
Administrative, Misc., and Investigational	A9150–A9999
Enteral/Parenteral Therapy	B4034–B9999
Outpatient PPS	C1300–C9726
Durable Medical Equipment (DME)	E0100–E8002

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Procedures/Professional Services (Temporary)	G0008–G3001
Drugs and Biologicals	J0120–J9999
K Codes (Temporary)	K0001–K0699
Orthotic Procedures	L0112–L4398
Prosthetic Procedures	L5000–L9900
Medical Services	M0064–M0301
Pathology and Laboratory Services	P2028–P9615
Q Codes (Temporary)	Q0035–Q9967
Diagnostic Radiology Services	R0070–R0076
Temporary National Codes (Non-Medicare)	S0012–S9999
Vision Services	V2020–V2799
Hearing Services	V5008–V5364

II. GUIDELINES

- A. Transportation Services Including Ambulance (A0021–A0999)
1. Transportation service codes include ground and air ambulance, nonemergency transportation (taxi, bus, automobile, wheelchair van), and ancillary transportation-related fees.
 2. Modifiers are required when reporting transportation services. Modifiers are single digits used to identify origin and destination. The first modifier identifies the transport place of origin and the second modifier the destination. Origin and destination modifiers are as follows:
 - D Diagnostic or therapeutic site other than those identified in "P" or "H"
 - E Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility)
 - G Hospital-based dialysis facility (hospital or hospital-related)
 - H Hospital
 - I Site of transfer (for example, airport or helicopter pad) between types of ambulance
 - J Non-hospital-based dialysis facility
 - N Skilled nursing facility (SNF)
 - P Physician's office (includes HMO non-hospital facility, clinic, etc.)
 - R Residence

Durable Medical Equipment (DME), Orthotics, Prosthetics and Other HCPCS Codes

- S Scene of accident or acute event
- X Intermediate stop at physician's office enroute to the hospital (includes HMO non-hospital facility, clinic, etc.)
- 3. Transportation codes can also be found in the S and T codes. See S0207, S0208, S0209, S0215 and T2001–T2007.

- B Medical and Surgical Supplies (A4205–A8004)
 - 1. A wide variety of medical, surgical, and some DME related supplies and services are represented in this section.
 - 2. For rules related to DME supplies, accessories, maintenance, and repair, see G. Durable Medical Equipment below.

- C Administrative, Miscellaneous, and Investigational (A9150–A9999)
 - 1. These codes cover nonprescription drugs, exercise equipment, radiopharmaceutical diagnostic imaging agents, as well as other miscellaneous supplies.

- D Enteral and Parenteral Therapy (B4034–B9999)
 - 1. This section covers enteral formulae, enteral medical supplies, parenteral nutrition solutions and supplies, and enteral and parenteral pumps.

- E Outpatient PPS (C1300–C9728)
 - 1. These codes report drugs, biologicals, and devices used by hospitals.
 - 2. These codes are only used for facility (technical) services.

- F Durable Medical Equipment (DME) (E0100–E8002)
 - 1. All durable medical equipment shall have prior authorization from the payer before obtaining the equipment. The payer has the choice of vendor for purchase or rental of DME.
 - 2. If an injured/ill employee is receiving DME items for both compensable and non-compensable medical conditions, only those items that apply to the work related injury should be listed on claims and invoices submitted to the employer.
 - 3. If the rental price for DME exceeds or equals the total purchase price, the employer shall purchase instead of renting equipment. The vendor shall make the payer aware of the price options.
 - 4. The return of rented equipment is the dual responsibility of the injured worker and the DME supplier. The employer is not responsible for additional rental periods solely due to delay in equipment return.

- G Procedures/Professional Services (Temporary) (G0008–G3001)
 - 1. G codes identify professional health care procedures and services that would otherwise be reported using CPT codes.
 - 2. Procedures and professional services identified by G codes may have a corresponding CPT code. When both a G code and CPT code describe the same procedure, the CPT code is required for reporting purposes.
 - 3. G codes also include procedures and professional services that do not currently have a valid CPT code. In such cases, the applicable G code should be used for reporting purposes.

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H. Drugs and Biologicals (J0120–J9999)

1. These codes report drugs and biologicals that cannot be self administered and are typically administered by injection, infusion, or inhalation. Exceptions include oral immunosuppressive and oral chemotherapy drugs.
2. These codes report only the costs associated with provision of the drug. Administration including injection, infusion, or inhalation is reported separately using the applicable CPT code(s).
3. For oral anti-emetic drugs provided in conjunction with chemotherapy treatment, see Q0163–Q0181.
4. Additional codes for drugs and biologicals may be found in the Q codes and S codes.

I. Temporary Codes (K0001–K0899)

1. These codes are temporary codes used to report durable medical equipment that does not yet have a permanent national code.
2. For rules related to DME supplies, accessories, maintenance, and repair, see G. Durable Medical Equipment above.

J. Orthotic Procedures and Devices (L0112–L4398) and Prosthetic Procedures (L5000–L9900)

The payer shall only pay for orthotics and prosthetics prescribed by the treating physician for a compensable injury/illness. Prior authorization must be obtained from the payer.

K. Medical Services (M0064–M0301)

1. These codes are used to report office services, cellular therapy, prolotherapy, intragastric hypothermia, IV Chelation therapy, and fabric wrapping of an abdominal aneurysm.
2. These codes are rarely reported and may not be reimbursed as they represent services for which the therapeutic efficacy has not been established, the procedure is considered experimental, or the procedure has been replaced with a more effective treatment modality.

L. Pathology and Laboratory Services (P2028–P9615)

1. Included in this section are codes for chemistry and toxicology tests, pathology screening tests, microbiology tests, blood, and blood products.
2. Blood and blood product codes report the supply of the blood or blood product only.
3. The administration of blood or blood product is reported separately.
4. Code 36430 for transfusion of blood or blood components is reported only once per encounter regardless of the number of units provided.

M. Temporary Codes (Q0035–Q9957)

1. These temporary codes were developed for reporting services and supplies that do not have a permanent national HCPCS code or CPT code. Included in this section are codes for:
 - a. Oral anti-emetic drugs
 - b. Casting supplies
 - c. Splint supplies
 - d. Low osmolar contrast
 - e. High osmolar contrast
 - f. Other supplies/services
2. Cast supplies and splints should be reported with the appropriate code from Q4001–Q4051. These codes report the cost of the supply only.

3. Cast supplies and splints are reported in addition to the CPT code for fracture management.
4. Cast supplies and splints are reported in addition to CPT codes for application of the cast or splint.
5. Refer to the CPT guidelines for rules related to reporting fracture management and cast application.

N. Diagnostic Radiology Services (R0070–R0076)

1. These codes are used for transportation of portable x-ray and/or EKG equipment.
2. Only a single reasonable transportation charge is allowed for each trip to a single location.
3. When more than one patient receives x-ray or EKG services at the same location, the allowable transport charge is divided among all patients.

O. Temporary National Codes (Non-Medicare) (S0012–S9999)

1. These codes were developed by the Blue Cross/Blue Shield Association (BCBSA) and the Health Insurance Association of America (HIAA) to report drugs, services, and supplies for which there are no CPT or HCPCS Level II codes, but for which codes are needed by the private sector to implement policies, program, or claims processing.
2. See J codes for reporting rules related to drugs and biologicals.
3. For the purposes of pain management, if the drugs used in the refill of the pain pump must be compounded, report the compounding service with code S9430 Pharmacy compounding and dispensing services. The compounding service shall be reimbursed at \$157.44 per individual refill. For purposes other than pain management, S9430 shall be reimbursed by report (BR).

P. Vision, Hearing, and Speech-Language Pathology Services (V2020–V2799, V5008–V5364)

1. Vision services includes codes for reporting vision-related supplies, including spectacles, lenses, contact lenses, prostheses, intraocular lenses, and miscellaneous lenses.
2. Hearing services includes codes for hearing tests and related supplies and equipment, speech-language pathology screenings, and repair of augmentative-communicative systems.

III. MODIFIERS

HCPCS Level II modifiers are required for some supplies and services. Commonly reported HCPCS Level II modifiers include:

- AI Item furnished in conjunction with a urological, ostomy, or tracheostomy supply
- AV Item furnished in conjunction with a prosthetic device, prosthetic, or orthotic
- AW Item furnished in conjunction with a surgical dressing
- KC Replacement of special power wheelchair interface
- NU Purchased new equipment
- RR Rental equipment (listed amount is the per-month allowance)
- UE Purchased used equipment

Inpatient Hospital and Outpatient Facility Payment Schedule and Rules

I. INPATIENT AND OUTPATIENT CARE RULES

A. Definition:

For purposes of this schedule, "inpatient" means being admitted to a hospital setting for twenty-four (24) hours or more. An inpatient admission does not require official admission to the hospital.

B. Billing and Reimbursement Rules for Inpatient Care:

1. Facilities must submit the bill for inpatient services within thirty (30) days after discharge. For those cases involving extended hospitalization, interim bills must be submitted every thirty (30) days.
2. Reimbursement for acute inpatient hospital services shall be the maximum reimbursement allowance fixed by the rules set forth in this section of the Fee Schedule, regardless of the total charge.
3. Non-covered charges include but are not necessarily limited to:
 - a. Convenience items,
 - b. Charges for services not related to the work injury/illness,
 - c. Services that were not certified by the payer or their representative as medically necessary.
4. When reviewing surgical claims, including for outlier consideration, the following apply:
 - a. Most operative procedures require cardiopulmonary monitoring either by the physician performing the procedure or an anesthesiologist/anesthetist. Because these services are integral to the operating room environment, they are considered as part of the OR fee and are not separately reimbursed, nor are they included separately in the total charge for outlier consideration:
 1. Cardiac monitors
 2. Oximetry
 3. Blood pressure monitor

4. Lasers
 5. Microscopes
 6. Video equipment
 7. Set up fees
 8. Additional OR staff
 9. Gowns
 10. Gloves
 11. Drapes
 12. Towels
 13. Mayo stand covers
 14. On-call or call-back fees
 15. After-hours fees
- b. Billing for surgery packs as well as individual items in the packs is not allowed and shall not be included in the total charge for outlier consideration.
- c. A majority of invasive procedures requires availability of vascular and/or airway access, therefore, the work associated with obtaining this access is included in the cost of the service, i.e., anesthesia—airway access is associated with general anesthesia and is included in the anesthesia charges.
- d. Recovery room and ICU rates include the charge for cardiac monitoring and oximeter. It is assumed the patient is placed in these special areas for monitoring and specialized care which is bundled into the special care rate. Call-back fees are not reimbursed for recovery room.
- e. Separate reimbursement is not allowed for setting up portable equipment at the patient's bedside.
- f. The following items do not qualify for separate reimbursement regardless of inpatient or outpatient status, and are not included in the total charge for outlier consideration:
1. Applicators, cotton balls, band-aides
 2. Syringes
 3. Aspirin
 4. Thermometers, blood pressure apparatus
 5. Water pitchers
 6. Alcohol prep
 7. Ice bags
5. Maximum reimbursement is set for the following line item charges:
- a. IV pump/daily – \$50.00
 - b. Venipuncture reimbursement is limited to \$4.25 per collection. A collection fee is not appropriate for finger stick, throat culture, or stool specimen collection.
 - c. Pharmacy add-mixture/dispensing fee is limited to \$4.50 per mixture.
- C. Implants, Durable Medical Equipment, and Supplies
Generally, durable medical equipment and supplies provided or administered in a hospital setting are not separately reimbursed since they are included in the payment reimbursement.

Unless otherwise specifically provided herein, implantables used in the inpatient setting are included in the applicable DRG reimbursement for inpatient treatment, and, therefore, the provider of inpatient services is not required to furnish the payer with an invoice for implantables.

For implantables used in the outpatient setting, reimbursement shall be made separately from the facility fee and all other charges, and the provider shall furnish a suitable invoice evidencing the cost of the implantable to the payer within sixty (60) days from the date of service the implantable is used. Upon receipt of this invoice, the payer shall pay the amount due within thirty (30) days thereafter.

Only the actual invoiced cost of the item(s), plus ten percent (10%), will be reimbursed. Tax, handling, and freight charges are included in the facilities invoiced cost and shall not be reimbursed separately.

D. Reimbursement Methodology

The inpatient maximum reimbursement allowable (MRA) totals are provided by DRG in this Fee Schedule. As of the effective date of this publication, the DRG maximum reimbursement allowable is based upon the 2009 CMS relative weights multiplied by the base rate as determined herein. Any DRGs outside of this Fee Schedule shall be reimbursed at seventy-five percent (75%) of charge. DRG MRAs represent payment in full, unless the outlier payment is applicable, or unless a contract between the payer and provider governs reimbursement, or unless otherwise specifically stated in this Fee Schedule.

1. DRG Payment is calculated by multiplying the Base Rate times the Relative Weight for the DRG.
2. The Base Rate for Mississippi is the current National Medicare Base Rate in effect as of the date of discharge, multiplied by two (2).
3. Common Medicare add-ons, such as for teaching hospitals (GME), DSH and Capital PPS, will not be allowed, and shall be considered as already included in the enhanced DRG Payment under this Fee Schedule.
4. All implantables shall be included in the applicable DRG reimbursement for inpatient treatment, and shall not be reimbursed separately in addition to the DRG payment.
5. Outlier Payments. To provide additional reimbursement for cases where the DRG payment is deemed inadequate by the Commission to cover the costs incurred by the facility, the Commission has established an outlier payment for high-cost cases.

The amount eligible for outlier reimbursement is equal to Total Charges minus DRG Payment, minus Implantable Charges minus Non-Covered or Non-Qualified charges (as provided in Part I.B. above) minus the Outlier Threshold. The Outlier Threshold amount shall be specific to each facility and shall be equal to one-half (1/2) of the Medicare DRG outlier threshold in effect for each facility at the time of discharge.

6. Any amount determined to be eligible for additional outlier reimbursement shall be reimbursed at fifteen percent (15%) above the facility's cost for the outlier eligible charges. Cost is determined using the facility's cost-to-charge ratio, as determined by Medicare (CMS), which is in effect at the time of discharge. Outlier payment is figured by multiplying the eligible outlier amount by the cost-to-charge ratio, and then adding fifteen percent (15%) to compute the additional outlier payment due.

E. Instructions

The current CMS base rate payment and related files may be found by:

1. Going to www.cms.gov
2. Select the Medicare link (currently, upper left in the list)
3. Select Acute Inpatient PPS (currently under Medicare Fee-for-Service Payment heading in the right-hand side column)
4. From this page, you can get either the rules or the data files
5. The current base rate will be in the rules. To find it:

- a. Select IPPS Regulations and Notices in left-hand column.
 - b. Click on the year column so the most recent years are at the top.
 - c. Find "Hospital Inpatient Prospective Payment Systems and FY 2008 Rates" (The year will change annually. Remember, CMS inpatient is on the federal fiscal year, so the new year begins October 1 each year).
 - d. Click on the link for the year. Usually, there will be a Published/Draft option. The published option is as the rule appeared in the *Federal Register*.
 - e. Look for a table headlined: NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR. (The headline may be slightly different. Typically, this is one of the first tables in the document).
 - f. The wage index for Mississippi hospitals is less than 1.0. The full update amount should be used. Therefore, find the line reading: Final Rate for FY 2007 (after multiplying FY 2006 base rate by above factors) where the wage index is less than or equal to 1.0000.
Labor: \$3,094.17, Nonlabor: \$1,896.43
 - g. Adding those two amounts together produces \$4,990.60, which is the 2006 National Base Rate.
6. The hospital cost-to-charge ratio, used for reducing outliers to cost as well as the DRG relative weights, is found in the Inpatient Prospective Payment System data files from the page in Step 4 above:
- a. Click on Acute Inpatient Files for Download
 - b. Sort by year so the most recent years are at the top.
 - c. The MS-DRG relative weight file will be Table 5. Note: Make sure you select the correct fiscal year as proposed files for next year may be in this list.
 - d. The cost to charge ratio will be in Impact file for IPPS FY 2008 Final Rule November 2007
 - e. After downloading, the Impact File will be an Excel spreadsheet. CMS changes the column names from time to time, but the cost to charge ratio is in a column called OPCCR (Column Q in the 2008 version).
- F. Emergency Room Services
Emergency room facility fees, supplies, and treatment are reimbursed according to the Ambulatory Payment Classification system, as set forth herein under the heading "Ambulatory Surgery Center/Outpatient Facility Reimbursement" - at a discount of twenty percent (20%) off billed charges. Radiology, lab, and physician services are reimbursed according to the Rules contained elsewhere in this Fee Schedule.
- G. Observation Services
1. Definition
Observation services are those services furnished by a hospital on the hospital's premises, and include use of a bed and periodic monitoring by a hospital's staff. The service must be reasonable and necessary to evaluate a patient's condition or to determine need for inpatient admission. To qualify for observation status, the patient needs observation due to an unforeseen circumstance or has a medical condition with a significant degree of instability.
 2. General Guidelines
 - a. Observation begins when the patient monitoring begins and ends when the order for discharge is written or given verbally by the physician.

- b. On rare occasions, an observation stay may be extended to forty-eight (48) hours. In such cases, medical necessity must be established and pre-authorization must be given for payment by the payer.
 - c. Services which are NOT considered necessary for observation are as follows:
 - 1. Services that are not reasonable and necessary for the diagnosis and treatment of the work related injury, but are provided for convenience of the patient, family, or physician.
 - 2. Any substitution of an outpatient observation for a medically appropriate inpatient admission.
 - 3. Services ordered as inpatient by the physician but billed as outpatient by the facility.
 - 4. Standing orders for observation following outpatient surgery.
 - 5. Test preparation for a surgical procedure.
 - 6. Continued care of a patient who has had a significant procedure as identified with OPPS indicator S or T.
 - d. Observation is not reimbursable for routine preparation furnished prior to an outpatient service or recovery after an outpatient service. Please refer to the criteria for observation services.
3. Billing and Reimbursement
- a. Observation status is billed at an hourly monitoring rate. The hourly rate is all inclusive with the exception of non-significant ancillary services.
 - b. Observation is billed at the rate of \$300.00 for the first three (3) hours and \$80.00 per hour thereafter. Laboratory and radiology are reimbursed according to the Fee Schedule payment limits.
 - c. Revenue code 762 is used to bill observation charges.
 - d. Observation services provided to a patient who is subsequently admitted as an inpatient should be included on the inpatient claim.
- H. Disputed Medical Charges; Abusive or Unfair Billing
- 1. Disputes over charges, fees, services, or other issues related to treatment under the terms of the Workers' Compensation Law shall be resolved in accordance with the Dispute Resolution Rules set forth elsewhere in this Fee Schedule.
 - 2. If the Commission determines that the charge amount for items substantially and consistently exceeds the facility's mark-up ratio, or if a facility's charges for other services or DRGs is substantially and consistently higher than the average charges made for the same services or DRGs by other facility's in the State, then the Commission may consider this to be an indication of abusive or unfair billing practices, and may order the facility in question to appear and show cause why penalties and other sanctions as allowed by Law should not be imposed on said facility for such abusive billing practices.
- For purposes of this provision, the mark-up ratio shall be the inverse of the facility's cost-to-charge ratio. The average charges by facilities for service or DRGs may be determined by reference to the publicly available Medpar file for Medicare inpatient admissions, with due consideration being given to the differences between the Medicare inpatient population and the workers' compensation inpatient population.

II. INPATIENT REHABILITATION FACILITIES (IRFs)

A. Inpatient Rehabilitation Facility Reimbursement Methodology

MWCC reimbursement for inpatient rehabilitation facilities (IRFs) will be based upon the CMS prospective payment system (PPS).

1. The MWCC Fee Schedule maximum reimbursement allowance for IRFs will be twice the IRF CMS pricer calculation, unless the payer and provider have a separate contract governing the reimbursement of services provided by an IRF.
2. The IRF reimbursement due under this Fee Schedule will be calculated using the CMS IRF pricer calculation in effect on the date of discharge.
3. The CMS IRF pricer is used only for facilities that have met the CMS qualifications for IRF.
4. Reimbursement for IRFs is not calculated using the DRG methodology.
5. The CMS IRF pricer is available at: http://www.cms.hhs.gov/PCPricer/D8_IRF.asp

B. CMS Inpatient Rehabilitation Facility Reimbursement

Medicare regulations define inpatient rehabilitation facilities (IRFs) in the Code of Federal Regulations, Part 412, and subpart B. Medicare payments to IRFs are based on the IRF prospective payment system (PPS) under subpart P of part 412. The IRF must be currently accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), licensed by the State, and certified by Medicare as an IRF at the time the patient is treated.

The IRF must possess a Medicare/Medicaid provider number, or CMS Certification Number. The provider number consists of six digits. The first two digits indicate the state, 25 is for Mississippi, and the remaining four digits identify the facility as an IRF. The four digit suffix must be in the range of 3025-3099 for rehabilitation facilities, exempt units must have a T in the third position, e.g., 25TXXX. (<http://www.cms.hhs.gov/transmittals/downloads/R29SOMA.pdf>)

Unless governed by contract between payer and provider, or unless total billed charges are less, the reimbursement for an IRF under this Fee Schedule shall be the IRF PPS calculated rate multiplied by two. Other inpatient DRG or PPS calculations are not appropriate to use for IRF services. The IRF PPS rate is calculated using the formula for the current fiscal year, including outlier. The final calculation is published in the *Federal Register*, prior to October 1 of each year, or at <http://www.cms.hhs.gov/inpatientrehabfacpps/downloads/cms1551f.pdf>.

IRF reimbursement is based upon the case mix group (CMG) to which the patient is assigned. MWCC will accept the CMG assigned by the Medicare CMG grouper. The CMG must be reported on the claim with revenue code 0024. This code indicates that this claim is being paid under the PPS and the revenue code can appear on a claim only once.

The *Federal Register* explains the formula for calculating the IRF PPS rate. The rates are calculated on case mix group (CMG) assignment from the combinations of ICD-9-CM codes with additional factors of labor share, wage index, rural adjustment (if applicable) and low income percentage (LIP) for a final adjusted IRF PPS reimbursement.

This calculated IRF PPS reimbursement is multiplied by two for the MWCC reimbursement rate.

- Unadjusted IRF PPS (CMG Tier 1, 2, 3, or no comorbidities)
- x Labor Share (FY 2007 *Federal Register* Table 5)
- = Labor portion of federal payment.

- x CBSA Based Wage Index (See Federal Register Table I) Jackson, MS
- = Wage-Adjusted Amount
- + Non-labor amount (Unadjusted federal PPS less labor portion of federal payment)
- = Wage-adjusted federal payment
- x Rural Adjustment (See Federal Register)
- = Wage and rural adjusted federal payment
- x LIP adjustment (low income percentage based on disproportionate share hospital (DSH) calculation)
- = Wage, rural and LIP adjusted federal PPS payment rate
- x 2 (MWCC reimbursement adjustment)
- = MWCC IRF PPS adjusted payment

MWCC will use the Medicare Pricer which is available as a free download from: (http://www.cms.hhs.gov/PCPricerDS_IRF.asp#TopOfPage). The Medicare pricer returns the payment rate specific to the facility

Pricer returns the following information:

- *
- PS Return Code
- MSA /CBSA (effective October 1, 2005)
- Wage Index
- Average LOS
- Relative Weight
- Total Payment Amount
- PPS Federal Payment Amount
- Facility Specific Payment Amount
- Outlier Payment Amount
- Low-income Payment (LIP) Amount
- Teaching Amount (effective October 1, 2005)
- LOS
- Regular Days Used

- LTR Days Used
- Transfer Percentage
- Facility Specific Rate pre-blend
- Standard Payment Amount
- PPS federal amount pre-blend
- Facility costs
- Outlier threshold
- Submitted HIPPS/CMG code
- PPS Pricer CMG code
- Calculation version code

III. AMBULATORY SURGERY CENTER/OUTPATIENT FACILITY REIMBURSEMENT

A. Reimbursement for all hospital-based outpatient and freestanding ambulatory surgery center services shall be based on the Ambulatory Payment Classification (APC) system as developed by the Centers for Medicare and Medicaid Services (CMS) beginning January 1, 2008. The Base Rate effective from and after July 1, 2010 for payments made under this Schedule is \$91.10.

B. For implantables used in the outpatient setting, reimbursement shall be made separately from the facility fee and all other charges; the provider shall furnish a suitable invoice evidencing the cost of the implantable to the payer within sixty (60) days from the date of service. Upon receipt of this invoice, the payer shall pay the amount due within thirty (30) days thereafter. Implantables shall be reimbursed at payer cost plus ten percent (10%).

A "suitable invoice" is an acquisition invoice from the manufacturer that contains pricing information showing the actual cost of the implant(s) being billed, or, as in situations such as a bulk purchase, containing information from which the actual cost of the implant(s) can be readily determined. The invoice must be on company letterhead or other identifiable documentation from the implant manufacturer, not the hospital/facility, unless otherwise agreed to by the payer. Reimbursement is limited to 110% of the original manufacturer's invoice price.

C. All "C" status and "E" status codes shall be paid using a relative weight of twenty-three (23).

D. Status Code "N" items and services are packaged into APC rates, and are paid under OPPS; payment is packaged into payment for other services including outliers. Therefore, there is no separate APC payment. Status Code "P" (Partial hospitalization) is also paid under OPPS.

E. If more than one surgical procedure is furnished in a single operative encounter, the multiple procedure rule applies. The primary procedure is reimbursed at one hundred percent (100%) of the maximum reimbursable allowance (MRA), the second and subsequent procedures are reimbursed at fifty percent (50%).

F. Outlier Payments: In an effort to target outliers to high cost and complex cases where a very costly service could cause a facility to incur a significant financial loss, the following outlier payment formula is to be used to calculate the appropriate, additional reimbursement:

Step 1: Reduce charges to cost using the default cost to charge ratio. The current default cost to charge ratio for urban facilities is 0.244; the current default ratio for rural facilities is 0.192.

Step 2: Deduct implantable cost as it's paid separately. This is the cost of furnishing the service.

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Step 1. Test to see if outlier meets 1.75 condition. Is the number from Step 2 more than 1.75 times the ASC payment rate? If no, no outlier payment is due. If yes, proceed to Step 4.

Step 4. Test to see if outlier meets the \$2,175 threshold test. Add \$2,175 to the ASC payment rate; is the total more or less than the figure from Step 2 (the cost of furnishing the service)? If greater than the figure in Step 2, no outlier is due; if less than the figure in Step 2, proceed to Step 5.

$$\text{Step 5. Determine outlier payment: } \frac{\text{Cost} - (\text{ASC payment} \times 1.75)}{2}$$

OR

$$(\text{Step 2 Amount} - \text{Step 3 Amount})/2$$

EXAMPLE: As an example of how this might work, Hospital X, an urban facility, bills \$90,000 for CPT 23470 (reconstruct shoulder joint). We will assume there is a \$2,500-cost implantable device used and that MWCC payment is \$10,830.

Step 1. Reduce charges to cost using the default cost to charge ratio:

$$\$90,000 \times 0.244 = \underline{\$21,960}$$

Step 2. Deduct implantable cost as it's paid separately:

$$\$21,960 - \$2,500 = \underline{\$19,460}$$

Step 3. Test to see if outlier meets 1.75 condition:

$$\$10,830 \times 1.75 = \underline{\$18,952}$$

Is \$19,460 = \$18,952? Yes, it is more than 1.75 times the payment.

Step 4. Test to see if outlier meets the \$2,175 test:

$$\$10,830 + \$2,175 = \underline{\$13,005}$$

Is \$19,460 = \$13,005? Yes, it is more than \$2,175.

Step 5. Determine outlier payment:

$$\frac{\text{Cost} - (\text{ASC payment} \times 1.75)}{2}$$

$$\frac{\$19,460 - (\$10,830 \times 1.75)}{2} = \underline{\$254}$$

The outlier payment in this case would be \$254.

The Mississippi Workers' Compensation Commission has adopted and continues to use the Medicare Ambulatory Payment Groups which were in effect under this Fee Schedule as of November 1, 2004, for classifying payment of facility fees to Ambulatory Surgery Centers. The payment groups and allowable facility fees are as follows:

Payment Group Total	Allowable Facility Fee
1	\$ 475.00
2	\$ 637.00
3	\$ 729.00
4	\$ 900.00
5	\$1,024.00
6	\$1,161.00
7	\$1,423.00
8	\$1,401.00
9	\$2,100.00

FEE DATA NOTES

1. All professional fees are based on existing RBRVS values and conversion factors as of August 1, 2007, EXCEPT:
 - A. New CPT codes from 2008 are valued using 2008 RBRVS;
 - B. New CPT codes from 2009 and 2010 are valued using 2010 RBRVS with no change to current conversion factors;
 - C. Anesthesia units are updated to the 2010 ASA Relative Value Guide;
 - D. Dental codes are updated to the 2010 RBRVS.

2. Outpatient facility fees are based on the 2010 Ambulatory Payment Classification system, with a base rate of \$91.19.
 - A. "C" and "E" status codes are included, and assigned a relative weight of 23.

Introduction

Pursuant to Mississippi Code Annotated (MCA), section 71-3-15(3)(Rev. 2000), the following Fee Schedule, including Cost Containment and Utilization Management rules and guidelines, is hereby established in order to implement a medical cost containment program. This Fee Schedule, and accompanying rules and guidelines, applies to medical services rendered after the effective date of July 1, 2010, and, in the case of inpatient treatment, to services where the discharge date is on or after July 1, 2010. This Fee Schedule establishes the maximum level of medical and surgical reimbursement for the treatment of work-related injuries and/or illnesses, which the Mississippi Workers' Compensation Commission deems to be fair and reasonable.

This Fee Schedule shall be used by the Workers' Compensation Commission, insurance payers, and self-insurers for approving and paying medical charges of physicians, surgeons, and other health care providers for services rendered under the Mississippi Workers' Compensation Law. This Fee Schedule applies to all medical services provided to injured workers by physicians, and also covers other medical services arranged for by a physician. In practical terms, this means professional services provided by hospital-employed physicians, as well as those physicians practicing independently, are reimbursed under this Fee Schedule.

The Commission will require the use of the most current version of the CPT book and HCPCS codes and modifiers in effect at the time services are rendered. All coding, billing and other issues, including disputes, associated with a claim, shall be determined in accordance with the CPT rules and guidelines in effect at the time service is rendered, unless otherwise provided in this Fee Schedule or by the Commission. As used in this Fee Schedule, CPT refers to the American Medical Association's *Current Procedural Terminology* codes and nomenclature. CPT is a registered trademark of the American Medical Association. HCPCS is an acronym for the Centers for Medicare and Medicaid Services' (CMS) Healthcare Common Procedure Coding System and includes codes for procedures, equipment, and supplies not found in the CPT book. However, the inclusion of a service, product or supply in the CPT book or HCPCS book does not necessarily imply coverage, reimbursement or endorsement.

I. FORMAT

This Fee Schedule is comprised of the following sections: Introduction; General Rules; Billing and Reimbursement Rules; Medical Records Rules; Dispute Resolution Rules; Utilization Review Rules; Rules for Modifiers and Code Exceptions; Pharmacy Rules; Nurse Practitioner and Physician Assistant Rules; Home Health Rules; Skilled Nursing Facility Rules; Evaluation and Management; Anesthesia; Pain Management; Surgery; Radiology; Pathology and Laboratory; Medicine Services; Physical Medicine; Dental; Durable Medical Equipment (DME), Orthotics, Prosthetics and Other HCPCS Codes; Inpatient Hospital Payment Schedule and Rules, and Forms. Each section listed above has specific instructions (rules/guidelines). The Fee Schedule is divided into these sections for structural purposes only. Providers are to use the specific section(s) that contains the procedure(s) they perform or the service(s) they render. In the event a rule/guideline contained in one of the specific service sections conflicts with a general rule/guideline, the specific section rule/guideline will supersede.

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This Fee Schedule utilizes *Current Procedural Terminology* (CPT) codes and guidelines under copyright agreement with the American Medical Association. The descriptions included are full procedure descriptions. A complete list of modifiers is included in a separate section for easy reference.

II. SCOPE

The *Mississippi Workers' Compensation Medical Fee Schedule* does the following:

- A. Establishes rules/guidelines by which the employer shall furnish, or cause to be furnished, to an employee who suffers a bodily injury or occupational disease covered by the Mississippi Workers' Compensation Law, reasonable and necessary medical, surgical, and hospital services, medicines, supplies or other attendance or treatment as necessary. The employer shall provide to the injured employee such medical or dental surgery, crutches, artificial limbs, eyes, teeth, eyeglasses, hearing apparatus, and other appliances which are reasonable and necessary to treat, cure, and/or relieve the employee from the effects of the injury/illness, in accordance with MCA §71-3-15 (Rev. 2000), as amended.
- B. Establishes a schedule of maximum reimbursement allowances (MRA) for such treatment, attendance, service, device, apparatus, or medicine.
- C. Establishes rules/guidelines by which a health care provider shall be paid the lesser of (a) the provider's total billed charge, or (b) the maximum reimbursement allowance (MRA) established under this Fee Schedule.
- D. Establishes rules for cost containment to include utilization review of health care and health care services, and provides for the acquisition by an employer/payer, other interested parties, and the Mississippi Workers' Compensation Commission, of the necessary records, medical bills, and other information concerning any health care or health care service under review.
- E. Establishes rules for the evaluation of the appropriateness of both the level and quality of health care and health care services provided to injured employees, based upon medically accepted standards.
- F. Authorizes employers/payers to withhold payment from, or recover payment from, health facilities or health care providers that have made excessive charges or which have provided unjustified and/or unnecessary treatment, hospitalization, or visits.
- G. Provides for the review by the employer/payer or Commission any health facility or health care provider records and/or medical bills that have been determined not to be in compliance with the schedule of charges established herein.
- H. Establishes that a health care provider or facility may be required by the employer/payer to explain in writing the medical necessity of health care or health care service that is not usually associated with, is longer and/or more frequent than, the health care or health care service usually accompanying the diagnosis or condition for which the patient is being treated.
- I. Provides for medical cost containment review and decision responsibility. The rules and definitions hereunder are not intended to supersede or modify the Workers' Compensation Act, the administrative rules of the Commission, or court decisions interpreting the Act or the Commission's administrative rules.
- J. Provides for the monitoring of employer/payers to determine their compliance with the criteria and standards established by this Fee Schedule.
- K. Establishes deposition/witness fees.
- L. Establishes fees for medical reports.

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- M. Provides for uniformity in billing of provider services.
- N. Establishes rules/guidelines for billing.
- O. Establishes rules/guidelines for reporting medical claims for service.
- P. Establishes rules/guidelines for obtaining medical services by out-of-state providers.
- Q. Establishes rules/guidelines for Utilization Review to include pre-certification, concurrent review, discharge planning and retrospective review.
- R. Establishes rules for dispute resolution which includes an appeal process for determining disputes which arise under this Fee Schedule.
- S. Establishes a Peer Review system for determining medical necessity. Peer review is conducted by professional practitioners of the same specialty as the treating medical provider on a particular case.
- T. Establishes the list of health care professionals who are considered authorized providers to treat employees under the Mississippi Workers' Compensation Law; and who, by reference in this rule, will be subject to the rules, guidelines and maximum reimbursement limits in this Fee Schedule.
- U. Establishes financial and other administrative penalties to be levied against payers or providers who fail to comply with the provisions of the Fee Schedule, including but not limited to interest charges for late billing or payment, percentage penalties for late billing or payment, and additional civil penalties for practices deemed unreasonable by the Commission.

III. MEDICAL NECESSITY

The concept of medical necessity is the foundation of all treatment and reimbursement made under the provision of section 71-3-15, Mississippi Code of 1972, as amended. For reimbursement to be made, services and supplies must meet the definition of "medically necessary." Utilization management or review decisions shall not be based solely on the application of clinical guidelines, but must include review of clinical information submitted by the provider and represent an individualized determination based on the worker's current condition and the concept of medical necessity predicated on objective or appropriate subjective improvements in the patient's clinical status.

- A. For the purpose of the Workers' Compensation Program, any reasonable medical service or supply used to identify or treat a work-related injury/illness which is appropriate to the patient's diagnosis, is based upon accepted standards of the health care specialty involved, represents an appropriate level of care given the location of service, the nature and seriousness of the condition, and the frequency and duration of services, is not experimental or investigational, and is consistent with or comparable to the treatment of like or similar non-work related injuries, is considered "medically necessary." The service must be widely accepted by the practicing peer group, based on scientific criteria, and determined to be reasonably safe. It must not be experimental, investigational, or research in nature except in those instances in which prior approval of the payer has been obtained. For purposes of this provision, "peer group" is defined as similarly situated physicians of the same specialty, licensed in the State of Mississippi, and qualified to provide the services in question.
- B. Services for which reimbursement is due under this Fee Schedule are those services meeting the definition of "medically necessary" above and includes such testing or other procedures reasonably necessary and required to determine or diagnose whether a work-related injury or illness has been sustained, or which are required for the remedial treatment or diagnosis of an on-the-job injury, a

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work-related illness, a pre-existing condition affected by the injury or illness, or a complication resulting from the injury or illness, and which are provided for such period as the nature of the injury or process of recovery may require.

- C. Treatment of conditions unrelated to the injuries sustained in an industrial accident may be denied as unauthorized if the treatment is directed toward the non-industrial condition or if the treatment is not deemed medically necessary for the patient's rehabilitation from the industrial injury

IV. DEFINITIONS

Act means Mississippi Workers' Compensation Law, Mississippi Code Annotated (MCA), section 71-3-1 et seq. (Rev. 2000 as amended)

Adjust means that a payer or a payer's agent reduces or otherwise alters a health care provider's request for payment.

Appropriate care means health care that is suitable for a particular patient, condition, occasion, or place.

Bill means a claim submitted by a provider to a payer for payment of health care services provided in connection with a covered injury or illness.

Bill adjustment means a reduction of a fee on a provider's bill, or other alteration of a provider's bill.

By report (BR) means that the procedure is new, or is not assigned a maximum fee, and requires a written description included on or attached to the bill. "BR" procedures require a complete listing of the service, the dates of service, the procedure code, and the payment requested. The report is included in the reimbursement for the procedure.

Carrier means any stock company, mutual company, or reciprocal or inter-insurance exchange authorized to write or carry on the business of Workers' Compensation insurance in this State, or self-insured group, or third-party payer, or self-insured employer, or uninsured employer

CMS-1500 means the CMS-1500 form and instructions that are used by non-institutional providers and suppliers to bill for outpatient services. Use of the most current CMS-1500 form is required.

Commission means the Mississippi Workers' Compensation Commission.

Case means a covered injury or illness occurring on a specific date and identified by the worker's name and date of injury or illness

Consultation means a service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. If a consultant, subsequent to the first encounter, assumes responsibility for management of the patient's condition, that physician becomes a treating physician. The first encounter is a consultation and shall be billed and reimbursed as such. A consultant shall provide a written report of his/her findings. *A second opinion is considered a consultation.*

Controverted claim is a workers' compensation claim which is pending before the Commission and in which the patient or patient's legal representative has filed a Petition to Controvert.

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Covered injury or illness means an injury or illness for which treatment is mandated under the Act.

Critical care means care rendered in a variety of medical emergencies that requires the constant attention of the practitioner, such as cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, and is usually provided in a critical care unit or an emergency department.

Day means a continuous 24-hour period.

Diagnostic procedure means a service that helps determine the nature and causes of a disease or injury.

Durable medical equipment (DME) means specialized equipment designed to stand repeated use, appropriate for home use, and used solely for medical purposes.

Expendable medical supply means a disposable article that is needed in quantity on a daily or monthly basis.

Follow-up care means the care which is related to the recovery from a specific procedure and which is considered part of the procedure's maximum reimbursement allowance, but does not include complications.

Follow-up days are the days of care following a surgical procedure which are included in the procedure's maximum reimbursement allowance amount, but which do not include complications. The follow-up day period begins on the day of the surgical procedure(s).

Health care review means the review of a health care case, bill, or both by the payer or the payer's agent.

Incident to means that the services and supplies are commonly furnished as an integral part of the primary service or procedure.

Incidental surgery means surgery performed through the same incision, on the same day, by the same doctor, not increasing the difficulty or follow-up of the main procedure, or not related to the diagnosis.

Incorrect payment means the provider was not reimbursed according to the rules/guidelines of the Fee Schedule and the payer has failed to provide any reasonable basis for the adjusted payment.

Independent medical examination (IME) means a consultation provided by a physician to evaluate a patient at the request of the Commission. This evaluation may include an extensive record review and physical examination of the patient and requires a written report.

Independent procedure means a procedure that may be carried out by itself, completely separate and apart from the total service that usually accompanies it.

Inpatient services means services rendered to a person who is admitted as an inpatient to a hospital.

Maximum reimbursement allowance (MRA) means the maximum fee allowed for medical services as set forth in this Fee Schedule.

Medical only case means a case that does not involve more than five (5) days of disability or lost work time and for which only medical treatment is required.

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Medically accepted standard means a measure set by a competent authority as the rule for evaluating quality or quantity of health care or health care services and which may be defined in relation to any of the following:

- Professional performance
- Professional credentials
- The actual or predicted effects of care
- The range of variation from the norm

Medically necessary means any reasonable medical service or supply used to identify or treat a work-related injury/illness which is appropriate to the patient's diagnosis, is based upon accepted standards of the health care specialty involved, represents an appropriate level of care given the location of service, the nature and seriousness of the condition, and the frequency and duration of services, is not experimental or investigational, and is consistent with or comparable to the treatment of like or similar non-work related injuries. Utilization management or review decisions shall not be based on application of clinical guidelines, but must include review of clinical information submitted by the provider and represent an individualized determination based on the worker's current condition and the concept of medical necessity predicated on objective or appropriate subjective improvements in the patient's clinical status.

Medical record means a record in which the medical service provider records the subjective findings, objective findings, diagnosis, treatment rendered, treatment plan, and return to work status and/or goals and impairment rating as applicable.

Medical supply means either a piece of durable medical equipment or an expendable medical supply.

Observation services means services rendered to a person who is designated or admitted to a hospital or facility as observation status.

Operative report means the practitioner's written description of the surgery and includes all of the following:

- A preoperative diagnosis;
- A postoperative diagnosis;
- A step-by-step description of the surgery;
- A description of any problems that occurred in surgery; and
- The condition of the patient upon leaving the operating room.

Optometrist means an individual licensed to practice optometry.

Orthotic equipment means an orthopedic apparatus designed to support, align, prevent, or correct deformities, or improve the function of a moveable body part.

Orthotist means a person skilled in the construction and application of orthotic equipment.

Outpatient service means services provided to patients at a time when they are not hospitalized as inpatients.

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Payer means the employer or self-insured employed group, carrier, or third-party administrator (TPA) who pays the provider billings.

Pharmacy means the place where the science, art, and practice of preparing, preserving, compounding, dispensing, and giving appropriate instruction in the use of drugs is practiced.

Practitioner means a person licensed, registered, or certified as an acupuncturist, audiologist, doctor of chiropractic, doctor of dental surgery, doctor of medicine, doctor of osteopathy, doctor of podiatry, doctor of optometry, massage therapist, nurse, nurse anesthetist, nurse practitioner, occupational therapist, orthotist, pharmacist, physical therapist, physician assistant, prosthetist, psychologist, or other person licensed, registered, or certified as a health care professional or provider.

Primary procedure means the therapeutic procedure most closely related to the principal diagnosis, and in billing, the CPT code with the highest relative value unit (RVU) that is neither an add-on code nor a code exempt from modifier 51 shall be considered the primary procedure. Reimbursement for the primary procedure is not dependent on the ordering or re-ordering of codes.

Procedure means a unit of health service.

Procedure code means a five-digit numerical sequence or a sequence containing an alpha character and preceded or followed by four digits, which identifies the service performed and billed.

Properly submitted bill means a request by a provider for payment of health care services submitted to a payer on the appropriate forms with appropriate documentation and within the time frame established under the guidelines of the Medical Fee Schedule.

Prosthesis means an artificial substitute for a missing body part.

Prosthetist means a person skilled in the construction and application of prostheses.

Provider means a facility, health care organization, or a practitioner who provides medical care or services.

Secondary procedure means a surgical procedure performed during the same operative session as the primary surgery but considered an independent procedure that may not be performed as part of the primary surgery.

Special report means a report requested by the payer to explain or substantiate a service or clarify a diagnosis or treatment plan.

Specialist means a board-certified practitioner, board-eligible practitioner, or a practitioner otherwise considered an expert in a particular field of health care service by virtue of education, training, and experience generally accepted by practitioners in that particular field of health care service.

Usual and customary rate/fee is a reimbursement allowance equal to the amount displayed by the Ingenix MDR Charge Payment System (Mississippi State Version) for the procedure at the 40th percentile. The Ingenix MDR Charge Payment System is a national database of Relative and Actual Charge Data (RACD) which includes charge information for the State of Mississippi.

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V. HOW TO INTERPRET THE FEE SCHEDULE

CPT Code

The first column lists the American Medical Association's (AMA) CPT code. CPT 2008 codes are used by arrangement with the AMA.

Add-on Codes

* denotes procedure codes that are considered "add-on" codes as defined in the CPT book.

Modifier 51 Exempt

* denotes procedure codes that are exempt from the use of modifier 51 and are not designated as add-on procedures/services as defined in the CPT book.

Conscious Sedation

K denotes procedure codes that include conscious sedation as an inherent part of providing the procedure.

Description

This Fee Schedule uses actual 2008 CPT full descriptions.

Relative Value

This column lists the relative value unit (RVU) assigned to each procedure. There are, however, procedures too variable to accept a set value—these are "by report" procedures and are noted BR.

Amount

This column lists the total reimbursable as a monetary amount.

PC Amount

Where there is an identifiable professional and technical component to a procedure, the portion considered to be the professional component is listed. The professional component gives the total reimbursable as a monetary amount. The technical component can be identified as the Amount minus the PC Amount.

FUD

Follow-up days included in a surgical procedure's global charge are listed in this column.

Assist Surg

The assistant surgeon column identifies procedures that are approved for an assistant to the primary surgeon whether a physician, physician assistant (PA), registered nurse first assistant (RNFA, RA), or other individual qualified for reimbursement as an assistant under the Fee Schedule.

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ASC Amount

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Ambulatory Surgery Center (ASC) payment is made for facility services furnished in conjunction with outpatient surgical procedures.

Facility Fee

The facility fee is paid to the facility for the technical portion of services provided in conjunction with outpatient pain management, pathology, laboratory, and radiology procedures.

VI. AUTHORIZED PROVIDERS

The following health care providers are recognized by the Mississippi Workers' Compensation Commission as acceptable to provide treatment to injured workers under the terms of the Act, and must comply with the rules, guidelines, billing and reimbursement policies and maximum reimbursement allowance (MRA) contained in this Fee Schedule when providing treatment or service under the terms of the Act.

- Acupuncturist (L.A.C.)
- Audiologist
- Certified Registered Nurse Anesthetist (C.R.N.A.)
- Doctor of Chiropractic (D.C.)
- Doctor of Dental Surgery (D.D.S.)/Doctor of Dental Medicine (D.D.M.)
- Doctor of Osteopathy (D.O.)
- Licensed Clinical Social Worker (L.C.S.W.)
- Licensed Nursing Assistant
- Licensed Practical Nurse (L.P.N.)
- Massage Therapist
- Medical Doctor (M.D.)
- Nurse Practitioner (N.P.)
- Occupational Therapist (O.T.)
- Optometrist (O.D.)
- Oral Surgeon (M.D., D.O., D.M.D., D.D.S.)
- Pharmacist (R.Ph.)
- Physical Therapist (P.T.)
- Physical or Occupational Therapist Assistant (P.T.A.)
- Physician Assistant (P.A.)
- Podiatrist (D.P.M.)
- Prosthetist or Orthotist
- Psychologist (Ph.D.)
- Registered Nurse (R.N.)
- Registered Nurse First Assistant (R.N.F.A., R.A.)
- Speech Therapist

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All health care providers, as listed herein, are subject to the rules, limitations, exclusions, and maximum reimbursement allowances of this Fee Schedule. Medical treatment under the terms of the Act may be provided by any other person licensed, registered or certified as a health care professional if approved by the payer or Commission, and in such case, said provider and payer shall be subject to the rules and guidelines, including maximum reimbursement amounts, provided herein.

VII. INFORMATION PROGRAM

The Workers' Compensation Commission shall provide ongoing information regarding this Fee Schedule for providers, payers, their representatives and any other interested persons or parties. This information shall be provided primarily through informational sessions and seminar presentations at our Annual Education Conference as well as the distribution of appropriate information materials via the Commission's website, and by other means as needed.

General Rules

I. CONFIRMATORY CONSULTATION

As provided in section 71-3-15(1) of the Act, and in M.W.C.C. General Rule 9, a payer/employer may request a second opinion examination or evaluation for the purpose of evaluating temporary or permanent disability or medical treatment being rendered. This examination is considered a confirmatory consultation. The confirmatory consultation is billed using the appropriate level and site-specific consultation code with modifier 32 appended to indicate a mandated service and paid in accordance with the Fee Schedule.

II. CODING STANDARD

- A. The most current version of the American Medical Association's *Current Procedural Terminology* (CPT) book, and, where appropriate, the codes and descriptors of the American Society of Anesthesiologists' *Relative Value Guide*™, in effect at the time service is rendered or provided shall be the authoritative coding guide, unless otherwise specified in this Fee Schedule.
- B. The most current version of HCPCS Level II codes developed by CMS in effect at the time service is rendered or provided shall be the authoritative coding guide for durable medical equipment, prosthetics, orthotics, and other medical supplies (DMEPOS), unless otherwise specified in this Fee Schedule.

III. DEPOSITION/WITNESS FEES; MEDICAL RECORDS AFFIDAVIT

- A. Any health care provider who gives a deposition or is otherwise subpoenaed to appear in proceedings pending before the Commission shall be paid a witness fee as provided by M.W.C.C. Procedural Rule 18(h) in the amount of \$25.00 per day plus mileage reimbursement at the rate authorized by M.W.C.C. General Rule 14. Procedure code 99075 must be used to bill for a deposition.
- B. In addition to the above fee and mileage reimbursement, any health care provider who gives testimony by deposition or who appears in person to testify at a hearing before the Commission shall be paid \$500.00 for the first hour and \$125.00 per quarter hour thereafter. This fee includes necessary preparation time. In the event a deposition is cancelled through no fault of the provider, the provider shall be entitled to a payment of \$250.00 unless notice of said cancellation is given to the provider at least 72 hours in advance. In the event a deposition is cancelled through no fault of the provider within 24 hours of the scheduled time, then, in that event, the provider shall be paid the rate due for the first hour of a deposition. Nothing stated herein shall prohibit a medical provider and a party seeking to take the medical provider's deposition from entering into a separate contract which provides for reimbursement other than as above provided.

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- C. Pursuant to Mississippi Workers' Compensation Commission Procedural Rule 9, an examining or treating physician may execute an affidavit in lieu of direct testimony. The Physician's Medical Record Custodian is allowed to sign the affidavit in lieu of the physician's signature. Such charge for execution of the affidavit is limited to a maximum reimbursement of \$25.00. Reimbursement for copies of medical records that are attached to affidavits shall be made as outlined elsewhere in the Fee Schedule.

IV. IMPAIRMENT RATING

- A. In determining the extent of permanent impairment attributable to a compensable injury, the provider shall base this determination on the most current edition of the *Guides to the Evaluation of Permanent Impairment*, as published and copyrighted by the American Medical Association which is in effect at the time the service is rendered. Only a medical doctor is entitled under these rules to reimbursement for conducting an impairment rating evaluation.
- B. A provider is entitled to reimbursement for conducting an impairment rating evaluation and determining the extent of permanent impairment, and should bill for such services using CPT codes 99455. The reimbursement for CPT code 99455 shall be \$250.00.

V. INDEPENDENT MEDICAL EXAMINATION (IME)

- A. An independent medical examination (IME) may be ordered by the Mississippi Workers' Compensation Commission or its Administrative Judges. A practitioner other than the treating practitioner must do the medical examination, and the Commission or Judge shall designate the examiner.
- B. An independent medical examination (IME) shall include a study of previous history and medical care information, diagnostic studies, diagnostic x-rays, and laboratory studies, as well as an examination and evaluation. An IME can only be ordered by the Workers' Compensation Commission or one of its Administrative Judges. A copy of the report must be sent to the patient, or his attorney if represented, the payer, and the Mississippi Workers' Compensation Commission.
- C. The fee for the IME may be set by the Commission or Judge, or negotiated by the payer and provider prior to setting the appointment, and in such cases, reimbursement shall be made according to the order of the Commission or Judge, or according to the mutual agreement of the parties. In the absence of an agreement or order regarding reimbursement for an IME, the provider shall bill for the IME using the appropriate level and site-specific consultation code appended with modifier 32 to indicate a mandated service, and shall be reimbursed according to the Fee Schedule.

VI. MAXIMUM MEDICAL IMPROVEMENT

- A. When an employee has reached maximum medical improvement (MMI) for the work related injury and/or illness, the physician should promptly, and at least within fourteen (14) days, submit a report to the payer showing the date of maximum medical improvement.
- B. Maximum medical improvement is reached at such time as the patient reaches the maximum benefit from medical treatment or is as far restored as the permanent character of his injuries will permit and/or the current limits of medical science will permit. Maximum medical improvement may be found even though the employee will require further treatment or care.

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VII. OUT-OF-STATE MEDICAL TREATMENT

- A. Each employer shall furnish all reasonable and necessary drugs, supplies, hospital care and services, and medical and surgical treatment for the work-related injury or illness. All such care, services, and treatment shall be performed at facilities within the state when available.
- B. When billing for out-of-state services, supporting documentation is necessary to show that the service being provided cannot be performed within the state, the same quality of care cannot be provided within the state, or more cost-effective care can be provided out-of-state. In determining whether out-of-state treatment is more cost effective, this question must be viewed from both the payer and patient's perspective. As stated in General Rule 9, treatment should be provided in an area reasonably convenient to the place of the injury or the residence of the injured employee, in addition to being reasonably suited to the nature of the injury.
- C. Reimbursement for out-of-state services shall be based on one of the following, in order of preference: (1) the workers' compensation fee schedule for the state in which services are rendered, or (2) in cases where there is no applicable fee schedule for the state in which services are rendered, or the fee schedule in said state excludes or otherwise does not provide reimbursement allowances for the services rendered, reimbursement should be paid at the usual and customary rate for the geographical area in which the services are rendered, or (3) reimbursement for out-of-state services may be based on the mutual agreement of the parties.
- D. Prior authorization must be obtained from the payer for referral to out-of-state providers. The documentation must include the following:
1. Name and location of the out-of-state provider,
 2. Justification for an out-of-state provider, including qualifications of the provider and description of services being requested.

VIII. AUTHORIZATION FOR TREATMENT

- A. Prior Authorization: Providers must request authorization from the payer before service is rendered for the services and supplies listed below:
1. Non-emergency elective inpatient hospitalization
 2. Non-emergency elective inpatient surgery
 3. Non-emergency elective outpatient surgery
 4. Physical medicine treatments after 15 visits or 30 days, whichever comes first
 5. Rental or purchase of supplies or equipment over the amount of \$50.00 per item
 6. Rental or purchase of TENS
 7. Home health services
 8. Pain clinic/therapy programs, including interdisciplinary pain rehabilitation programs
 9. External spinal stimulators
 10. Pain control programs
 11. Work hardening programs, back schools, functional capacity testing, ISO kinetic testing
 12. Referral for orthotics or prosthetics
 13. Referral for acupuncture
 14. Referral for biofeedback
 15. Referral to psychological testing/counseling

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- 16. Referral to substance abuse program
 - 17. Referral to weight reduction program
 - 18. Referral to any non-emergency medical service outside the State of Mississippi
 - 19. Repeat MRI (more than one per injury)
 - 20. Repeat CT Scan (more than one per injury)
 - 21. Intraoperative neurophysiologic monitoring (e.g., SSEP, VEP, DEP, BAEP, MEP)
- B. Response Time. The payer must respond within two (2) business days to a request of prior authorization for non-emergency services.
- C. Federal Facilities. Treatment provided in federal facilities requires authorization from the payer. However, federal facilities are exempt from the billing requirements and reimbursement policies in this manual.
- D. Pre-certification for Non-emergency Surgery. Providers must pre-certify all non-emergency surgery. However, certain catastrophic cases require frequent returns to the operating room (O.R.) (e.g., burns may require daily surgical debridement). In such cases, it is appropriate for the provider to obtain certification of the treatment plan to include multiple surgical procedures. The provider's treatment plan must be specific and agreement must be mutual between the provider and the payer regarding the number and frequency of procedures certified.
- E. Retrospective Review. Failure to obtain pre-certification as required by this Fee Schedule shall not, in and of itself, result in a denial of payment for the services provided. Instead, the payer, if requested to do so by the provider within one (1) year of the date of service or discharge, shall conduct a retrospective review of the services, and if the payer determines that the services provided would have been pre-certified, in whole or in part, if pre-certification had been timely sought by the provider, then the payer shall reimburse the provider for the approved services according to the Fee Schedule; or, if applicable, according to the separate fee agreement between the payer and provider, less a ten percent (10%) penalty for the provider's failure to obtain pre-certification as required by this Fee Schedule. This penalty shall be computed as ten percent (10%) of the total allowed reimbursement. If, upon retrospective review, the payer determines that pre-certification would not have been given, or would not have been given as to part of the requested services, then the payer shall dispute the bill and proceed in accordance with the Billing and Payment Rules as hereafter provided.
- F. Authorization Provided by Employer or Payer. When authorization for treatment is sought and obtained from the employer, or payer, whether verbally or in writing, and medical treatment is rendered in good faith reliance on this authorization, the provider is entitled to payment from the employer or payer for the initial visit or evaluation, or in emergency cases, for treatment which is medically necessary to stabilize the patient. Reimbursement is not dependent on, and payment is due regardless of, the outcome of medically necessary services which are provided in good faith reliance upon authorization given by the employer or payer.

IX. RETURN TO WORK

If an employee is capable of some form of gainful employment, it is advisable for the physician to release the employee to light work and make a specific report to the payer as to the date of such release and setting out any restrictions on such light work. It can be to the employee's economic advantage to be released to light or alternative work, since he/she can receive compensation based on sixty-six and two-thirds percent (66 2/3%) of the difference between the employee's earnings in such work and the employee's pre-injury average weekly wage. The physician's judgment in such matters is extremely important, particularly as to whether the patient is medically capable of returning to work in some capacity.

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Return to work decisions should be based on objective findings, and the physician's return to work assessment should identify, if possible, any alternative duty employment to which the patient may return if return to full duty is not medically advisable.

X. SELECTION OF PROVIDERS

The selection of appropriate providers for diagnostic testing or analysis, including but not limited to CAT scans, MRI, x-ray, and laboratory, shall be at the direction of the treating or prescribing physician. In the absence of specific direction from the treating or prescribing physician, the selection shall be made by the payer, in consultation with the treating or prescribing physician.

Physical or occupational therapy, including work hardening, functional capacity evaluations, back schools, chronic pain programs, or massage therapy shall be provided upon referral from a physician. In the absence of specific direction from the treating or prescribing physician, the selection of a provider for these services shall be made by the payer in consultation with the treating or prescribing physician.

Referral for an electromyogram and/or a nerve conduction study shall be at the discretion and direction of the physician in charge of care, and neither the payer nor the payer's agent may unilaterally or arbitrarily redirect the patient to another provider for these tests. The payer or the payer's agent may, however, discuss with the physician in charge of care appropriate providers for the conduct of these tests in an effort to reach an agreement with the physician in charge as to who will conduct an electromyogram and/or nerve conduction study in any given case.

The selection of providers for the purchase or rental of durable medical equipment shall be at the direction of the payer.

The selection of providers for medical treatment or service, other than as above provided, shall be in accordance with the provisions of MCA section 71-3-15 (Rev. 2000).

XI. DRUG SCREENING

Only one (1) drug screen or drug test result shall be eligible for reimbursement for each drug test conducted on the same patient on the same day, except and unless the initial screening results are deemed by the prescribing provider to be inconsistent or inherently unreliable. In that event, a confirmation screening may be ordered by the prescribing provider and shall be paid for by the payer. In addition, treatment may not be discontinued based on the results of a drug test absent a confirmation test, which shall be reimbursed in addition to the initial screening test. Merely duplicate screenings or tests which are rerun to confirm initial results are not otherwise eligible for reimbursement.

XII. MILEAGE REIMBURSEMENT

The payer shall reimburse each claimant for all travel to obtain medical treatment which is being obtained under the provisions of the Mississippi Workers' Compensation Law, including travel to a pharmacy to obtain medication or supplies necessary for treatment of a compensable injury, regardless of the number of miles traveled. There is no minimum distance of travel required for reimbursement, and reimbursement shall be made for each mile of round trip travel necessitated by the compensable injury, at the rate adopted by the Commission and in effect at the time of the travel. Only reasonable and necessary miles traveled are subject to reimbursement.

Billing and Reimbursement Rules

I. GENERAL PROVISIONS

- A. **Maximum Reimbursement Allowance (MRA).** Unless the payer and provider have a separate fee contract which provides for a different level of reimbursement, the maximum reimbursement allowance for health care services shall be the lesser of (a) the provider's total billed charge, or (b) the maximum specific fee established by the Fee Schedule. Items or services or procedures which do not have a maximum specific fee established by this Fee Schedule shall be reimbursed at the usual and customary fee as defined in this Fee Schedule, and in such cases, the maximum reimbursement allowance shall be the lesser of (1) the provider's total billed charge, or (2) the usual and customary fee as defined by this Fee Schedule.

If this Fee Schedule does not establish a maximum specific fee for a particular service or procedure, and a usual and customary rate cannot be determined because the Ingenix MDR Charge Payment System database does not contain a fee for same, then the maximum reimbursement allowance shall be equal to the national Medicare allowance plus thirty percent (30%). In the absence of an established Medicare value, and assuming none of the above provisions apply, the maximum reimbursement allowance shall be the provider's total billed charge.

- B. **Separate Fee Contract.** An employer/payer may enter into a separate contractual agreement with a medical provider regarding reimbursement for services provided under the provisions of the Mississippi Workers' Compensation Law, and if an employer/payer has such a contractual agreement with a provider designed to reduce the cost of workers' compensation health care services, the contractual agreement shall control as to the amount of reimbursement and shall not be subject to the maximum reimbursement allowance otherwise established by the Fee Schedule. However, all other rules, guidelines and policies as provided in this Fee Schedule shall apply and shall be considered to be automatically incorporated into such agreement.
1. **Repricing Agreements.** Payers and providers may voluntarily enter into repricing agreements designed to contain the cost of workers' compensation health care after the medical care of service has been provided, and in such case, the reimbursement voluntarily agreed to by the parties shall control to the exclusion of the Fee Schedule. However, the time spent by the payer and provider attempting to negotiate a post-care repricing agreement does not extend the time elsewhere provided in this Fee Schedule for billing claims, paying claims, requesting correction of an incorrect payment, requesting reconsideration, seeking dispute resolution, or reviewing and responding to requests for correction or reconsideration or dispute resolution. In addition, applicable interest and penalties related to late billing and/or late payment shall continue to accrue as otherwise provided. Efforts to negotiate a post-care repricing agreement do not justify late billing or payment, and either party may seek further relief in accordance with the rules provided herein should billing or payment not be made within the time otherwise due under these

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rules. No party shall be obligated to negotiate or enter into a repricing agreement of any kind whatsoever.

No party, in attempting to negotiate a repricing or other post treatment price reduction agreement, shall state or imply that consent to such an agreement is mandatory, or that the failure to enter into any such agreement may result in audit, delay of payment, or other adverse consequence. If the Commission determines that any party, or other person in privity therewith, has made such false or misleading statements in an effort to coerce another party's consent to a repricing or other price reduction agreement outside the Fee Schedule, the Commission may refer the matter to the appropriate authorities to consider whether such conduct warrants criminal prosecution under section 71-3-69 of the Law. This statute declares that any false or misleading statement or representation made for the purpose of wrongfully withholding any benefit or payment otherwise due under the terms of the Workers' Compensation Law shall be considered a felony. In addition, the Commission may levy a civil penalty in an amount not to exceed ten thousand dollars (\$10,000.00) if it finds that payment of a just claim has been delayed without reasonable grounds, as provided in section 71-3-59(2) of the Law.

- C. **Billing Forms.** Billing for provider services shall be standardized and submitted on the following forms. Providers must bill outpatient professional services on the most recently authorized paper or electronic version, 837p, of the CMS-1500 form, regardless of the site of service. Health care facilities must bill on the most recently authorized uniform billing form. The electronic version, 837i, of the UB-04 (CMS-1450) is required beginning May 23, 2007. Billing must be submitted using the most current paper or electronic forms which are authorized by CMS.
- D. **Identification Number.** All professional reimbursement submissions by Covered Healthcare Providers as defined under CMS rules for the implementation of the National Provider Identifier (NPI) must include the National Provider Identifier (NPI) field so as to enable the specific identification of individual providers without the need for other unique provider identification numbers. Providers who do not yet have an NPI should continue to use their legacy identifiers until such time as an NPI is obtained. Providers are required to obtain an NPI within the dates specified by CMS in its implementation rules.
- E. **Physician Specialty.** The rules and reimbursement allowances in the *Mississippi Workers' Compensation Medical Fee Schedule* do not address physician specialization within a specialty. Payment is not based on the fact that a physician has elected to treat patients with a particular/specific problem. Reimbursement to qualified physicians is the same amount regardless of specialty.
- F. **"No Show" Appointments.** When an appointment is made for a physician visit by the employer or payer, and the claimant/patient does not show, the provider is entitled to payment at the rate allowed for a minimal office visit.
- G. **"After Hours" and Other Adjunct Service Codes.** When an office service occurs after a provider's normal business hours, procedure code 99050 may be billed. Other adjunct service codes (99051-99060) may be billed as appropriate. Typically, only a single adjunct service code is reported per encounter. However, there may be circumstances in which reporting multiple adjunct codes per patient encounter may be appropriate.
- H. **Portable Services.** When procedures are performed using portable equipment, bill the appropriate procedure code. The charge for the procedure includes the cost of the portable equipment.
- I. **Injections.**
 - 1. Reimbursement for injections includes charges for the administration of the drug and the cost of the supplies to administer the drug. Medications are charged separately.
 - 2. The description must include the name of the medication, strength, and dose injected.
 - 3. When multiple drugs are administered from the same syringe, reimbursement will be for a single injection.

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4. Reimbursement for anesthetic agents such as Xylocaine and Carbocaine, when used for infiltration, is included in the reimbursement for the procedure performed and will not be separately reimbursed.
 5. Reimbursement for intra-articular and intra-bursal injections (steroids and anesthetic agents) may be separately billed. The description must include the name of the medication, strength, and volume given.
- J. Supplies. Use CPT code 99070 or specific HCPCS Level II codes to report supplies over and above those usually included with the office visit or service rendered. Do not bill for supplies that are currently included in surgical packages, such as gauze, sponges, and Steri-Strips®. Supplies and materials provided by the physician over and above those usually included with the office visit (drugs, splints, sutures, etc.) may be charged separately and reimbursed at a reasonable rate.

II. INSTRUCTIONS TO PROVIDERS

- A. All bills for service must be coded with the appropriate CPT, ASA, or HCPCS Level II code.
- B. The medical provider must file the appropriate billing form and necessary documentation within thirty (30) days of rendering services on a newly diagnosed work-related injury or illness. Subsequent billings must be submitted at least every thirty (30) days, or within thirty (30) days of each treatment or visit, whichever last occurs, with the appropriate medical records to substantiate the medical necessity for continued services. Late billings will be subject to discounts, not to exceed one and one-half percent (1.5%) per month of the bill or part thereof which was not timely billed, from the date the billing or part thereof is first due until received by the payer. Any bill or part thereof not submitted to the payer within sixty (60) days after the due date under this rule shall be subject to an additional discount penalty equal to ten percent (10%) of the total bill or part thereof. Any bill for services rendered which is not submitted to the payer within one (1) year after the date of service, or date of discharge for inpatient care, will not be eligible or considered for reimbursement under this Fee Schedule, unless otherwise ordered by the Commission or its Cost Containment Division.
- C. Fees in excess of the maximum reimbursement allowance (MRA) must not be billed to the employee, employer, or payer. The provider cannot collect any non-allowed amount.
- D. If it is medically necessary to exceed the Fee Schedule limitations and/or exclusions, substantiating documentation must be submitted by the provider to the payer with the claim form.
- E. If a provider believes an incorrect payment was made for services rendered, or disagrees for any reason with the payment and explanation of review tendered by the payer, then the provider may request reconsideration pursuant to the rules set forth herein.
- F. If, after the resolution of a reconsideration request or a formal dispute resolution request, or otherwise, the provider is determined to owe a refund to the payer, the amount refunded shall bear interest at the rate of one and one-half percent (1.5%) per month from the date the refunded amount was first received by the provider, until refunded to the payer.

III. INSTRUCTIONS TO PAYERS

- A. An employer's/payer's payment shall reflect any adjustments in the bill made through the employer's/payer's bill review program. The employer/payer must provide an explanation of review (EOR) to a health care provider whenever reimbursement differs from the amount billed by the provider. This must be done individually for each bill.

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- B. In a case where documentation does not indicate the service was performed, the charge for the service may be denied. The explanation of review (EOR) must clearly and specifically indicate the reason for the denial.
- C. (1) When a billed service is documented, but the code selected by the provider is not, in the payer's/reviewer's estimation, the most accurate code available to describe the service, the reviewer must not deny payment, but shall reimburse based on the revised code. The explanation of review (EOR) must clearly and specifically detail the reason(s) for recoding the service or otherwise altering the claim. No claim shall be recoded or otherwise revised or altered without the payer having actually reviewed the medical records associated with the claim which document the service(s) provided.

(2) As an alternative to recoding or altering a claim, the payer may treat the matter under rule E(1) and (2) below by paying any undisputed portion of the bill, and notifying the provider by explanation of review (EOR) that the remaining parts of the bill are denied or disputed.

(3) Recoding cannot be used solely for cost containment. Recoding may only be used for the correction of miscoded services. Whenever there is any dispute concerning coding, the provider must be notified immediately and given the opportunity to furnish additional information, although nothing herein suspends the time periods for making payment or giving notice of dispute. Any recoding or so-called "down coding," which is found by the Commission or its Cost Containment Division to be solely for the purpose of cost containment, will subject the party engaging in such conduct to additional penalties as allowed by law.
- D. Properly submitted bills must be paid within thirty (30) days of receipt by the payer. Properly submitted bills not fully paid within thirty (30) days of receipt by the payer shall automatically include interest on the unpaid balance at the rate of one and one-half percent (1.5%) per month from the due date of any unpaid remaining balance until such time as the claim is fully paid and satisfied. Properly submitted bills not fully paid within sixty (60) days of receipt will be subject to an additional penalty equal to ten percent (10%) of the unpaid remaining balance, including interest as herein provided.
- E. (1) When an employer/payer disputes or otherwise adjusts a bill or portion thereof, the employer/payer shall pay the undisputed or unadjusted portion of the bill within thirty (30) days of receipt of the bill. Failure to pay the undisputed portion when due shall subject the payer to interest and penalty as above provided on the undisputed portion of the bill. If the dispute is ultimately resolved in the provider's favor, interest and penalty on the disputed amounts will apply from the original due date of the bill.

(2) When a payer disputes a bill or portion thereof, the payer shall notify the provider within thirty (30) days of the receipt of the bill of the reasons for disputing the bill or portion thereof, and shall notify the provider of its right to provide additional information and to request reconsideration of the payer's action. The payer shall set forth the clear and specific reasons for disputing a bill or portion thereof on the explanation of review (EOR), and shall provide additional documentation if necessary to provide an adequate explanation of the dispute.
- F. Reimbursement determinations shall be based on medical necessity of services to either establish a diagnosis or treat an injury/illness. Thus, where service is provided in good faith reliance on authorization given by the employer or payer, reimbursement shall not be dependent on the outcome of medically necessary diagnostic services or treatment.

IV. FACILITY FEE RULES

Please refer to the Pain Management section for the State-specific facility reimbursement rules to be used for outpatient pain management procedures.

Please refer to the Surgery section for the State-specific facility reimbursement rules to be used for ambulatory surgery center (ASC) procedures.

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- A. **Prepayment Review for Facilities.** The payer must perform a prepayment review on inpatient hospital bills and outpatient surgery bills in order to verify the charges submitted.
1. At a minimum, the pre-payment review should:
 - a. Validate that prior authorization was approved according to Fee Schedule guidelines;
 - b. Validate that the length of stay and the level of service was appropriate for the diagnosis;
 - c. Review the bill for possible overcharges or billing errors;
 - d. Determine if an on-site audit is appropriate;
 - e. Identify over utilization of services;
 - f. Identify those bills and case records that shall be subject to professional review by a physician or appropriate peer.
 2. The payer must reimburse the hospital within thirty (30) days of receipt of a valid claim form if prepayment review criteria are met. An exception to the thirty (30) day payment time will be made if additional documentation is requested for prepayment review, and in such cases, payment should be made within thirty (30) days following receipt of this additional documentation if prepayment review criteria are met. If a full audit is scheduled, fifty percent (50%) of the total bill must be paid prior to the audit, and in such event, the payer shall not be liable for interest and penalty as above provided on any additional sums which may be due following completion of the audit. Failure to pay fifty percent (50%) of the total bill prior to the audit shall result in interest and penalty as above provided being added to the total amount determined to be due, from the original due date until paid.
 3. If the hospital does not forward copies of requested medical records to the payer after two (2) consecutive written requests following the initial request, or if it fails to submit necessary or adequate documentation to support the hospital services rendered, the payer should perform a charge audit.
- B. **Charge Audit.** All charge audits must be performed on-site unless otherwise agreed to by the provider and payer.
1. The following information must be provided to the hospital by the payer/auditor when scheduling an audit:
 - a. Patient name
 - b. Account number
 - c. Date(s) of service
 - d. Diagnosis(es)
 - e. Total amount of bill
 - f. Insurance company
 - g. Name of audit requester
 - h. Telephone number and address of requester
 2. A hospital must schedule a charge audit within thirty (30) days of a request by a payer/auditor.
 3. Hospitals shall be reimbursed an audit fee of \$50.00 for associated audit costs.
 4. When a charge audit is necessary, the auditor must identify additional charges for medically necessary hospital services that were ordered by the authorized physician and were provided, but were not included, on the initial bill.

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- 5. The auditor must review and verify the audit findings with a hospital representative at the conclusion of the audit. The hospital may waive its right to the exit conference.
- 6. The auditor must provide written explanation of the final reimbursement determination based on the audit findings, whether or not an exit conference is held with the hospital. This written explanation must be provided within thirty (30) days following the conclusion of the audit.
- C. When any hospital bill that has been prescreened and found to be correct, or when corrections have been made to the bill as required, or when a hospital bill has been audited and verified as correct, it must be paid within thirty (30) days thereafter.
- D. Any hospital bill not paid when due under these rules shall automatically include interest at the rate of one and one-half percent (1.5%) per month from the due date of such bill until paid. Any such bill not paid within sixty (60) days after it is due under these rules will be subject to an additional penalty equal to ten percent (10%) of the total amount due, including interest as herein provided.
- E. Implantables. An implantable is an item that is implanted into the body for the purpose of permanent placement, and remains in the body as a fixture. Absorbable items, temporary items, or other items used to help place the implant, are not within the definition of "implantable" and are not reimbursed as such.

Implantables are included in the applicable DRG reimbursement for inpatient treatment, and, therefore, the provider of inpatient services is not required to furnish the payer with an invoice for implantables. For implantables used in the outpatient setting, reimbursement shall be made separately from the facility fee and all other charges; the provider shall furnish a suitable invoice evidencing the cost of the implantable to the payer within sixty (60) days from the date of service. Upon receipt of this invoice, the payer shall pay the amount due within thirty (30) days thereafter. Implantables shall be reimbursed at cost plus ten percent (10%).

A "suitable invoice" is an acquisition invoice from the manufacturer that contains pricing information showing the actual cost of the implant(s) being billed, or, as in situations such as a bulk purchase, containing information from which the actual cost of the implant(s) can be readily determined. The invoice must be on company letterhead from the implant supplier or manufacturer, not the hospital/facility, unless otherwise agreed to by the payer. Reimbursement is limited to 110% of the original manufacturer's invoice price.

V. EXPLANATION OF REVIEW (EOR)

- A. Payers must provide an explanation of review (EOR) to health care providers for each bill whenever the payer's reimbursement differs from the amount billed by the provider, or when an original claim is altered or adjusted by the payer. The EOR must be provided within thirty (30) days of receipt of the bill, and must accompany any payment that is being made.
- B. A payer may use the listed EOR codes and descriptors or may develop codes of their own to explain why a provider's charge has been reduced or disallowed, or why a claim has been altered or adjusted in some other way. In all cases, the payer must clearly and specifically detail the reasons for adjusting or altering a bill, including references to the applicable provisions of the Fee Schedule or CPT book, or other source(s) used as the basis for the EOR. Should the EOR include an alteration in the codes submitted on the original claim, it must be based on a review of the medical records documenting the service.
- C. The EOR must contain appropriate identifying information to enable the provider to relate a specific reimbursement to the applicable claimant, the procedure billed, and the date of service.
- D. Acceptable EORs may include manually produced or computerized forms that contain the EOR codes, written explanations, and the appropriate identifying information.
- E. The following EOR codes may be used by the payer to explain to the provider why a procedure or service is not reimbursed as billed, provided clear and specific detail is included, along with

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references to the applicable provisions of the Fee Schedule or CPT book, or other source(s) used as the basis for the EOR:

- 001 These services are not reimbursable under the Workers' Compensation Law for the following reason(s): [Provide specific reason(s) why services are not reimbursable under the Workers' Compensation Law]
- 002 Charges exceed maximum reimbursement allowance [Specify]
- 003 Charge is included in the basic surgical allowance [Specify]
- 004 Surgical assistant is not routinely allowed for this procedure. Documentation of medical necessity required [Specify]
- 005 This procedure is included in the basic allowance of another procedure [Specify the other procedure]
- 006 This procedure is not appropriate to the diagnosis [Specify]
- 007 This procedure is not within the scope of the license of the billing provider [Specify]
- 008 Equipment or services are not prescribed by a physician [Specify]
- 009 This service exceeds reimbursement limitations [Specify]
- 010 This service is not reimbursable unless billed by a physician [Specify]
- 011 Incorrect billing form [Specify]
- 012 Incorrect or incomplete identification number of billing provider [Specify]
- 013 Medical report required for payment [Specify]
- 014 Documentation does not justify level of service billed [Specify]
- 015 Place of service is inconsistent with procedure billed [Specify]
- 016 Invalid procedure code [Specify]
- 017 Prior authorization was not obtained [Specify]

VI. REQUEST FOR RECONSIDERATION

- A. When, after examination of the explanation of review (EOR) and other documentation, a health care provider is dissatisfied with a payer's payment or dispute of a bill for medical services, reconsideration may be requested by the provider. Any other matter in dispute between the provider and payer may be subject to reconsideration as herein provided at the request of either party, including, but not limited to, a request by the payer for refund of an alleged over-payment. Alleged over-payments should be addressed through the dispute resolution process, if necessary, and not by way of unilateral recoupment initiated by the payer on subsequent billings.
- B. A provider or payer must make a written request for reconsideration within thirty (30) days from the receipt of the explanation of review (EOR) or other written documentation evidencing the basis for the dispute. A request for reconsideration must be accompanied by a copy of the bill in question, the payers' explanation of review (EOR), and/or any additional documentation to support the request for reconsideration.
- C. The payer or provider, upon receipt of a request for reconsideration, must review and re-evaluate the original bill and accompanying documentation, and, must notify the requesting party within twenty (20) days thereafter of the results of the reconsideration. The response must adequately explain the reason(s) for the decision, and cite the specific basis upon which the final determination was made. If the payer finds the provider's request for reconsideration is meritorious, and that additional

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payment(s) should be made, or if the provider finds the payer's request for refund or other payment is meritorious, the additional payment should be made within the above twenty (20) day period. Any additional payment(s) made in response to a provider's or payer's request for reconsideration shall include interest from the original due date of the bill or payment, and an additional ten percent (10%) penalty if applicable.

- D. If the dispute is not resolved within the above time after a proper request for reconsideration has been served by the provider or payer, then either party may request further review by the Commission pursuant to the Dispute Resolution Rules set forth hereafter.
- E. Failure to seek reconsideration within the time above provided shall bar and prohibit any further reconsideration or review of the bill or other issue in question unless, for good cause shown, the Commission or its representative extends the time for seeking reconsideration or review under these rules. In no event shall the time for seeking reconsideration hereunder be extended by more than an additional thirty (30) days, and any such request for additional time in which to seek reconsideration or further review must be made in writing to the Commission within the initial thirty (30) day period set forth in paragraph B. above.
- F. Requests by either provider or payer for refunds, or for additional payment, or other requests related to the billing or payment of a claim, must be sought in accordance with the specific rules set forth herein. No retrospective audits or dispute requests shall be allowed beyond the time otherwise provided herein for seeking reconsideration and/or review.

Medical Records Rules

I. MEDICAL RECORDS

- A. The medical record, which documents the patient's course of treatment, is the responsibility of the provider and is the basis for determining medical necessity and for substantiating the service(s) rendered; therefore, failure to submit necessary or adequate documentation to support the services rendered may result in the services being disallowed.
- B. A medical provider may not charge any fee for completing a medical report or form required by the Workers' Compensation Commission which is part of the required supporting documentation which accompanies a request for payment. The supporting documentation that is required to substantiate the medical treatment is included in the fee for service and does not warrant a separate fee as it is incidental to providing medical care. CPT code 99080 is appropriate for billing special reports beyond those required by this Fee Schedule and requested by the payer or their representatives.
- C. Medical records must be legible and include, as applicable:
 - 1. Initial office visit notes which document a history and physical examination appropriate to the level of service indicated by the presenting injury/illness or treatment of the ongoing injury/illness;
 - 2. Progress notes which reflect patient complaints, objective findings, assessment of the problem, and plan of care or treatment;
 - 3. Copies of lab, x-ray, or other diagnostic tests that reflect current progress of the patient and/or response to therapy or treatment;
 - 4. Physical medicine/occupational therapy progress notes that reflect the patient's response to treatment/therapy;
 - 5. Operative reports, consultation notes with report, and/or dictated report; and
 - 6. Impairment rating (projected and actual) and anticipated MMI date.
- D. A plan of care should be included in the medical record and should address, as applicable, the following:
 - 1. The disability;
 - 2. Degree of restoration anticipated;
 - 3. Measurable goals;
 - 4. Specific therapies to be used;
 - 5. Frequency and duration of treatments to be provided;
 - 6. Anticipated return to work date;
 - 7. Projected impairment.

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- E. Health care providers must submit copies of records and reports to payers upon request. Providers can facilitate the timely processing of claims and payment for services by submitting appropriate documentation to the payer when requested. Only those records for a specific date of injury are considered non-privileged as it relates to a workers' compensation injury. The employer/payer is not privileged to non-work related medical information.
- F. Providers must submit documentation for the following:
1. The initial office visit;
 2. A progress report if still treating after thirty (30) days;
 3. Evaluation for physical medicine treatment (P.T., O.T., C.M.T., O.M.T.);
 4. A progress report every thirty (30) days for physical medicine services;
 5. An operative report or office note (if done in the office) for a surgical procedure;
 6. A consultation;
 7. The anesthesia record for anesthesia services;
 8. A functional capacity or work hardening evaluation;
 9. When billing a by-report (BR) service, a description of the service is required;
 10. Whenever a modifier is used to describe an unusual circumstance;
 11. Whenever the procedure code descriptors include a written report
- G. Hospitals and other inpatient facilities must submit required documentation with the appropriate billing forms as follows:
1. Admission history and physical;
 2. Discharge summary;
 3. Operative reports;
 4. Pathology reports;
 5. Radiology reports;
 6. Consultations;
 7. Other dictated reports;
 8. Emergency room records.

II. COPIES OF RECORDS

- A. Outpatient Records. The payer may request additional records or reports from the provider concerning service or treatment provided to a patient other than on an inpatient basis. These additional records and reports will be reimbursed as follows:

1-5 pages — \$15.00

6+ pages — \$.50 per page in addition to the above fee

This applies to copies of microfiche and other electronic media or storage systems.

As provided by MCA section 11-1-52(1) (Supp. 2006), as amended, the provider may add ten percent (10%) of the total charge to cover the cost of postage and handling, and may charge an additional fifteen dollars (\$15.00) for retrieving records stored off the premises where the provider's facility or office is located.

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- B. Inpatient Records. The payer may request additional records or reports from a facility concerning inpatient service or treatment provided to a patient. Such reports or records requested by the payer will be reimbursed as follows:
- 1-5 pages — \$15.00/per admission
 - 6+ pages — \$.50 per page/per admission in addition to the above fee
- This applies to copies of microfiche and other electronic media or storage systems.
- There is a maximum reimbursement allowance of fifty dollars (\$50.00) for a particular inpatient medical record, exclusive of postage, handling and retrieval charges as set forth below. This is per admission.
- As provided by MCA section 11-1-52(1) (Supp. 2006), as amended, the provider may add ten percent (10%) of the total charge to cover the cost of postage and handling, and may charge an additional fifteen dollars (\$15.00) for retrieving records stored off the premises where the provider's facility or office is located.
- C. Copies of records requested by the patient and/or the patient's attorney or legal representative will be reimbursed by the requesting party according to the provisions of this section on additional reports and records.
- D. Documentation submitted by the provider which has not been specifically requested will not be subject to reimbursement.
- E. Health care providers may charge up to ten dollars (\$10.00) per film for copying x-rays or for providing copies of x-rays via electronic or other magnetic media. (Copies of film do not have to be returned to the provider.)
- F. Payers, their representatives, and other parties requesting records and reports must be specific in their requests so as not to place undue demands on provider time for copying records.
- G. Providers should respond promptly (within fourteen (14) working days) to requests for additional records and reports.
- H. Records requested by the Mississippi Workers' Compensation Commission will be furnished by the provider without charge to the Commission.
- I. Any additional reimbursement, including copy service vendors, other than is specifically set forth above, is not required, and providers or their vendors will not be paid any additional amounts.

Dispute Resolution Rules

I. GENERAL PROVISIONS

- A. Unresolved disputes may be appealed to and resolved by the Mississippi Workers' Compensation Commission
- B. Reconsideration must be sought by the provider or payer prior to a request for resolution of a dispute being sent to the Commission. This provides the payer and provider an opportunity to resolve most concerns in a timely manner
- C. All communication between parties in dispute will be handled by the Mississippi Worker's Compensation Commission, Cost Containment Division. In addition, there will be no communication between the parties in dispute and any Peer Reviewer who might be called upon to assist the Commission in the resolution of a dispute

II. FORMS AND DOCUMENTATION

- A. Valid requests for resolution of a dispute must be submitted on the "Request for Resolution of Dispute" form (in the Forms section) along with the following:
 - 1. Copies of the original and resubmitted bills in dispute that include dates of service, procedure codes, charges for services rendered and any payment received, and an explanation of any unusual services or circumstances;
 - 2. EOR including the specific reimbursement;
 - 3. Supporting documentation and correspondence;
 - 4. Specific information regarding contact with the payer; and
 - 5. Any other information deemed relevant by the applicant for dispute resolution.
- B. A request for Resolution of Dispute must be submitted to:

Mississippi Workers' Compensation Commission
Cost Containment Division
1428 Lakeland Drive
P O. Box 5300
Jackson, MS 39296-5300

III. TIME FOR FILING

A Request for Resolution of Dispute must be filed with the Commission within twenty (20) days following the payer's or provider's response to a request for reconsideration of any matter in dispute, or, in cases where the payer or provider fails to respond to a request for reconsideration, within twenty (20) days of the expiration of the time in which said response should have been provided. Failure to file a Request for Resolution of Dispute within this time shall bar any further action on the disputed issue(s) unless, for good cause shown, the Commission or its Cost Containment Director extends the time for filing said request. In

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no event will the time for filing a Request for Resolution of Dispute be extended more than once or more than an additional twenty (20) days from the time said request was first due to be filed, provided the request for additional time in which to file a Request for Resolution of Dispute is filed within the initial twenty (20) day period provided herein; and, absent compelling circumstances, a dispute resolution request will not be considered by the Cost Containment Division if submitted more than one (1) year after the date of service. The decision to extend the time for filing a Request for Resolution of Dispute based on "good cause" shall be entirely at the discretion of the Commission or its Cost Containment Director. Mere neglect will not constitute "good cause."

IV. PROCEDURE BY COST CONTAINMENT DIVISION

- A. Requests for dispute resolution will be reviewed and decided by the Cost Containment Division of the Commission within thirty (30) days of receipt of the request, unless additional time is required to accommodate a Peer Review. The payer and/or provider may be contacted by telephone or other means for additional information if necessary, however, both parties to a dispute may submit in writing any information or argument they deem relevant to the issue in dispute, if not already submitted with the request for dispute resolution, and this information shall be considered by the Cost Containment Division when rendering a decision. Any written information or argument submitted for consideration by a party to a dispute, without a request from the Commission, must be received by the Cost Containment Division within ten (10) days after filing the request for dispute resolution in order to merit consideration.
- B. Every effort will be made to resolve disputes by telephone or in writing. The payer and provider may be requested to attend an informal hearing conducted by a Commission representative. Failure to appear at an informal hearing may result in dismissal of the request for dispute resolution.
- C. Following review of all documentation submitted for dispute resolution and/or following contact with the payer and/or provider for additional information and/or negotiation, the Cost Containment Division shall render an administrative decision on the request for dispute resolution.
- D. Cases involving medical care determination may be referred for Peer Review, but only on request of the Commission. The peer review consultant will render an opinion and submit same to the Commission representative within the time set by the Cost Containment Division. The Commission representative will notify the parties in dispute if a Peer Review has been requested, and of the peer consultant's determination.

V. COMMISSION REVIEW OF A DISPUTE

- A. Any party aggrieved by the decision of the Cost Containment Division shall have twenty (20) days from the date of said decision to request review by the Commission. Failure to file a written request for review with the Commission within this twenty (20) day period shall bar any further review or action with regard to the issue(s) presented. No extension of time within which to file for Commission review of a dispute under these Rules shall be allowed. In the event a request for review is not filed with the Commission within twenty (20) days or within allowed by any extension which has been granted, the parties to the dispute shall have fourteen (14) days thereafter in which to comply with the final decision of the Cost Containment Division.
 - 1. A party to a dispute may, when a written request for review has not been timely filed with the Commission, file with the Commission a written request to compel compliance with the final administrative decision of the Cost Containment Division. The Commission may consider such a request with or without a hearing. A request to compel compliance with the final decision of the Cost Containment Division may be filed at any time following fourteen (14) days after the decision of the Cost Containment Division becomes final.

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- B. The request for review by the Commission shall be filed with the Cost Containment Division of the Mississippi Workers' Compensation Commission, and shall be in writing and shall state the grounds on which the requesting party relies. All documentation submitted to and considered by the Cost Containment Division, including the Request for Resolution of Dispute form, along with a copy of the decision of the Cost Containment Division, shall be attached to the request for review which is filed with the Commission.
- C. The Commission shall review the issue(s) solely on the basis of the documentation submitted to the Cost Containment Division. No additional documentation not presented to and considered by the Cost Containment Division shall be considered by the Commission on review, unless specifically requested by the Commission, and no hearing or oral argument shall be allowed.
- D. The Commission shall consider the request for review and issue a decision thereon within thirty (30) days after said request is filed, unless otherwise provided by the Commission.
- E. Following the decision of the Commission, or following the conclusion of the dispute resolution process at any stage without an appeal to the Commission, no further audit, adjustment, refund, review, consideration, reconsideration or appeal with respect to the claim in question may be sought by either party.
- F. The costs incurred in seeking Commission review or in seeking compliance with an Administrative Decision rendered by the Cost Containment Director, including reasonable attorney fees, if any, shall be assessed to the party who requested review if that party's position is not sustained by the Commission, and to the party who has failed to comply with a prior decision if compliance therewith is ordered by the Commission. Otherwise, each party shall bear their own costs, including attorney's fees.
- G. If the Commission determines that a dispute is based on or arises from a billing error, a payment adjustment or error, including but not limited to improper bundling of service codes, unbundling, down-coding, code shifting, or other action by either party to the dispute, or if the Commission determines that a provider or payer has unreasonably refused to comply with the Law, the Rules of the Commission, including this Fee Schedule, or with any decision of the Commission or its representatives, and that this causes proceedings with respect to the billing and/or payment for covered medical services to be instituted or continued or delayed without reasonable grounds, then the Commission may require the responsible party or parties to pay the reasonable expenses, including attorney's fees, if any, to the opposing party, and, in addition, the Commission may levy against the responsible party or parties a civil penalty not to exceed the sum of ten thousand dollars (\$10,000.00), payable to the Commission, as provided in section 71-3-59(2) of the Law. The award of costs and penalties as herein provided shall be in addition to interest and penalty charges which may apply under other provisions of this Fee Schedule.

Utilization Review Rules

The Mississippi Workers' Compensation Commission requires mandatory utilization review of certain medical services and charges associated with the provision of medical treatment covered under the Act and subject to the Fee Schedule. These rules are set forth to encourage consistency in the procedures for interaction between workers' compensation utilization review agents, representatives or organizations, providers, and payers. The provisions herein set forth regarding utilization review are in addition to the requirements of MCA section 41-83-1 et seq. (Rev. 2005), as amended, and any regulations adopted pursuant thereto by the State Department of Health or the State Board of Medical Licensure, and in the event of conflict between this Fee Schedule, and the requirements of the above statute, and any implementing regulations, the provisions of this Fee Schedule or other applicable rules of the Mississippi Workers' Compensation Commission shall govern.

I. SERVICES REQUIRING UTILIZATION REVIEW

Mandatory Utilization review is required for the following:

- A. All admissions to inpatient facilities of any type
- B. All surgical procedures, inpatient and outpatient
- C. Repeat MRI (more than one per injury)
- D. Repeat CT Scan (more than one per injury)
- E. Work hardening programs, pain management programs, back schools, massage therapy, acupuncture, biofeedback
- F. External spinal stimulators
- G. Physical medicine treatments, after fifteen (15) visits or thirty (30) days, whichever comes first
- H. Home health
- I. Psychiatric treatment

II. DEFINITIONS

Case Management. The clinical and administrative process in which timely, individualized, and cost effective medical rehabilitation services are implemented, coordinated, and evaluated by a nurse or other case manager employed by the payer, on an ongoing basis for patients who have sustained an injury or illness. Use of case management is optional in Mississippi.

Certification. A determination by a utilization review organization or agent that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the requirements of the workers' compensation program.

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Clinical Peer. A health professional that holds unrestricted license and is qualified to practice in the same or similar specialty as would typically manage the medical condition, procedures, or treatment under review. Generally, as a peer in a similar specialty, the individual must be in the same profession (i.e., the same licensure category as the ordering provider).

Clinical Rationale. A statement that provides additional clarification of the clinical basis for a non-certification determination. The clinical rationale should relate the non-certification determination to the worker's condition or treatment plan, and should supply a sufficient basis for a decision to pursue an appeal.

Clinical Review Criteria. The written screens, decision rules, medical protocols, or guidelines used by the payer's Utilization Management Program as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services.

Concurrent Review. Utilization management conducted during a worker's hospital stay or course of treatment, sometimes called continued stay review.

Discharge Planning. The process of assessing a patient's need for medically appropriate treatment after hospitalization and affecting an appropriate and timely discharge.

Expedited Appeal. An expedited appeal is a request for additional review of a determination not to certify imminent or ongoing services, an admission, an extension of stay, or other medical services of an imminent or ongoing nature. Also sometimes referred to as a reconsideration request.

First Level Clinical Review. Review conducted by registered nurses and other appropriate licensed or certified health professionals. First level clinical review staff may approve requests for admissions, procedures, and services that meet clinical review criteria, but must refer requests that do not meet clinical review criteria to second level clinical peer reviewers for approval or denial.

Notification. Correspondence transmitted by mail, telephone, facsimile, email, and/or electronic data interchange (EDI).

Pre-certification. The review and assessment of medical necessity and appropriateness of services before they occur. The appropriateness of the site or level of care is assessed along with the duration and timing of the proposed services.

Provider. A licensed health care facility, program, agency, or health professional that delivers health care services.

Retrospective Review. Utilization review conducted after services have been provided to the worker.

Second Level Clinical Review. Clinical review conducted by appropriate clinical peers when a request for an admission, procedure, or service does not meet clinical review criteria.

Standard Appeal. A request to review a determination not to certify an admission, extension of stay, or other health care service.

Third Level Clinical Review. Clinical review conducted by appropriate clinical peers who were not involved in second level review when a decision not to certify a requested admission, procedure, or service has been appealed. The third level peer reviewer must be in the same or like specialty as the requesting provider.

Utilization Review. Evaluation of the necessity, appropriateness, and efficiency for the use of health care services. It includes both prospective and concurrent review, and may include retrospective review under certain circumstances.

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Utilization Reviewer: An entity, organization, or representative thereof, or other person performing utilization review activities or services on behalf of an employer, payer or third-party claims administrator.

Variance: A deviation from a specific standard.

III. STANDARDS

Utilization review organizations or programs are required to meet the following standards:

- A. The payer's utilization reviewer must comply with the requirements of MCA section 41-83-1 et seq. (Rev. 2005), as amended, and any regulations adopted pursuant thereto by the State Department of Health or the State Board of Medical Licensure, and shall have utilization review agents or representatives who are properly qualified, trained, supervised, and supported by explicit clinical review criteria and review procedures.
- B. The first level review is performed by individuals who are health care professionals, who possess a current and valid professional license, and who have been trained in the principles and procedures of utilization review.
- C. The first level reviewers are required to be supported by a doctor of medicine who has an unrestricted license to practice medicine.
- D. The second level review is performed by clinical peers who hold a current, unrestricted license and are oriented in the principles and procedures of utilization review. The second level review shall be conducted for all cases where clinical determination to certify cannot be made by first level clinical reviewers. Second level clinical reviewers shall be available within one (1) business day by telephone or other electronic means to discuss the determination with the attending physicians or other ordering providers. In the event more information is required before a determination can be rendered by a second level reviewer, the attending/ordering provider must be notified of the delay and given a specific time frame for determination.
- E. The payer's utilization reviewer shall conduct third level reviews by requiring peers who serve in this capacity to hold a current, unrestricted license and be board certified in a specialty board approved by the American Board of Medical Specialties. Board certification requirement is not applicable to reviewers who are not doctors of medicine. Third level clinical reviewers shall be in the same profession or similar specialty as typically manages the medical condition, procedure, or treatment under review.
- F. The payer's utilization reviewer shall maintain written policies and procedures for the effective management of its utilization review activities, which shall be made available to the provider or the Commission, upon request.
- G. The payer maintains the responsibility for the oversight of the delegated functions if the payer delegates utilization review responsibility to a vendor. The vendor or organization to which the function is being delegated must be currently certified by the Mississippi Board of Health, Division of Licensure and Certification to perform utilization management in the State of Mississippi. A copy of the license or certification held by the utilization review agent shall be furnished to the provider, or to the Commission, upon request. The payer who has another entity perform utilization review functions or activities on its behalf maintains full responsibility for compliance with the rules.
- H. The payer's utilization reviewer shall maintain a telephone review service that provides access to its review staff at a toll free number from at least 9:00 a.m. to 5:00 p.m. CST each normal business day. There should be an established procedure for receiving or redirecting calls after hours or receiving faxed requests. Reviews should be conducted during hospitals' and health professionals' reasonable and normal business hours.

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- I. The payer's utilization reviewer shall collect only the information necessary to certify the admission procedure or treatment, length of stay, frequency, and duration of services. The utilization reviewer should have a process to share all clinical and demographic information on individual workers among its various clinical and administrative departments to avoid duplicate requests to providers. (Providers may use the Mississippi Workers' Compensation Commission Utilization Review Request Form.)

IV. PROCEDURES FOR REVIEW DETERMINATIONS

The following procedures are required for effective review determination.

- A. Review determinations must be made within two (2) business days of receipt of the necessary information on a proposed non-emergency admission or service requiring a review determination. The Mississippi Workers' Compensation Utilization Review Request Form may be used to request pre-certification.
- B. When an initial determination is made to certify, notification shall be provided promptly, at least within one (1) business day or before the service is scheduled, whichever first occurs, either by telephone or by written or electronic notification to the provider or facility rendering the service. If an initial determination to certify is provided by telephone, a written notification of the determination shall be provided within two (2) business days thereafter. The written notification shall include the number of days approved, the new total number of days or services approved, and the date of admission or onset of services.
- C. When a determination is made not to certify, notify the attending or ordering provider or facility by telephone within one (1) business day and send a written notification within one (1) business day thereafter. The written notification must include the principal reason/clinical rationale for the determination not to certify and instructions for initiating an appeal. Reasons for a determination not to certify may include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the attending physician.
- D. The payer's utilization reviewer shall inform the attending physician and/or other ordering provider of their right to initiate an expedited appeal or standard appeal of a determination not to certify, and the procedure to do so.
 1. Expedited appeal—When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review, and the attending physician believes that the determination warrants immediate appeal, the attending physician shall have an opportunity to appeal that determination over the telephone or by electronic mail or facsimile on an expedited basis within one (1) business day.
 - a. Each private review agent shall provide for reasonable access to its consulting physician(s) for such appeals.
 - b. Both providers of care and private review agents should attempt to share the maximum information by phone, fax, or otherwise to resolve the expedited appeal (sometimes called a reconsideration request) satisfactorily.
 - c. Expedited appeals, which do not resolve a difference of opinion, may be resubmitted through the standard appeal process.
 2. Standard appeal—A standard appeal will be considered, and notification of the appeal decision given to the provider, not later than twenty (20) days after receiving the required documentation for the appeal.
 - a. An attending physician who has been unsuccessful in an attempt to reverse a determination not to certify should be provided the clinical rationale for the determination upon request.

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3. Retrospective review—For retrospective review, the review determination shall be based on the medical information available to the attending or ordering provider at the time the medical care was provided, and on any other relevant information regardless of whether the information was available to or considered by the provider at the time the care or service was provided.
 - a. When there is retrospective determination not to certify an admission, stay, or other service, the attending physician or other ordering provider and hospital or facility shall receive written notification, or notification by facsimile or electronic mail, within twenty (20) days after receiving the request for retrospective review and all necessary and supporting documentation.
 - b. Notification should include the principal reason for the determination and a statement of method for standard appeal.
4. Emergency admissions or surgical procedures—Emergency admissions or surgical procedures must be reported to the payer by the end of the next business day. Post review activities will be performed following emergency admissions, and a continued stay review will be initiated.
 - a. If a licensed physician certifies in writing to the payer or its agent or representative within seventy-two (72) hours of an admission that the injured worker admitted was in need of emergency admission to hospital care, such shall constitute a prima facie case for the medical necessity of the admission. An admission qualifies as an emergency admission if it results from a sudden onset of illness or injury which is manifested by acute symptoms of sufficient severity that the failure to admit to hospital care could reasonably result in (1) serious impairment of bodily function(s), (2) serious or permanent dysfunction of any bodily organ or part or system, (3) permanently placing the person's health in jeopardy, or (4) other serious medical consequence.
 - b. To overcome a prima facie case for emergency admission as established above, the utilization reviewer must demonstrate by clear and convincing evidence that the patient was not in need of an emergency admission.
- E. Failure of the health care provider to provide necessary information for review, after being requested to do so by the payer or its review agent, may result in denial of certification.
- F. When a payer and provider have completed the utilization review appeals process and cannot agree on a resolution to a dispute, either party, or the patient, can appeal to the Cost Containment Division of the Mississippi Workers' Compensation Commission, and should submit this request on the Request for Dispute Resolution Form adopted by the Commission. A request for resolution of a utilization review dispute should be filed with the Commission within twenty (20) days following the conclusion of the underlying appeal process provided by the utilization reviewer. The Commission shall consider and decide a request for resolution of a utilization review dispute in accordance with the Dispute Resolution Rules provided elsewhere in this Fee Schedule.
- G. Failure of by the utilization reviewer to timely notify the provider of a decision whether to certify or approve an admission, procedure, service or other treatment shall be deemed to constitute approval by the payer of the requested treatment, and shall obligate the payer to reimburse the provider in accordance with other applicable provisions of this Schedule. Timely notification means notification by mail, facsimile, electronic mail, or telephone, followed by written notification, to the provider within the applicable time periods set forth in these Utilization Review Rules.
- H. Upon request of the provider, or the Commission, a utilization reviewer must furnish a copy of the license or certification obtained from the State Department of Health which authorizes the reviewer to engage in utilization review activities in the State of Mississippi.
- I. Upon a finding by the Commission that a payer or the payer's utilization reviewer has failed without reasonable grounds to comply with the time requirements of these rules, penalties pursuant to Miss. Code Ann. Section 71-3-59 (Rev. 2000) may be assessed against the payer.

Rules for Modifiers and Code Exceptions

Please see the modifier rules in each section of the *Mississippi Workers' Compensation Medical Fee Schedule* for a complete listing of appropriate modifiers for each area.

- A. Modifier codes must be used by providers to identify procedures or services that are modified due to specific circumstances.
- B. When modifier 22 is used to report an increased service, a report explaining the medical necessity of the situation must be submitted with the claim to the payer. It is not appropriate to use modifier 22 for routine billing.
- C. The use of modifiers does not imply or guarantee that a provider will receive reimbursement as billed. Reimbursement for a modified service or procedure is based on documentation of medical necessity and determined on a case-by-case basis.
- D. Modifiers allow health care providers to indicate that a service was altered in some way from the stated description without actually changing the definition of the service.

I. MODIFIERS FOR CPT (HCPCS LEVEL I) CODES

This section contains a list of modifiers used with CPT codes. Also consult each practice-area section of the Fee Schedule for additional modifiers.

21 Prolonged Evaluation and Management Services

When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category, it may be identified by adding modifier 21 to the evaluation and management code number. A report may also be appropriate.

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.

23 Unusual Anesthesia

Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

24 Unrelated Evaluation and Management Services by the Same Physician During a Postoperative Period

The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

26 Professional Component

Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component (HCPCS Level II Modifier)

Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

Mississippi's note: The technical component is calculated by subtracting the professional component amount from the total amount for the reimbursement.

32 Mandated Services

Services related to mandated consultation and/or related services (e.g., third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

47 Anesthesia by Surgeon

Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) Note: Modifier 47 would not be used as a modifier for the anesthesia procedures 00100-01999.

Mississippi's note: Reimbursement is made for base units only.

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Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five-digit code.

51 Multiple Procedures

When multiple procedures, other than E/M Services, physical medicine and rehabilitation services, or provision of supplies (e.g., vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes (see the applicable CPT book appendix).

Mississippi's note: This modifier should not be appended to designated "modifier 51 exempt" codes as specified in the applicable CPT book.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 Discontinued Procedure

Under certain circumstances the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

54 Surgical Care Only

When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

55 Postoperative Management Only

When one physician performed the postoperative management and another physician performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

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56 Preoperative Management Only

When one physician performed the preoperative care and evaluation and another physician performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

57 Decision for Surgery

An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. Note: For treatment of a problem that requires a return to the operating or procedure room, see modifier 78.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures or services other than E/M services that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

62 Two Surgeons

When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If an additional procedure(s) (including an add-on procedure(s)) is performed during the same surgical session, a separate code(s) may be reported with modifier 62 added. Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those service(s) may be reported using a separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

66 Surgical Team

Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of modifier 66 to the basic procedure number used for reporting services.

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76 Repeat Procedure by Same Physician

It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

77 Repeat Procedure by Another Physician

The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.

78 Return to the Operating Room for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period

The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

80 Assistant Surgeon

Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

Mississippi's note: Reimbursement is twenty percent (20%) of the maximum reimbursement allowance.

81 Minimum Assistant Surgeon

Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.

Mississippi's note: Physician reimbursement is ten percent (10%) of the allowable.

82 Assistant Surgeon (when qualified resident surgeon not available)

The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).

90 Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.

91 Repeat Clinical Diagnostic Laboratory Test

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results, due to testing problems with specimens or equipment, or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describes a series of test results (e.g.,

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glucose tolerance tests, evocative/suppression testing). This modifier may only be used for a laboratory test(s) performed more than once on the same day on the same patient.

92 Alternative Laboratory Platform Testing

When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701–86703). The test does not require permanent dedicated space, hence by its design it may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.

99 Multiple Modifiers

Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

AA Anesthesiologist Services Performed Personally by an Anesthesiologist

Report modifier AA when the anesthesia services are personally performed by an anesthesiologist.

AD Medical Supervision by a Physician: More Than Four Concurrent Anesthesia Procedures

Report modifier AD when the anesthesiologist supervises more than four concurrent anesthesia procedures.

AS Assistant at Surgery Services Provided by Registered Nurse First Assistant, Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist (Mississippi Modifier)

Assistant at surgery services provided by a registered nurse first assistant or other qualified individual (excluding assistant at surgery services provided by a physician) are identified by adding modifier AS to the listed applicable surgical procedures. The use of the AS modifier is appropriate for any code that otherwise is reimbursable for a physician assisting a surgeon in the operating room.

Mississippi's note: AS reimbursement is ten percent (10%) of the allowable. For assistant at surgery services provided by a physician, see modifiers 80, 81, and 82.

NP Nurse Practitioner (Mississippi Modifier)

This modifier should be added to the appropriate CPT code to indicate that the services being billed were rendered or provided by a nurse practitioner.

PA Physician Assistant (Mississippi Modifier)

This modifier should be added to the appropriate CPT code to indicate that the services being billed were rendered or provided by a physician assistant.

PT – Physical or Occupational Therapist Assistant (Mississippi Modifier)

This modifier should be added to the appropriate CPT code to indicate that the services being billed were rendered or provided by either a Physical Therapist Assistant or an Occupational Therapist Assistant.

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CA – CARF Accredited

This modifier should be used in conjunction with CPT code 97799 (“unlisted physical medicine/rehabilitation service or procedure”) to indicate chronic pain treatment being administered by a CARF accredited provider as part of a pre-approved interdisciplinary pain rehabilitation program.

CP – Chronic Pain Treatment

This modifier should be used only in conjunction with CPT Code 97799 (“unlisted physical medicine/rehabilitation service or procedure”) to indicate chronic pain treatment being administered as part of a pre-approved interdisciplinary pain rehabilitation program.

QK Medical Direction of Two, Three, or Four Concurrent Anesthesia Procedures Involving Qualified Individuals (CRNA) by an Anesthesiologist

Report modifier QK when the anesthesiologist supervises two, three, or four concurrent anesthesia procedures involving qualified individuals (CRNA or AA).

QX CRNA Service: With Medical Direction by an Anesthesiologist

Regional or general anesthesia provided by the CRNA or AA with medical direction by a physician may be reported by adding modifier QX.

QY Medical Direction of One Certified Registered Nurse Anesthetist (CRNA) by an Anesthesiologist

Report modifier QY when the anesthesiologist supervises one CRNA or AA.

QZ CRNA Service: Without Medical Direction by an Anesthesiologist

Regional or general anesthesia provided by the CRNA or AA without medical direction by a physician may be reported by adding modifier QZ.

II. MODIFIERS APPROVED FOR AMBULATORY SURGERY CENTER (ASC) HOSPITAL OUTPATIENT USE

This section contains a list of modifiers used with ambulatory surgery center and hospital-based outpatient services. Also consult each practice-area section of the Fee Schedule for additional modifiers.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on

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the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

27 Multiple Outpatient Hospital E/M Encounters on the Same Date

For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (e.g., hospital emergency department, clinic). Note: This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient evaluation and management services provided by the same physician on the same date and performed in multiple outpatient setting(s) (e.g., hospital emergency department, clinic), see Evaluation and Management, Emergency Department, or Preventive Medicine Services codes.

50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five digit code.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.

58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. Note: For treatment of a problem that requires a return to the operating or procedure room, see modifier 76.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures or services other than E/M services that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an

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E/M service: To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

73 Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of modifier 73. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

74 Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of modifier 74. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

76 Repeat Procedure by Same Physician

It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

77 Repeat Procedure by Another Physician

The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.

78 Return to the Operating Room for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period

The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

Medical Fee Schedule**91 Repeat Clinical Diagnostic Laboratory Test**

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

III. MODIFIERS FOR HCPCS LEVEL II CODES

This section contains a list of commonly used modifiers with HCPCS Level II DME codes. Other HCPCS Level II modifiers, including those which can be used with CPT codes, are acceptable modifiers.

AU Item furnished in conjunction with a urological, ostomy, or tracheostomy supply

AV Item furnished in conjunction with a prosthetic device, prosthetic, or orthotic

AW Item furnished in conjunction with a surgical dressing

KC Replacement of special power wheelchair interface

NU Purchased new equipment

RR Rental equipment (listed amount is the per-month allowance)

UE Purchased used equipment

IV. CODE EXCEPTIONS

A. **Unlisted Procedure Codes.** If a procedure is performed that is not listed in the Medical Fee Schedule, the provider must bill with the appropriate "Unlisted Procedure" code and submit a narrative report to the payer explaining why it was medically necessary to use an unlisted procedure code.

The CPT book contains codes for unlisted procedures. Use these codes only when there is no procedure code that accurately describes the service rendered. A report is required as these services are reimbursed by report (see below).

B. **By Report (BR) Codes.** By report (BR) codes are used by payers to determine the reimbursement for a service or procedure performed by the provider that does not have an established maximum reimbursement allowance (MRA).

1. Reimbursement for procedure codes listed as "BR" must be determined by the payer based on documentation submitted by the provider in a special report attached to the claim form. The required documentation to substantiate the medical necessity of a procedure does not warrant a separate fee. Information in this report must include, as appropriate:

- a. A complete description of the actual procedure or service performed;
- b. The amount of time necessary to complete the procedure or service performed;

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- c. Accompanying documentation that describes the expertise and/or equipment required to complete the service or procedure.
2. Reimbursement of "BR" procedures should be based on the usual and customary rate.
- C. **Category II Codes.** This Fee Schedule does not include Category II codes as published in *CPT 2008*. Category II codes are supplemental tracking codes that can be used for performance measurements. These codes describe clinical components that are typically included and reimbursed in other services such as evaluation and management (E/M) or laboratory services. These codes do not have an associated relative value or fee.
- D. **Category III Codes.** This Fee Schedule does not include Category III codes published in *CPT 2008*. If a provider bills a Category III code, payment may be denied.
- E. **Add-On Codes.** Some of the listed procedures are commonly carried out in addition to the primary procedure performed. These additional or supplemental procedures are designated as add-on codes with a + symbol, and are listed in the applicable CPT book. Add-on codes can be readily identified by specific descriptor nomenclature which includes phrases such as "each additional" or "(List separately in addition to code for primary procedure)."
- The "add-on" code concept in the CPT book applies only to add-on procedures/services performed by the same physician. Add-on codes describe additional intra-service work associated with the primary procedure (e.g., additional digit(s), lesion(s), neurotomy(s), vertebral segment(s), tendon(s), joint(s)).
- Add-on codes are always performed in addition to the primary service/procedure, and must never be reported as a stand-alone code. All add-on codes found in the CPT book are exempt from the multiple procedure concept (see modifier 51 definition in this section). Add-on codes are reimbursed at one hundred percent (100%) of the maximum reimbursement allowance.
- Refer to the most current version of the CPT book for a complete list of add-on codes.
- F. **Codes Exempt From Modifier 51.** Certain codes are exempt from the use of modifier 51 but have not been designated as CPT add-on procedures/services. Please consult the most current CPT book for the list of codes that are exempt from modifier 51. Codes designated as exempt from modifier 51 are identified with a ⊕ symbol, and are listed in the most current CPT book.
- All codes exempt from modifier 51 found in the CPT book are exempt from the multiple procedure concept (see modifier 51 definition in this section). Codes exempt from modifier 51 are reimbursed at one hundred percent (100%) of the maximum reimbursement allowance or the provider's usual charge whichever is less.
- G. **Moderate (Conscious) Sedation.** To report moderate (conscious) sedation provided by the physician also performing the diagnostic or therapeutic service for which conscious sedation is being provided, see codes 99143–99145. It is not appropriate for the physician performing the sedation and the service for which the conscious sedation is being provided to report the sedation separately when the code is listed with the conscious sedation symbol K. The conscious sedation symbol identifies services that include moderate (conscious) sedation. A list of codes for services that include moderate (conscious) sedation is also included in the most current CPT book.
- For procedures listed with K, when a second physician other than the health care professional performing the diagnostic or therapeutic services provides moderate (conscious) sedation in the facility setting (e.g., hospital, outpatient hospital/ambulatory surgery center, skilled nursing facility), the second physician reports the associated moderate sedation procedure/service using codes 99148–99150. Moderate (conscious) sedation services are not reported additionally when performed by the second physician in the non-facility setting (e.g., physician office, freestanding imaging center).
- Moderate sedation codes are not used to report minimal sedation (anxiolysis), deep sedation, or monitored anesthesia care.

Nurse Practitioner, Physician Assistant and Physical or Occupational Therapist Assistant Rules

- I. Modifier NP should be attached to the appropriate CPT code when billing services rendered by the nurse practitioner. The nurse practitioner must use his/her unique identifier to bill for all services. Nurse practitioners must comply with the requirements for a National Provider Identifier (NPI) as specified in the Billing and Reimbursement Rules of this Fee Schedule.
- II. The nurse practitioner is reimbursed at eighty-five percent (85%) of the maximum allowable for the procedure.
- III. There is only one fee allowed for each CPT code. It is the decision of the physician or the nurse practitioner as to who will bill for a service when both have shared in the provision of the service. Incorrect billing of the service may cause a delay or improper payment by the payer. The payer will reimburse the bill which is received first.

The medical doctor (MD) must be on-site on the date of service in order for physician reimbursement to apply.
- IV. The physician assistant shall be reimbursed at the same rate as for the nurse practitioner, and the same rules as apply to the nurse practitioners with regard to billing and reimbursement, shall apply to the physician assistant.
- V. Modifier PA should be attached to the appropriate CPT code when billing services rendered by the physician assistant.
- VI. The Physical Therapist Assistant or Occupational Therapist Assistant shall be reimbursed at eighty-five percent (85%) of the maximum allowable for the procedure. Modifier 'PT' should be attached to the appropriate CPT code(s) when billing services rendered by a Physical Therapist Assistant or an Occupational Therapist Assistant.

Pharmacy Rules

I. SCOPE

This section provides specific rules for the dispensing of and payment for medications and other pharmacy services prescribed to treat work-related injury/illness under the terms of the Act.

II. DEFINITIONS

- A. Medications are defined as drugs prescribed by a licensed health care provider and include name brand and generic drugs as well as patented or over-the-counter drugs, compound drugs and physician-dispensed or repackaged drugs.
- B. Average Wholesale Price means the AWP based on the most current edition of the *Drug Topics Red Book* in effect at the time the medication is dispensed.

III. RULES

- A. **Generic Equivalent Drug Products.** Unless otherwise specified by the ordering physician, all prescriptions will be filled under the generic name.

When the physician writes "brand medically necessary" on the prescription, the pharmacist will fill the order with the brand name. When taking telephone orders, the pharmacist will assume the generic brand is to be used unless "brand medically necessary" is specifically ordered by the treating physician. Without exception, the treating physician has the authority to order a brand name medication if he/she feels the trademark drug is substantially more effective.
- B. A payer or provider may not prohibit or limit any person from selecting a pharmacy or pharmacist of his/her choice, and may not require any person to purchase pharmacy services, including prescription drugs, exclusively through a mail-order pharmacy or program, or to obtain medication dispensed by the physician or in the physician's office, provided the pharmacy or pharmacist selected by the claimant has agreed to be bound by the terms of the Workers' Compensation Law and this Fee Schedule with regard to the provision of services and the billing and payment therefor.
- C. Dietary supplements, including but not limited to minerals, vitamins, and amino acids are not reimbursable unless a specific compensable dietary deficiency has been clinically established.
- D. Not more than one dispensing fee shall be paid per drug within a ten (10) day period.

IV. REIMBURSEMENT

- A. Reimbursement for pharmaceuticals ordered for the treatment of work-related injury/illness is as follows:
 - 1. Brand/Trade Name Medications: Average Wholesale Price (AWP) plus a five dollar (\$5.00) dispensing fee.

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2. Generic Medications: Average Wholesale Price (AWP) plus a five dollar (\$5.00) dispensing fee.
3. Over-the-counter medications are reimbursed at usual and customary rates.
4. Dispensing fees are payable only if the prescription is filled under the direct supervision of a registered pharmacist. If a physician dispenses medications from his/her office, a dispensing fee is not allowed.
5. Repackaged and/or Physician Dispensed Medication. If the National Drug Code ("NDC") for the drug product as dispensed is a repackaged drug, the maximum allowable fee shall be the lesser of AWP using a) the NDC for the underlying drug product from the original labeler, or b) the therapeutic equivalent drug product from the original labeler NDC.

For purposes of this provision, "therapeutically equivalent drugs" means drugs that have been assigned the same Therapeutic Equivalent Code starting with the letter "A" in the Food and Drug Administration's publication "Approved Drug Products with Therapeutic Equivalence Evaluations" ("Orange Book"). The Orange Book may be accessed through the Food and Drug Administration website at <http://www.accessdata.fda.gov/scripts/cder/ob/default.cfm>.

National Drug Code "for the underlying drug product from the original labeler" means the NDC of the drug product actually utilized by the repackager in producing the repackaged product.

6. Compound Medications. Compound drugs or medications shall be billed by listing each drug and its NDC number included in the compound and calculating the charge for each drug separately. Payment shall be based on the sum of the fee for each ingredient, plus a single dispensing fee of five dollars (\$5.00). If the NDC for any ingredient is a repackaged drug, reimbursement for the repackaged ingredient(s) shall be as above provided.
 7. If information pertaining to the original labeler of the underlying drug product used in repackaged or compound medications is not provided or is otherwise unknown or unavailable, the payer shall reimburse using the lowest priced generic therapeutic equivalent drug product.
- B. Supplies and equipment used in conjunction with medication administration should be billed with the appropriate HCPCS codes and shall be reimbursed according to the Fee Schedule. Supplies and equipment not listed in the Fee Schedule will be reimbursed at the usual and customary rate.
- C. Mail-order pharmaceutical services are subject to the rules and reimbursement limitations of this Fee Schedule when supplying medications to Mississippi Workers' Compensation claimants.

Home Health Rules

I. SCOPE

This section of the Fee Schedule pertains to home health services provided to patients who have a work-related injury/illness.

- A. The determination that the injury/illness or condition is work related must be made by the payer and home health services shall be pre-certified as medically necessary by the payer's Utilization Management Program.
- B. All nursing services and personal care services shall have prior authorization by the payer.
- C. A description of needed nursing or other attendant care must accompany the request for authorization.

II. REIMBURSEMENT

- A. If a payer and provider have a mutually agreed upon contractual arrangement governing the payment for home health services to injured/ill employees, the payer shall reimburse under the contractual agreement and not according to the Fee Schedule.
- B. In the absence of a mutually agreed upon contractual arrangement governing payment for home health service, reimbursement shall be made as in other cases (see Billing and Reimbursement Rules) in an amount equal to the maximum reimbursement allowance (MRA).
Billing for home health services is appropriate using the applicable billing form for other institutional providers or facilities.
- C. A visit made simultaneously by two or more workers from a home health agency to provide a single covered service for which one supervises or instructs the other shall be counted as one visit.
- D. A visit is defined as time up to and including the first two hours.
- E. The maximum reimbursement rates listed herein are inclusive of mileage and other incidental travel expenses, unless otherwise agreed to by the payer and provider.
- F. The hourly rates set forth in this section of the Schedule apply to all hours worked. No additional reimbursement is allowed for overtime hours, unless otherwise agreed to by the parties in a separate fee contract.

III. RATES

- A. The following rates and codes apply to services provided by or through a home health agency:

Service	Fee Per Visit	Billing Code
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Skilled Nursing Care	\$110.00	G0154
Physical Therapy	\$120.00	G0151
Speech Therapy	\$125.00	G0153
Occupational Therapy	\$125.00	G0152
Medical Social Services	\$125.00	G0155
Home Health Aid	\$60.00	G0156

For services that exceed two hours, reimbursement for time in excess of the first two hours shall be pro-rated and based on an hourly rate equal to fifty percent (50%) of the above visit fee. For home health services rendered in two (2) hours or less, reimbursement shall be made for a visit as above provided.

NOTE: In addition to the Skilled Nursing Care fees above, an additional sum of \$7.16 per visit shall be added to cover the cost of medical supplies, provided the billing form adequately specifies what supplies were utilized.

B. The following Private Duty Rates shall apply:

Skilled Nursing Care – R.N.	\$44.00 per hour
Skilled Nursing Care – L.P.N.	\$37.00 per hour
Certified Nurse Assistant	\$20.00 per hour
Sitter	\$13.00 per hour

C. Any reimbursement to persons not working under a professional license, such as a spouse or relative, will be at the rate of \$8.00 per hour unless otherwise negotiated by the payer and caregiver or provider.

D. Professional providers not assigned a maximum allowable rate for home health services and who have not negotiated their rates with the payer prior to provision of home health care, shall be reimbursed at the usual and customary rate, or the total billed charge, whichever is less.

Skilled Nursing Facility Rules

- I. The maximum reimbursement amount for medical care provided within the confines of a freestanding skilled nursing facility, a hospital based skilled nursing facility, or a swing bed facility, shall be three hundred dollars (\$300.00) per day. This rate covers and includes all routine and ancillary health care services provided to a claimant during each day of a covered skilled nursing facility stay.

- II. The following services are excluded from the daily skilled nursing facility rate, and shall be reimbursed separately and in addition to the above daily rate: cardiac catheterization; angiography, magnetic resonance imaging (MRI) and computerized axial tomography (CT) scans; radiation therapy and chemotherapy; emergency services, which are defined as an admission or services necessitated by a sudden onset of illness or injury which is manifested by acute symptoms of sufficient severity that the failure to provide services could reasonably result in (a) serious impairment of bodily function(s), (b) serious or permanent dysfunction of any bodily organ or part or system; (c) permanently placing the person's health in jeopardy, or (d) other serious medical consequence; outpatient services when provided in a hospital or other free standing outpatient facility separate from the skilled nursing facility; customized prosthetic services; ambulance transportation related to any of the above service; and services provided independent of the facility by physicians, and other medical practitioners (e.g., NP, PA, CRNA, psychologist).

- III. As in other cases, the above provisions shall not apply to any mutual agreement or contract entered into by the payer and provider which sets forth the terms for the provision of skilled nursing facility services and reimbursement therefor.

Evaluation and Management

This section contains rules and codes used to report evaluation and management services.

Note: Rules used by all physicians in reporting their services are presented in the General Rules section.

I. DEFINITIONS AND RULES

Definitions and rules pertaining to evaluation and management services are as follows:

- A. **Consultations.** The CPT book defines a consultation as "a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source." (This includes referrals for a second opinion.) Consultations are reimbursable only to physicians with the appropriate specialty for the services provided.

In order to qualify as a consultation the following criteria must be met:

- The verbal or written request for a consult must be documented in the patient's medical record.
- The consultant's opinion and any services ordered or performed must be documented by the consulting physician in the patient's medical record.
- The consulting physician must provide a written report to the requesting physician or other appropriate source.

A payer/employer may request a second opinion examination or evaluation for the purpose of evaluating temporary or permanent disability or medical treatment being rendered, as provided in MCA §71-3-15(1) (Rev. 2000). This examination is considered a confirmatory consultation. The confirmatory consultation is billed using the appropriate level and site specific consultation code, 99241-99245 for office or other outpatient consultations and 99251-99255 for inpatient consultations, with modifier 32 appended to indicate a mandated service.

- B. **Referral.** Subject to the definition of "consultation" provided in this Fee Schedule, a referral is the transfer of the total or specific care of a patient from one physician to another and does not constitute a consultation. (Initial evaluations and subsequent services are designated as listed in E/M services)
- C. **New and Established Patient Service.** Several code subcategories in the Evaluation and Management section are based on the patient's status as new or established. The new versus established patient guidelines also clarify the situation in which a physician is on call or covering for another physician. In this instance, classify the patient encounter the same as if it were for the physician who is unavailable.

- *New Patient.* A new patient is one who has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, for this same injury or within the past three years.
 - *Established Patient.* An established patient is a patient who has been treated for the same injury by any physician, of the same specialty, who belongs to the same group practice
- D. E/M Service Components. The first three components of history, examination, and medical decision-making are the keys to selecting the correct level of E/M codes, and all three components must be met or exceeded in the documentation of an initial evaluation. However, in established, subsequent, and follow-up categories, only two of the three must be met or exceeded for a given code
1. The history component is categorized by four levels
 - a. *Problem Focused.* Chief complaint, brief history of present illness or problem
 - b. *Expanded Problem Focused.* Chief complaint, brief history of present illness; problem-pertinent system review
 - c. *Detailed.* Chief complaint, extended history of present illness, problem-pertinent system review extended to include a review of limited number of additional systems; pertinent past, family medical and/or social history directly related to the patient's problems
 - d. *Comprehensive.* Chief complaint, extended history of present illness; review of systems that are directly related to the problems identified in the history of the present illness, plus a review of all additional body systems, complete past, family, and social history
 2. The physical exam component is similarly divided into four levels of complexity:
 - a. *Problem Focused.* An exam limited to the affected body area or organ system.
 - b. *Expanded Problem Focused.* A limited examination of the affected body area or organ system and other symptomatic or related organ systems.
 - c. *Detailed.* An extended examination of the affected body areas and other symptomatic or related organ systems.
 - d. *Comprehensive.* A general multi-system examination or a complete examination of a single organ system.

The CPT book identifies the following body areas:

- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back
- Each extremity

The CPT book identifies the following organ systems:

- Constitutional symptoms (fevers, weight loss, etc.)
- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal

- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic

3. Medical decision-making is the final piece of the E/M coding process. Medical decision making refers to the complexity of establishing a diagnosis or selecting a management option that can be measured by the following:
- a. The number of diagnoses and/or the number of management options to be considered.
 - b. The amount and/or complexity of medical records, diagnostic tests, and other information that must be retrieved, reviewed, and analyzed.
 - c. The risk of significant complications, morbidity, mortality, as well as co-morbidities associated with the patient's presenting problems, the diagnostic procedures, and/or the possible management options.

E. Contributory Components

1. Counseling, coordination of care, and the nature of the presenting problem are not major considerations in most encounters, so they generally provide contributory information to the code selection process. The exception arises when counseling or coordination of care dominates the encounter (more than fifty percent (50%) of the time spent). Document the exact amount of time spent to substantiate the selected code and what was clearly discussed during the encounter. Counseling is defined in the CPT book as a discussion with a patient and/or family concerning one or more of the following areas:
 - a. Diagnostic results, impressions, and/or recommended diagnostic studies.
 - b. Prognosis.
 - c. Risks and benefits of management (treatment) options.
 - d. Instructions for management (treatment) and/or follow-up.
 - e. Importance of compliance with chosen management (treatment) options.
 - f. Risk factor reduction.
 - g. Patient and family education.
2. E/M codes are designed to report actual work performed, not time spent. But when counseling or coordination of care dominates the encounter, time overrides the other factors and determines the proper code. For office encounters, count only the time spent face-to-face with the patient and/or family. For hospital or other inpatient encounters, count the time spent rendering services for that patient while on the patient's unit, on the patient's floor, or at the patient's bedside.

F. Interpretation of Diagnostic Studies in the Emergency Room

1. Only one fee for the interpretation of an x-ray or EKG procedure will be reimbursed per procedure.
2. The payer is to provide reimbursement to the provider that directly contributed to the diagnosis and treatment of the individual patient.
3. It is necessary to provide a signed report in order to bill the professional component of a diagnostic procedure. The payer may require the report before payment is rendered.
4. If more than one bill is received, physician specialty should not be the deciding factor in determining which physician to reimburse.

Example: In many EDs, an emergency room (ER) physician orders the x-ray on a particular patient. If the ER physician interprets the x-ray making a notation as to the findings in the chart and then treats the patient according to these radiological findings, the ER physician should be paid for the interpretation and report. There may be a radiologist on staff at the particular facility with quality control responsibilities at that particular facility. However, the fact that the radiologist reads all x-rays taken in the ED for quality control purposes is not sufficient to command a separate or additional reimbursement from the payer.

5. A review alone of an x-ray or EKG does not meet the conditions for separate payment of a service, as it is already included in the ED visit.

II. GENERAL GUIDELINES

The E/M code section is divided into subsections by type and place of service. Keep the following in mind when coding each service setting:

- A patient is considered an outpatient at a health care facility until formal inpatient admission occurs.
- All physicians use codes 99281–99285 for reporting emergency department services, regardless of hospital-based or non-hospital-based status.
- Admission to a hospital or nursing facility includes E/M services provided elsewhere on the same day.

III. OFFICE OR OTHER OUTPATIENT SERVICES (99201–99215)

Use the Office or Other Outpatient Services codes to report the services for most patient encounters. Multiple office or outpatient visits provided on the same calendar date are billable if medically necessary and include documentation to support medical necessity.

IV. HOSPITAL OBSERVATION SERVICES (99217–99220)

CPT codes 99217 through 99220 report E/M services provided to patients designated or admitted as "observation status" in a hospital. It is not necessary that the patient be located in an observation area designated by the hospital to use these codes; however, whenever a patient is placed in a separately designated observation area of the hospital or emergency department, these codes should be used.

The instructional notes for Initial Hospital Observation Care include the following:

- A. Use these codes to report the encounters by the supervising physician when the patient is designated as "observation status."
- B. These codes include initiation of "observation status," supervision of the health care plan for observation, and performance of periodic reassessments.
- C. When a patient is admitted to observation status in the course of an encounter in another site of service (e.g., hospital emergency department, physician's office, nursing facility), all E/M services provided by that physician on the same day are included in the admission for hospital observation. Only one physician can report initial observation services. Do not use these observation codes for post-recovery of a procedure that is considered a global surgical service.
- D. Observation services are included in the inpatient admission service when provided on the same date. Use Initial Hospital Care codes for services provided to a patient who, after receiving

observation services, is admitted to the hospital on the same date. The observation service is not reported separately.

- E. Admission to a hospital or nursing facility includes evaluation and management services provided elsewhere (office or emergency department) by the admitting physician on the same day.
 - F. For a patient admitted to the hospital on a date subsequent to the date of observation status, the hospital admission would be reported separately with the appropriate Initial Hospital Care code 99221–99223.
 - G. For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes 99234–99236.
- See Office and Other Outpatient Consultation codes to report observation encounters by other physicians.

V. OBSERVATION CARE DISCHARGE SERVICES (99217)

- A. CPT code 99217 is used only if discharge from observation status occurs on a date other than the initial date of observation. The code includes final examination of the patient; discussion of the hospital stay; instructions for continuing care; and preparation of discharge records.
- B. If a patient is admitted to and subsequently discharged from observation status on the same date, see codes 99234–99236.
- C. Do not report observation discharge 99217 in conjunction with a hospital admission.

VI. HOSPITAL INPATIENT SERVICES (99221–99239)

The codes for hospital inpatient services report admission to a hospital setting, follow-up care provided in a hospital setting, and hospital discharge day management. For inpatient care, the time component includes not only face-to-face time with the patient but also the physician's time spent in the patient's unit or on the patient's floor. This time may include family counseling or discussing the patient's condition with the family; establishing and reviewing the patient's record; documenting within the chart; and communicating with other health care professionals, such as other physicians, nursing staff, respiratory therapists, etc.

- A. If the patient is admitted to a facility on the same day as any related outpatient encounter (office, emergency department, nursing facility, etc.), report the total care as one service with the appropriate Initial Hospital Care code.
- B. For initial hospital care of a patient admitted on one date and discharged a subsequent day, report 99221–99223 for the initial inpatient care, 99231–99233 for the subsequent hospital care excluding the discharge day.
- C. For a patient admitted and discharged for inpatient services or observation status on the same date, report the service with CPT codes 99234–99236.
- D. Code 99238 or 99239 reports hospital discharge day management, but excludes discharge of a patient from observation status and inpatients admitted and discharged on the same date. When concurrent care is provided on the day of discharge by a physician other than the attending physician, report these services using Subsequent Hospital Care codes.

VII. MULTIPLE HOSPITAL VISITS

Not more than one hospital visit per day shall be payable except when documentation describes the medical necessity of more than one visit by a particular practitioner. Hospital visit codes shall be combined into the single code that best describes the service rendered.

VIII. CONSULTATIONS (99241–99255)

Consultations in *CPT 2008* fall under two subcategories: Office or Other Outpatient Consultations, and Inpatient Consultations. If counseling dominates the encounter, time determines the correct code.

Most requests for a consultation come from the attending physician, the employer, an attorney, or other appropriate source. Include the name of the requesting physician or other source on the claim form or electronic billing. Confirmatory consultations may be requested by the patient and/or family or may result from a second (or third) opinion. When requested by the patient and/or family the service is not reported with consultation codes, but may be reported using the office, home service, or domiciliary/rest home care codes. When required by the attending physician or other appropriate source, report the service with a consultation code for the appropriate site of service, 99241–99245 for office or other outpatient consultation or 99251–99255 for inpatient consultation.

The consultant may initiate diagnostic and/or therapeutic services, such as writing orders or prescriptions and initiating treatment plans.

The opinion rendered and services ordered or performed must be documented in the patient's medical record and a report of this information communicated to the requesting entity.

Report separately any identifiable procedure or service performed on, or subsequent to, the date of the initial consultation.

When the consultant assumes responsibility for the management of any or all of the patient's care subsequent to the consultation encounter, consult codes are no longer appropriate. Depending on the location, identify the correct subsequent or established patient codes.

IX. EMERGENCY DEPARTMENT SERVICES (99281–99288)

Emergency department (ED) service codes do not differentiate between new and established patients and are used by hospital-based and non-hospital-based physicians. The notes in the *CPT* book clearly define an emergency department as "an organized hospital-based facility for the provision of unscheduled episodic services to patients who present for immediate medical attention. The facility must be available 24 hours a day." This guideline indicates that care provided in the ED setting for convenience should not be coded as an ED service. Also note that more than one ED service can be reported per calendar day if medically necessary.

Codes 99281–99288 are used to report services provided in a medical emergency. If, however, the physician sees the patient in the emergency room out of convenience for either the patient or physician, the appropriate office visit code should be reported (99201–99215) and reimbursement will be made accordingly.

X. CRITICAL CARE SERVICES (99291–99300)

Critical care is the direct delivery by a physician(s) of medical care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition. Critical care involves high complexity decision making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition. Examples of vital organ system failure include, but are not limited to: central nervous system failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure. Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life threatening situations when these elements are not

present. Critical care may be provided on multiple days, even if no changes are made in the treatment rendered to the patient, provided that the patient's condition continues to require the level of physician attention described above.

Providing medical care to a critically ill, injured, or postoperative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the above requirements. Critical care is usually, but not always, given in a critical care area, such as the coronary care unit, intensive care unit, pediatric intensive care unit, respiratory care unit, or the emergency care facility.

Critical care services provided to infants 29 days through 24 months of age are reported with pediatric critical care codes 99293 and 99294. Critical care services provided to infants older than one month of age at the time of admission to an intensive care unit are reported with critical care codes 99291 and 99292. Critical care services provided to neonates (28 days of age or less at the time of admission to an intensive care unit) are reported with the neonatal critical care codes 99295, 99296, 99298, 99299, and 99300. The neonatal critical care codes are reported as long as the neonate qualifies for critical care services during the hospital stay. The reporting of pediatric and neonatal critical care services is not based on time, the type of unit (e.g., pediatric or neonatal critical care unit) or the type of provider delivering the care. For additional instructions on reporting these services, see the Inpatient Neonatal and Pediatric Critical Care section of the CPT book and codes 99293–99300.

Services for a patient who is not critically ill but happens to be in a critical care unit are reported using other appropriate E/M codes.

Critical care and other E/M services may be provided to the same patient on the same date by the same physician.

The following services are included in reporting critical care when performed during the critical period by the physician(s) providing critical care: the interpretation of cardiac output measurements (93561, 93562), chest x-rays (71010, 71015, 71020), pulse oximetry (94760, 94761, 94762), blood gases, and information data stored in computers (e.g., ECGs, blood pressures, Hematologic data (99090)), gastric intubation (43752, 91105), temporary transcutaneous pacing (92953), ventilatory management (94002–94004, 94660, 94662), and vascular access procedures (36000, 36410, 36415, 36591). Any services performed which are not listed above should be reported separately when performed in conjunction with critical services reported with code 99291–99292. When reporting inpatient neonatal and pediatric critical care services 99293–99300, consult the CPT book for additional procedures that are bundled into codes 99293–99300.

Codes 99291–99292 should not be reported for the physician's attendance during the transport of critically ill or injured patients to or from a facility or hospital. Physician transport services of the critically ill or injured pediatric patient (24 months of age or less) are separately reportable, see 99289, 99290.

The critical care codes 99291 and 99292 are used to report the total duration of time spent by a physician providing critical care services to a critically ill or critically injured patient, even if the time spent by the physician on that date is not continuous. For any given period of time spent providing critical care services, the physician must devote his or her full attention to the patient and, therefore, cannot provide services to any other patient during the same period of time.

XI. NURSING FACILITY SERVICES (99304–99318)

Nursing facility E/M services have been grouped into four subcategories: Initial Nursing Facility Care, Subsequent Nursing Facility Care, Nursing Facility Discharge Services, and Other Nursing Facility Services. Included in these codes are E/M services provided to patients in nursing facilities (formerly called skilled nursing facilities (SNFs)), intermediate care facilities (ICFs), long-term care facilities,

(LTCFs), and psychiatric residential treatment centers. Psychiatric residential treatment centers must provide a "24 hour therapeutically planned and professionally staffed group living and learning environment." Report other services, such as medical psychotherapy, separately when provided in addition to E/M services.

XII. DOMICILIARY, REST HOME (E.G., BOARDING HOME), OR CUSTODIAL CARE SERVICES (99324–99340)

The evaluation and management codes are used to report care given to patients residing in a facility that provides room and board and other personal assistance services. The facility is generally a long-term facility. The facility's services do not include a medical component. Typical times have not been established for this code group.

XIII. HOME SERVICES (99341–99350)

Services and care provided at the patient's home are coded from this subcategory. Typical times have not been established for this code group.

XIV. PROLONGED SERVICES (99354–99359)

A. *Prolonged Physician Service with Direct Patient Contact (99354–99357)*. Prolonged physician services are reportable in addition to other physician services, including any level of E/M service. The codes report the total duration of face-to-face time spent by the physician on a given date, even if the time is not continuous.

Codes 99354 or 99356 report the first hour of prolonged service on a given date, depending on the place of service. Code 99355 or 99357 is used to report each additional 30 minutes beyond the first hour. Services lasting less than 30 minutes are not reportable in this category, and the services must extend 15 minutes or more into the next time period to be reportable. For example, services lasting one hour and twelve minutes are reported by code 99354 or code 99356 alone. Services lasting one hour and seventeen minutes are reported using the code for the first hour plus the code for an additional 30 minutes.

Prolonged physician services should be reported only once per date of service, even if the time spent is not continuous. Please refer to the most current CPT book for a more complete explanation of prolonged physician care.

B. *Prolonged Physician Service without Direct Patient Contact*. Use code 99358 to report the first hour and 99359 for each additional 30 minutes. All aspects of time reporting are the same as explained above for direct patient contact services.

Prolonged physician services without direct patient contact may include review of extensive records and tests, and communication (other than telephone calls, 99441–99443) with other professionals and/or the patient and family. These are beyond the usual services and include both inpatient and outpatient settings. Report these services in addition to other services provided, including any level of E/M service.

XV. PHYSICIAN STANDBY SERVICES (99360)

Code 99360 is used to report physician standby service that is requested by another physician and that involves prolonged physician attendance without direct (face-to-face) patient contact. The physician may

not be providing care or services to other patients during this period. This code is not used to report time spent proctoring another physician. It is also not used if the period of standby ends with the performance of a procedure subject to a "surgical" package by the physician who was on standby.

Code 99380 is used to report the total duration of time spent by a physician on a given date on standby. Standby service of less than 30 minutes total duration on a given date is not reported separately.

Second and subsequent periods of standby beyond the first 30 minutes may be reported only if a full 30 minutes of standby was provided for each unit of service reported.

XVI. CASE MANAGEMENT SERVICES (99363–99368)

Physician case management is a process in which a physician is responsible for direct care of a patient, and for coordinating and controlling access to or initiating and/or supervising other health care services needed by the patient.

XVII. CARE PLAN OVERSIGHT SERVICES (99339–99340, 99374–99380)

Care plan oversight services are reported separately from codes for office/outpatient, hospital, home, nursing facility, or domiciliary services. The complexity and the approximate physician time spent in care plan oversight services provided within a thirty (30) day period determines the code to be billed.

Only one physician may report care plan oversight services during a given period of time, reflecting the physician's sole or predominant supervisory role with the patient. These codes should not be used for supervision of a patient in a nursing facility or under the care of a home health agency unless they require recurrent supervision of therapy. Care plan oversight services are considered part of the patient evaluation and management services when less than fifteen (15) minutes are provided during a thirty (30) day period.

XVIII. SPECIAL EVALUATION AND MANAGEMENT SERVICES (99450–99456)

This series of codes was introduced in *CPT 1995* to report physician evaluations in order to establish baseline information for insurance certification and/or work-related or medical disability.

XIX. OTHER EVALUATION AND MANAGEMENT SERVICES (99499)

This is an unlisted code to report E/M services not specifically defined in the CPT book.

XX. MODIFIERS

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code, separated by a hyphen. If more than one modifier is needed, place the multiple modifiers code 99 after the procedure code to indicate that two or more modifiers will follow. Modifiers commonly used with E/M procedures are as follows.

21 Prolonged Evaluation and Management Services

When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category, it may be identified by adding modifier 21 to the evaluation and management code number. A report may also be appropriate.

24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period

The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57.

For significant, separately identifiable non-E/M services, see modifier 59.

32 Mandated Services

Services related to mandated consultation and/or related services (eg, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

57 Decision for Surgery

An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

Anesthesia

I. INTRODUCTION

The base units in this section have been determined on an entirely different basis from the relative values in other sections. A conversion factor applicable to this section is not applicable to any other section.

The American Society of Anesthesiologists' (ASA) *Relative Value Guide*™ 2010 is recognized as an appropriate assessment of current relative values for specific anesthesiology procedures. It is the basis for the assigned base units for CPT codes in the Anesthesia section of the Fee Schedule.

The conversion factor for anesthesia services has been designated at \$45.00 per unit.

Total anesthesia value is defined in the following formula:

$$(\text{Base units} + \text{time units} + \text{modifying units}) \times \text{conversion factor} = \text{reimbursement}$$

II. BASE UNITS

Base units are listed for most procedures. This value is determined by the complexity of the service and includes all usual anesthesia services except the time actively spent in anesthesia care and the modifying factors. The base units include preoperative and postoperative visits, the administration of fluids and/or blood incident to the anesthesia care, and interpretation of noninvasive monitoring (ECG, temperature, blood pressure, oximetry, and other usual monitoring procedures). The basic anesthesia unit includes the routine follow-up care and observation (including recovery room observation and monitoring). When multiple surgical procedures are performed during the same period of anesthesia, only the highest base unit allowance of the various surgical procedures will be used.

III. TIME UNITS

Time begins when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or in an equivalent area. Time ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision. The anesthesia time units will be calculated in 15-minute intervals, or portions thereof, equaling one (1) time unit. No additional time units are allowed for recovery room time and monitoring.

IV. SPECIAL CIRCUMSTANCES

A. Physical Status Modifiers

Physical status modifiers are represented by the initial letter P followed by a single digit from one (1) to six (6) defined below:

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Status	Description	Base Units
P1	A normal healthy patient	0
P2	A patient with mild systemic disease	0
P3	A patient with severe systemic disease	1
P4	A patient with severe systemic disease that is a constant threat to life	2
P5	A moribund patient who is not expected to survive without the operation	3
P6	A patient declared brain-dead whose organs are being removed for donor purposes	0

The above six levels are consistent with the American Society of Anesthesiologists' (ASA) ranking of patient physical status. Physical status is included in the CPT book to distinguish between various levels of complexity of the anesthesia service provided.

B. Qualifying Circumstances

1. Qualifying circumstances warrant additional value due to unusual events. The following list of CPT codes and the corresponding anesthesia unit values may be listed if appropriate. The unit value listed is added to the existing anesthesia base units.

CPT	Description	Units
99100	Anesthesia for patient of extreme age, younger than one year and older than seventy (List separately in addition to code for primary anesthesia procedure)	1
99116	Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure)	5
99135	Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure)	5
99140	Anesthesia complicated by emergency conditions (specify conditions) (List separately in addition to code for primary anesthesia procedure) (An emergency is defined as existing when delay in treatment of a patient would lead to a significant increase in the threat to life or body part.)	2

2. Payers must utilize their medical consultants when there is a question regarding modifiers and/or special circumstances for anesthesia charges.

V. MONITORED ANESTHESIA CARE

Monitored anesthesia care occurs when the attending physician requests that an anesthesiologist be present during a procedure. This may be to insure compliance with accepted procedures of the facility. Monitored anesthesia care includes pre-anesthesia exam and evaluation of the patient. The anesthesiologist must participate or provide medical direction for the plan of care. The anesthesiologist, resident, or nurse anesthetist must be in continuous physical presence and provide diagnosis and treatment of emergencies. This will also include noninvasive monitoring of cardio-circulatory and respiratory systems with administration of oxygen and/or intravenous administration of medications. Reimbursement will be the same as if general anesthesia had been administered (time units + base units).

VI. REIMBURSEMENT FOR ANESTHESIA SERVICES

A. Criteria for Reimbursement

Anesthesia services may be billed for any one of the three following circumstances:

1. An anesthesiologist provides total and individual anesthesia service.
2. An anesthesiologist directs a CRNA or AA
3. Anesthesia provided by a CRNA or AA working independent of an anesthesiologist's supervision is covered under the following conditions:
 - a. The service falls within the CRNA's or AA's scope of practice and scope of license as defined by law.
 - b. The service is supervised by a licensed health care provider who has prescriptive authority in accordance with the clinical privileges individually granted by the hospital or other health care organization.

B. Reimbursement

1. The maximum reimbursement allowance for anesthesia is calculated by adding the base unit value, the number of time units, any applicable modifier and/or unusual circumstances units, and multiplying the sum by a dollar amount (conversion factor) allowed per unit.
2. Reimbursement includes the usual pre- and postoperative visits, the care by the anesthesiologist during surgery, the administration of fluids and/or blood, and the usual monitoring services. Unusual forms of monitoring, such as central venous, intra-arterial, and Swan-Ganz monitoring, may be reimbursed separately.
3. When an unlisted service or procedure is provided, the value should be substantiated with a report. Unlisted services are identified in this Fee Schedule as by report (BR)
4. When it is necessary to have a second anesthesiologist, the necessity should be substantiated BR. The second anesthesiologist will receive five base units + time units (calculation of total anesthesia value)
5. Payment for covered anesthesia services is as follows:
 - a. When the anesthesiologist provides an anesthesia service directly, payment will be made in accordance with the Billing and Reimbursement Rules of this Fee Schedule.
 - b. When an anesthesiologist provides medical direction to the CRNA or AA providing the anesthesia service, then the reimbursement will be divided between the two of them at fifty percent (50%).
 - c. When the CRNA or AA provides the anesthesia service directly, then payment will be the lesser of the billed charge or eighty percent (80%) of the maximum allowable listed in the Fee Schedule for that procedure.

6. Anesthesiologists, CRNAs, and AAs must bill their services with the appropriate modifiers to indicate which one provided the service. Bills NOT properly coded may cause a delay or error in reimbursement by the payer. Application of the appropriate modifier to the bill for service is the responsibility of the provider, regardless of the place of service. Modifiers are as follows:

- AA Anesthesiologist services performed personally by an anesthesiologist
- AD Medical supervision by a physician: more than four concurrent anesthesia procedures
- QK Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals (CRNA or AA) by an anesthesiologist
- QX CRNA or AA service: with medical direction by an anesthesiologist
- QY Medical direction of one certified registered nurse anesthetist (CRNA or AA) by an anesthesiologist
- QZ CRNA service: without medical direction by an anesthesiologist

VII. ANESTHESIA MODIFIERS

All anesthesia services are reported by using the anesthesia five-digit procedure codes. The basic value for most procedures may be modified under certain circumstances as listed below. When applicable, the modifying circumstances should be identified by the addition of the appropriate modifier (including the hyphen) after the usual anesthesia code. Certain modifiers require a special report for clarification of services provided.

Modifiers commonly used in anesthesia are as follows:

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.

Mississippi's note: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement.

23 Unusual Anesthesia

Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

32 Mandated Services

Services related to mandated consultation and/or related services (e.g., third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

53 Discontinued Procedure

Under certain circumstances the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure.

Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.

59 Distinct Procedural Service

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

AA Anesthesia Services Performed Personally by the Anesthesiologist:

Report modifier AA when the anesthesia services are personally performed by an anesthesiologist.

AD Medical Supervision by a Physician; More Than Four Concurrent Anesthesia Procedures:

Report modifier AD when the anesthesiologist supervises more than four concurrent anesthesia procedures.

QK Medical Direction of Two, Three, or Four Concurrent Anesthesia Procedures Involving Qualified Individuals:

Report modifier QK when the anesthesiologist supervises two, three, or four concurrent anesthesia procedures.

QX CRNA or AA Service with Medical Direction by a Physician:

Regional or general anesthesia provided by the CRNA or AA with medical direction by a physician may be reported by adding modifier QX.

QY Medical Supervision by Physician of One CRNA or AA:

Report modifier QY when the anesthesiologist supervises one CRNA or AA.

QZ CRNA or AA Service without Medical Direction by a Physician:

Regional or general anesthesia provided by the CRNA or AA without medical direction by a physician may be reported by adding modifier QZ.

Pain Management

In addition to the General Rules, this section provides specific rules for Pain Management services.

I. REIMBURSEMENT FOR PAIN MANAGEMENT SERVICES

A. Reimbursement for pain management services is based on the Resource Based Relative Value Scale (RBRVS).

B. Use of Fluoroscopy

The reimbursement for the use of fluoroscopy (CPT codes 77002 and 77003) is based on the RBRVS, regardless of the number of procedures performed, and may only be billed once per date of service.

CPT code 77002 is to be used for fluoroscopic guidance for needle placement for CPT code 64510 Cervical (stellate ganglion) sympathetic block, or CPT code 64520 Thoracic or lumbar blocks.

CPT code 77003 is to be used for fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (i.e., epidural, transforaminal epidural, or sacroiliac joint), and including facet nerve neurolytic agent destruction.

C. Reimbursement for Injection/Destruction Procedures

1. The current CPT codes for Pain Management typically have separate codes for injections that may involve additional levels (e.g., 64490 is for injection of cervical facet single or first level, and 64491 and 64492 are used for additional levels).
2. Facet injections, medial branch blocks and nerve destruction procedures are reimbursed at a maximum of three (3) total anatomic joint levels. Additional level or bilateral modifiers may be used to allow up to a maximum of two (2) additional service levels (but not more) for facet or medial branch blocks in the cervical/thoracic (64491 and 64492) or lumbar (64494 and 64495) for a maximum of three (3) procedure levels reimbursed per treatment session or day. Additional injected site levels, beyond the first three (3), will not be reimbursed. These procedures are unilateral by definition. Bilateral modifiers may be used when nerves are treated bilaterally. Reimbursement of the bilateral modifier is fifty percent (50%) of the base amount for the second or contralateral side.
3. Reimbursement for injection/destruction procedure codes is made on the basis of nerves treated (e.g., destruction by neurolytic agent of the L4–L5 facets counts as two (2) levels/nerves and should be billed as 64622 (first level/nerve) and 64623 (each additional level)). There are two nerves supplying each joint and reimbursement is based upon nerve(s) treated, not the joint levels treated. This applies to CPT codes 64622, 64623 (lumbar), and 64626, 64627 (cervical/thoracic). These procedures are unilateral by definition. Additionally, bilateral modifiers may be used when nerves are treated bilaterally. Reimbursement of the bilateral modifier is fifty percent (50%) of the base amount for the second or contralateral side.
4. Multiple Epidural Injections in a Single Treatment Day/Session. In order to obtain reimbursement for more than one epidural injection in a single treatment day/session (either multiple levels or bilateral injections) there must be appropriate documentation in the medical records of a medical

condition for which multiple injections would be appropriate. For bilateral injections, this includes the presence of significant bilateral radiating/radicular pain. For multiple level injections, this includes conditions for which an additional injected level could be anticipated to result in improved clinical outcomes. These conditions would include:

- Disc pathology (e.g., protrusion) at one level with a dermatomal pain distribution of an adjacent level (e.g., disc affects the traversing nerve root, such as an L4/5 disc herniation affecting the traversing L5 nerve root).
- Multiple dermatomal nerve root involvement.

A maximum of two (2) levels of transforaminal epidural steroid injections are reimbursable for a given date of service. This applies to codes 64479, 64480, 64483, and 64484.

Reimbursement is still limited to two epidural procedures (either two levels, or one level bilaterally) per date of service.

5. A maximum of one (1) interlaminar epidural steroid injection is reimbursable for a given date of service. This applies to codes 62310 and 62311.
6. A maximum of three (3) facet level procedures are reimbursable for a given date of service. This maximum applies to facet joint injections and nerve blocks, codes 64490 - 64495. Nerve destruction procedures, codes 64622-64627, are limited to two (2) facet levels (three (3) nerve branches), unilateral and bilateral, per given date of service.

D. Multiple Procedure Reimbursement

"Type" is defined as any procedure code involving an anatomically different structure (e.g., spinal nerve, facet joint, sacroiliac joint, trigger point, etc.). Joints and nerves in different anatomical regions (cervical, thoracic, lumbar, sacral) are considered to be different "types" and are limited to two (2) procedures per given day. Additional level or bilateral injections of a single procedure in the same area are not considered different "types," and for the purpose of this rule, are considered to be the same "type." However, the multiple level restrictions, as detailed herein, still apply.

Example: A three-level lumbar facet injection would be billed as 64493 for the first level and 64494 and 64495 for each additional level.

II. REIMBURSEMENT FOR REFILL OF PAIN PUMPS

- A. Code 95990. This CPT code, which applies to refilling and maintenance of an implantable pump or reservoir for drug delivery spinal (intrathecal, epidural) or brain (intraventricular), is reimbursed at the specified MRA listed in the Medicine section of the Fee Schedule.
- B. Evaluation and Management Services. Refilling and maintenance of implantable pump or reservoir for pain management drug delivery is a global service. An evaluation and management service is not paid additionally unless significant additional or other cognitive services are provided and documented. To report a significant, separately identifiable evaluation and management service, append modifier 25 to the appropriate evaluation and management code. Documentation is required and payment will be allowed if supported by the documentation.
- C. Drugs. Those drugs used in the refill of the pain pump shall be reimbursed in accordance with the Pharmacy Rules contained in the Pharmacy Rules section of this Fee Schedule.
- D. Compounding Fee. If the drugs used in the refill of the pain pump must be compounded, the compounding service shall be reimbursed at \$157.44 per individual refill. Report the compounding service with code S9430, Pharmacy compounding and dispensing services.

III. "DIAGNOSTIC ONLY" INJECTIONS AND PROCEDURES

- A. Valid "diagnostic only" injections require a reasonably alert patient capable of adequately determining the amount or level of pain relieved or produced by the procedure. This requires judicious use of sedatives in the performance of such procedures. Clearly, analgesic medications such as intravenous narcotics are to be avoided during the procedure and evaluation phase of testing, as these medications can affect the validity of such diagnostic tests. The results of the tests and drugs used during the injection or procedure must be part of the medical records, and available for review by the payer. Failure to document the patient's response to a diagnostic procedure or injection, and the level of alertness following the procedure or injection, could result in denial of reimbursement.
- B. Discography requires a reasonably alert patient capable of discriminating the quality and quantity of discomfort during the performance of the procedure in order to provide valid information on concordant or non-concordant pain. The results of the tests and drugs used during the procedure must be part of the medical records, and available for review by the payer. Failure to document the patient's response to the procedure, and level of alertness during discography could result in denial of reimbursement.
- C. Medial branch (facet nerve) or diagnostic intra-articular facet injections require an alert patient, free from undue influence of intravenous narcotics in order to more reliably determine the analgesic response to the procedure. Failure to document the patient's response to the procedure or injection, and level of alertness after the procedure for diagnostic facet nerve or facet intra-articular injections could result in denial of reimbursement.
- D. Diagnostic injections with local anesthetics require documentation of analgesic response through any validated pain measurement test (e.g., numerical pain scale, visual analogue scale). This should be performed after the procedure during the time that there would be an expected analgesic response (every thirty (30) minutes for at least one (1) hour). This must be documented and the documentation must be available to the payer for review. The documentation must also include the drugs used during the procedure, and comments on the patient's level of alertness at each time period when the pain or response is evaluated. If the patient's pre-procedure pain was determined by provocative exam tests or maneuvers, these should be repeated during the evaluation period following the procedure, to differentiate analgesia related to the procedure from positional analgesia, such as, for example, that which may be provided by lying in a recovery bed.
- E. Intravenous narcotic pain medications are typically to be avoided for diagnostic analgesic injections, such as facet joint or nerve blocks, as they would be expected to provide an analgesic benefit completely independent of the injection itself. Sedatives such as midazolam or propofol can be used judiciously, if necessary, avoiding excessive post-procedure sedation, depending on the experience level of the practitioner ordering or administering the medication. Proper documentation of a lack of undue influence of sedation and analgesics must be provided to support a request for reimbursement for diagnostic procedures.
- F. Other injections with both therapeutic and potentially diagnostic benefit, such as selective nerve root or peripheral nerve blocks or therapeutic facet injections (see T modifiers), would ideally be performed with minimal sedation and avoidance of intravenous narcotics. However, as these injections also have potential therapeutic benefit, this is NOT a requirement for reimbursement.

IV. PHYSICAL THERAPY

In the pain management setting, no more than two (2) modalities and/or procedures may be used on a date of service (e.g., heat/cold, ultrasound, diathermy, iontophoresis, TENS, electrical stimulation, muscle stimulation, etc.). Multiple modalities should be performed sequentially. Only one (1) modality can be reported for concurrently performed procedures.

V. GENERAL RULES

A. This Fee Schedule does not recognize a "series" of epidural injections, regardless of number. A trial of epidural injections is permitted provided there is appropriate documentation of a recognized indication for this procedure. Only a single injection can be approved unless there is documentation of analgesic response consistent with a response to the injection. Further injections require a positive analgesic response for approval. For the first injection, the initial analgesic response may be temporary. However, after the second injection, there must be a residual and progressive analgesic benefit in order to perform a third injection. Documentation of a positive patient response will be required to continue epidural treatment. If there is no documented residual pain relief after two (2) injections, no further injections will be considered medically necessary.

1. There is no recognized "series" of epidural injections, and repeat injections are contingent upon proper documentation of clinical responses as stated above. Repeat injections (up to two additional injections, for a total of three (3) per twelve (12) month period), however, do NOT require prior approval as long as the appropriate responses are properly documented. Specifically, the first injection must provide at least a temporary analgesic response. Subsequent epidural injections must provide progressive and durable relief of the targeted pain. Utilization management or review decisions shall not be based solely on the application of clinical guidelines, but must include review of clinical information submitted by the provider and represent an individualized determination based on the worker's current condition and the concept of medical necessity predicated on objective or appropriate subjective improvements in the patient's clinical status.

B. Reimbursement will be limited to three (3) epidural pain injections in a twelve (12) month period unless the payer gives prior approval for more than three (3) such injections. Separate billing for the drug injected is not appropriate and will not be reimbursed.

C. Modifiers

PM Pain Management

Modifier PM, which is a Mississippi-specific pain management code modifier, is no longer required, and will not be recognized for reimbursement for dates of service beginning August 1, 2007.

Modifiers T and D (Mississippi State Modifiers)

Facet joint/nerve injections can be used for diagnostic or therapeutic indications, or both. These injections should be used with modifier D to indicate a diagnostic intention of the injection, or with modifier T to indicate a therapeutic intention of the injection.

Intra-articular joint injections (cervical, thoracic, lumbar), which can have both diagnostic and therapeutic indications, should always be considered primarily therapeutic and should be billed using modifier T.

The number of facet injections subject to reimbursement is limited to four (4) dates of service with a maximum of two (2) therapeutic and two (2) diagnostic injections for the initial twelve (12) month period of treatment per anatomical region. This allows for a total of four (4) dates of service, regardless of the number of levels treated, which levels are treated, or which side (left or right or bilateral) is treated, in the same anatomical region. For coding purposes, the spine is divided into three (3) anatomical regions, cervical, thoracic, and lumbar/sacral. If treatment for facet related pain continues past twelve (12) months, further injections are limited to a total of two (2) dates of service per twelve (12) month period. This limit applies to both therapeutic and diagnostic injections combined, and reimbursement beyond the initial twelve (12) month period is further limited to no more than two (2) injections of either type, as determined by modifiers T or D, per twelve (12) month period. Failure to designate injections with the appropriate T or D modifier will limit reimbursement to no more than two (2) facet joint/nerve injections per twelve (12) month period. This rule applies to cervical, thoracic, and lumbar facet joint and facet joint nerve injections.

Facet injections in different anatomical areas are not subject to the above limits, as each different anatomical area would be subject to its own separate limit as described above. Nerve-destructive procedures (e.g. radiofrequency facet nerve neurotomy, codes 64622, 64623, 64626, 64627) do NOT count as an additional therapeutic procedure for the purpose of this rule.

A "different anatomical area" refers to the lumbar, thoracic, and cervical areas. Injections within the lumbar spine, for example, are considered to be within the same anatomical area regardless of the actual lumbar joint/nerve level, or which side (right or left), is treated, and all limits would apply in this anatomical area. The same rule applies to the thoracic and cervical anatomical areas, regardless of the level or laterality treated within the same anatomical area.

Facet nerve (medial branch ablation) for cervical, thoracic or lumbar nerves will only be reimbursed once per nine (9) month period.

In order to perform a repeat therapeutic facet joint injection (cervical, thoracic, or lumbar, codes 64490 – 64495), there must be documentation of a significant analgesic response that persists for at least four (4) weeks. This relief must be at least fifty percent (50%) of the pain in the specific anatomical area targeted by the injection, or there must be documentation of a durable (also four (4) weeks) measurable improvement in the range of motion of the involved joint area being treated.

- D. In order to be eligible for reimbursement under this Fee Schedule, pain management procedures or services which are specifically governed by the rules in this Pain Management section of the Fee Schedule must be performed by a licensed physician holding either an M.D. or D.O. degree. Pain management procedures specifically governed herein which are performed by any other person, such as a Certified Registered Nurse Anesthetist (CRNA), shall not be reimbursed under this Fee Schedule.
- E. Trigger point injection is considered one (1) procedure and is reimbursed as such regardless of the number of injection sites. Billing for multiple injections, and multiple regions, falls under the same one-procedure rule. Two codes are available for reporting trigger point injections: use 20552 for injection(s) of single or multiple trigger point(s) in one or two muscles, or 20553 when three or more muscles are involved. When billing for multiple injections, and multiple regions, only code 20552 OR 20553 is allowed per date of service.
- F. Sacroiliac arthroscopy (CPT code 73542) assumes the use of a fluoroscope and is considered an integral part of the procedure(s). Therefore, an additional fee for the fluoroscopy (CPT code 77002) is not warranted and will not be reimbursed. This code may only be used once per twelve (12) month period.
- G. Epidurography (CPT code 72275), a/k/a "epidural myelogram" or "epidural without dural puncture," is the proper code to use for contrast material injected into the epidural space. The epidurography code involves the inherent use of a fluoroscope, and, therefore, an additional fluoroscopy fee for procedure code 77003 is not reimbursable. This code may only be used once per twelve (12) month period.
- H. CPT code 62318 includes needle placement, catheter infusion and subsequent injections. Code 62318 should be used for multiple solutions injected by way of the same catheter, or multiple bolus injections during the initial procedure. The epidural needle or catheter placement is inherent to the procedure, and, therefore, no additional charge for needle or catheter placement is allowed.
- I. Investigational Procedures. The following procedures are considered investigational, and, therefore, do not presently qualify for reimbursement under the *Mississippi Workers' Compensation Medical Fee Schedule*.
1. Intradiscal electrothermal therapy (IDET) (22526, 22527) and intradiscal annuloplasty by other method (0062T, 0063T);
 2. Intraventricular administration of Morphine;

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3. Pulse radiofrequency, regardless of procedure involved or indication (e.g., medial branch radiofrequency, dorsal root radiofrequency, etc.). If pulsed radiofrequency is used, but not specifically recorded as such in the medical records, the payer may retroactively deny payment for the service and request for reimbursement from the provider;
 4. Intradiscal therapies used in discography, such as percutaneous disc decompression (Dekompressor), fluoroscopic, laser, radiofrequency, and thermal disc therapies;
 5. Percutaneous disc nucleoplasty;
 6. Epidural adhesiolysis, also known as Racz procedure or lysis of epidural adhesions.
- J. The following procedures must be performed fluoroscopically in order to qualify for reimbursement:
1. Facet injections (64490 - 64495)
 2. Sacroiliac (SI) injections (27096)
 3. Transforaminal epidural steroid injections (64479, 64460, 64483, 64484)
 4. Cervical translaminar/interlaminar epidural injections (62310)
- K. Any analgesia/sedation used in the performance of the procedures in this section is considered integral to the procedure, and will not be separately reimbursed. This rule applies whether or not the person administering the analgesia/sedation is the physician who is performing the pain management injection. Administration of analgesia/sedation by a different person from the physician performing the injection, including an RN, PA, CRNA, or MD/DO, DOES NOT allow for separate billing of analgesia/sedation.
- L. Anatomical descriptions of the procedures performed must accompany the bill for service in order for reimbursement to be made. These descriptions must include landmarks used in determining needle positioning, needles used, and the type and quantity of drugs injected. Tolerance to the procedure, and side effects or lack thereof should be included in this documentation.
- M. Discography. Discography is a diagnostic test to identify (or rule out) painful intervertebral discs. Discography is appropriate only in patients for whom no other treatment options remain except for possible surgical stabilization (spinal fusion). A discography is then used on these patients to determine which discs, if any, are painful and abnormal, so that a surgical correction (fusion) can be performed. If a patient is not considered to be a candidate for surgery (fusion), then a discogram is not considered medically necessary. Investigational intradiscal therapies such as percutaneous disc decompression (Dekompressor), fluoroscopic, laser, radiofrequency, and thermal disc therapies are not an indication for a discography.
- The radiographic interpretation codes 72285 and 72295 can only be used ONCE per treatment session and additional level modifiers are not allowed.
- When reporting the radiological supervision and interpretation professional components for discography (72285, 72295), the anatomical localization for needle placement is inclusive with the procedure and code 77003 should NOT be additionally reported.
- Radiographic interpretation codes 72285 and 72295 must include a thorough description of radiographic findings available in a separate report with hard copy radiographs or other media, such as digital, that will allow review of images (AP and lateral at a minimum).
- N. BOTOX. BOTOX is not indicated for the relief of musculoskeletal pain, and its use as such is not covered by the Fee Schedule. An exception is made when BOTOX treatment is indicated for spasticity or other indications and requires prior approval.
- O. Use of Opioids or Other Controlled Substances for Management of Chronic (Non-Terminal) Pain. It is recognized that optimal or effective treatment for chronic pain may require the use of opioids or other controlled substances. The proper and effective use of opioids or other controlled substances has

been specifically addressed by the Mississippi Board of Medical Licensure. Unless otherwise directed by the Commission, reimbursement for prescriptions for opioids or other controlled substances used for the management or treatment of chronic, non-terminal pain shall not be provided under this Fee Schedule unless treatment is sufficiently documented and complies with the following Rules and Regulations, as promulgated by the Mississippi State Board of Medical Licensure, and supplemented by the Commission accordingly.

1. DEFINITIONS. For the purpose of this provision, the following terms have the meanings indicated
 - a. "Chronic Pain" is a pain state in which the cause of the pain cannot be removed or otherwise treated and which in the generally accepted course of medical practice, no relief or cure of the cause of the pain is possible or none has been found after reasonable efforts including, but not limited to, evaluation by the attending physician and one or more physicians specializing in the treatment of the area, system, or organ of the body perceived as the source of the pain. Further, if a patient is receiving controlled substances for the treatment of pain for a prolonged period of time (more than six (6) months), then they will be considered for the purposes of this regulation to have "de facto" chronic pain and subject to the same requirements of this regulation. "Terminal Disease Pain" should not be confused with "Chronic Pain." For the purpose of this section, "Terminal Disease Pain" is pain arising from a medical condition for which there is no possible cure and the patient is expected to live no more than six (6) months.
 - b. "Acute Pain" is the normal, predicted physiological response to an adverse chemical, thermal, or mechanical stimulus and is associated with surgery, trauma and acute illness. It is generally time limited and is responsive to therapies, including controlled substances as defined by the U.S. Drug Enforcement Administration, Title 21 CFR Part 1301 Food and Drugs.
 - c. "Addiction" is a neurobehavioral syndrome with genetic and environmental influences that results in psychological dependence on the use of substances for their psychic effects and is characterized by compulsive use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and should not be considered addiction.
 - d. "Physical Dependence" is a physiological state of neuroadaptation to a substance which is characterized by the emergence of a withdrawal syndrome if the use of the substance is stopped or decreased abruptly, or if an antagonist is administered. Withdrawal may be relieved by re-administration of the substance. Physical dependence is a normal physiological consequence of extended opioid therapy for pain and should not be considered addiction.
 - e. "Substance Abuse" is the use of any substance(s) for non-therapeutic purposes, or use of medication for purposes other than those for which it is prescribed.
 - f. "Tolerance" is a physiological state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect or a reduced effect is observed with a constant dose. Tolerance occurs to different degrees for various drug effects, including sedation, analgesia and constipation. Analgesic tolerance is the need to increase the dose of opioid to achieve the same level of analgesia. Such tolerance may or may not be evident during treatment and does not equate with addiction.
2. Notwithstanding any other provisions of these rules and regulations, a physician may prescribe, administer, or dispense controlled substances in Schedules II, IIN, III, IIIN, IV and V, or other drugs having addiction-forming and addiction-sustaining liability to a person in the usual course of treatment of that person for a diagnosed condition causing chronic pain.
3. Notwithstanding any other provisions of these rules and regulations, as to the prescribing, administration, or dispensation of controlled substances in Schedules II, IIN, III, IIIN, IV and V, or

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other drugs having addiction-forming and addiction-sustaining liability, use of said medications in the treatment of chronic pain should be done with caution. A physician may administer, dispense or prescribe said medications for the purpose of relieving chronic pain, provided that the following conditions are met:

- a. Before initiating treatment utilizing a Schedules II, IIN, III, IIIN, IV or V controlled substance, or any other drug having addiction-forming and addiction-sustaining liability, the physician shall conduct an appropriate risk/benefit analysis by reviewing his own records of prior treatment, or review the records of prior treatment which another treating physician has provided to the physician, that there is an indicated need for long term controlled substance therapy. Such a determination shall take into account the specifics of each patient's diagnosis, past treatments and suitability for long term controlled substance use either alone or in combination with other indicated modalities for the treatment of chronic pain. This shall be clearly entered into the patient medical record, and shall include consultation/referral reports to determine the underlying pathology or cause of the chronic pain.
 - b. Documentation in the patient record shall include a complete medical history and physical examination that indicates the presence of one or more recognized medical indications for the use of controlled substances.
 - c. Documentation of a written treatment plan which shall contain stated objectives as a measure of successful treatment and planned diagnostic evaluations, e.g., psychiatric evaluation or other treatments. The plan should also contain an informed consent agreement for treatment that details relative risks and benefits of the treatment course. This should also include specific requirements of the patient, such as using one physician and pharmacy if possible, and urine/serum medication level monitoring when requested, but no less than once every twelve (12) months.
 - d. Periodic review and documentation of the treatment course is conducted at reasonable intervals (no less than every six months) with modification of therapy dependent on the physician's evaluation of progress toward the stated treatment objectives. This should include referrals and consultations as necessary to achieve those objectives.
4. No physician shall administer, dispense or prescribe a controlled substance or other drug having addiction-forming and addiction-sustaining liability that is non-therapeutic in nature or non-therapeutic in the manner the controlled substance or other drug is administered, dispensed or prescribed.
 5. No physician shall administer, dispense or prescribe a controlled substance for treatment of chronic pain to any patient who has consumed or disposed of any controlled substance or other drug having addiction-forming and addiction-sustaining liability other than in strict compliance with the treating physician's directions. These circumstances include those patients obtaining controlled substances or other abusable drugs from more than one physician and those patients who have obtained or attempted to obtain new prescriptions for controlled substances or other abusable drugs before a prior prescription should have been consumed according to the treating physician's directions. This requirement will not be enforced in cases where a patient has legitimately temporarily escalated a dose of their pain medication due to an acute exacerbation of their condition but have maintained a therapeutic dose level, however, it will be required of the treating physician to document in the patient record that such increase in dose level was due to a recognized indication and was within appropriate therapeutic dose ranges. Repetitive or continuing escalations should be a reason for concern and a re-evaluation of the present treatment plan shall be undertaken by the physician.
 6. No physician shall prescribe any controlled substance or other drug having addiction-forming or addiction-sustaining liability to a patient who is a drug addict for the purpose of "detoxification treatment," or "maintenance treatment," and no physician shall administer or dispense any narcotic controlled substance for the purpose of "detoxification treatment" or "maintenance treatment" unless they are properly registered in accordance with MCA section 303(g) 21 U.S.C.

823(g). Nothing in this paragraph shall prohibit a physician from administering narcotic drugs to a person for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are being made for referral for treatment. Not more than one (1) day's medication may be administered to the person or for the person's use at one time. Such emergency treatment may be carried out for not more than three (3) days. Nothing in this paragraph shall prohibit a physician from administering or dispensing narcotic controlled substances in a hospital to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction.

7. In addition to the specific Rules and Regulations promulgated by the Mississippi State Board of Medical Licensure as set forth above and incorporated herein, the payer may, as in other cases, obtain a second opinion from an appropriate and qualified physician to determine the appropriateness of the treatment being rendered, including but not limited to the appropriateness of the continuing use of opioids or other controlled substances for treatment of the patient's chronic pain. However, any such second opinion shall not be used as the basis for abrupt withdrawal of medication or payment therefor. Nothing in this paragraph shall prohibit a physician from administering narcotic drugs to a person for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are being made for referral or discontinuance of treatment, and the payer shall provide reimbursement in accordance with this Fee Schedule, as follows: not more than one (1) day's medication may be administered to the person or for the person's use at one time. Such emergency treatment may be carried out for not more than three (3) days. Discontinuance of treatment or reimbursement of prescriptions based on a second opinion obtained hereunder shall be subject to review by the Commission pursuant to the Dispute Resolution Rules set forth in the Dispute Resolution Rules section in this Fee Schedule.

- P Radiographic Codes in Pain Management. In the 2007 CPT book, code 76003 was replaced by code 77002, and code 76005 (fluoroscopy for injection) is replaced by code 77003. Description of service and reimbursement will remain the same.

Codes 72000–72220 which apply to radiographic examination of the spine are not reimbursed concurrent with the pain management procedures in this section or with fluoroscopy services.

Code 73542 is not separately reimbursed with facet or sacroiliac joint injections.

- Q Soft Tissue Injections. "Myofascial, myoneural, and trigger point injections" are synonymous and are to be reimbursed with the 20552 and/or 20553 codes. Modifiers for additional injections are not allowed with these codes. Reimbursement for codes 20552 and 20553 will be identical, and not additive.

Codes 20550 and 20551 are used for the injections of tendon origins and are NOT to be used for "myofascial, myoneural or trigger point" injections. Failure to observe this rule could result in denial of service on retrospective review and/or request for reimbursement.

Code 20612 is to be used for the aspirations/injection of a ganglion cyst and NOT for "myofascial, myoneural, or trigger point" injections. Failure to observe this rule could result in denial of service on retrospective review and/or request for reimbursement.

- R Implantation of spinal cord stimulators. The following conditions must be met for consideration of spinal cord stimulators.
- Patient must have a medical condition for which spinal cord stimulation (SCS) is a recognized and accepted form of treatment.
 - There must be a trial stimulation that includes a minimum seven (7) day home trial with the temporary stimulating electrode.
 - During the trial stimulation, the patient must report at least fifty percent (50%) pain reduction during the last four (4) days of the stimulation trial.
 - Psychological screening must be used to determine if the patient is free from:

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- Substance abuse issues
- Untreated psychiatric conditions
- Major psychiatric illness that could impair the patient's ability to respond appropriately to the trial stimulation

B. Sacroiliac joint injections (code 27096) require documentation of at least a four (4) week durable analgesic benefits or at least fifty percent (50%) pain relief in the anatomical area being targeted by the injection. A maximum of two (2) therapeutic sacroiliac joint injections are allowed per twelve (12) month period. This rule is limited only to the joint injected, and not the contralateral joint (i.e., right or left-sided joint).

Surgery

I. GENERAL GUIDELINES

A. Global Reimbursement

The reimbursement allowances for surgical procedures are based on a global reimbursement concept that covers performing the basic service and the normal range of care required after surgery.

Global reimbursement includes:

1. The operation per se
2. Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
3. Subsequent to the decision and/or authorization for surgery, one related E/M encounter on the date immediately prior to or on the date of the procedure (including history and physical), but does not include the initial consultation
4. Immediate postoperative care, including dictating operative notes, talking with the family and other physicians
5. Writing orders
6. Evaluating the patient in the post-anesthesia recovery area
7. Normal, uncomplicated follow-up (FU) care for the time periods indicated in the follow-up days (FUD) column to the right of each procedure code. The number in that column establishes the days during which no additional reimbursement is allowed for the usual care provided following surgery, absent complications or unusual circumstances.
8. The maximum reimbursement allowances cover all normal postoperative care, including the removal of sutures by the surgeon or associate. Follow-up days are specified by procedure. Follow-up days listed are for 0, 10, or 90 days and are listed in the Fee Schedule as 000, 010, or 090. Follow-up days may also be listed as MMM indicating that services are for uncomplicated maternity care, XXX indicating that the global surgery concept does not apply, YYY indicating that the follow-up period is to be set by the payer (used primarily with BR procedures), or ZZZ indicating that the code is related to another service and is treated in the global period of the other procedure billed in conjunction with the ZZZ procedure (used primarily with add-on and exempt from modifier 51 codes). The day of surgery is day one when counting follow-up days. Hospital discharge day management is considered to be normal, uncomplicated follow-up care.

B. Follow-up Care for Diagnostic Procedures

Follow-up care for diagnostic procedures (e.g., endoscopy, injection procedures for radiography) includes only the care related to recovery from the diagnostic procedure itself. Care of the condition for which the diagnostic procedure was performed or of other concomitant conditions is not included and may be charged for in accordance with the services rendered.

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- C. Follow-up Care for Therapeutic Surgical Procedures**
Follow-up care for therapeutic surgical procedures includes only care that is usually part of the surgical procedure. Complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring additional services concurrent with the procedure(s) or during the listed period of normal follow-up care may warrant additional charges.
- D. Separate Procedures**
Separate procedures are commonly carried out as an integral part of another procedure. They should not be billed in conjunction with the related procedure. These procedures may be billed when performed independently by adding modifier 59 to the specific "separate procedure" code.
- E. Additional Surgical Procedure(s)**
When an additional surgical procedure(s) is carried out within the listed period of follow-up care for a previous surgery, the follow-up periods will continue concurrently to their normal terminations.
- F. Microsurgery, Operating Microscope, and Use of Code 69990**
The surgical microscope is employed when the surgical services are performed using the technique of microsurgery. Code 69990 should be reported (without modifier 51 appended) in addition to the code for the primary procedure performed. Do not use 69990 for reporting visualization with magnifying loupes or corrected vision. Do not report code 69990 in addition to procedures where the use of the operating microscope is considered an inclusive component. The operating microscope is considered inclusive in the following codes only: 15756-15758, 15842, 19364, 19368, 20955-20962, 20969-20973, 26551-26554, 26556, 31526, 31531, 31536, 31541, 31545, 31546, 31561, 31571, 43116, 43496, 49906, 61548, 63075-63078, 64727, 64820-64823, 65091-68850. For purposes of clarification, if microsurgery technique is employed and the primary procedure code is not contained in the aforementioned list, it is appropriate to report 69990 with the primary procedure performed and reimbursement is required for said services. (For example, code 63030 is not included in the aforementioned list and, as such, it is appropriate for providers to report 69990 along with 63030 to describe microsurgical technique. Reimbursement for 69990 is required provided operative documentation affirms microsurgical technique and not just visualization with magnifying loupes or corrected vision.)
- G. Unique Techniques**
A surgeon is not entitled to an extra fee for a unique technique. It is inappropriate to use modifier 22 unless the procedure is significantly more difficult than indicated by the description of the code.
- H. Surgical Destruction**
Surgical destruction is part of a surgical procedure, and different methods of destruction (e.g., laser surgery) are not ordinarily listed separately unless the technique substantially alters the standard management of a problem or condition. Exceptions under special circumstances are provided for by separate code numbers.
- I. Incidental Procedure(s)**
An additional charge for an incidental procedure (e.g., incidental appendectomy, incidental scar excisions, puncture of ovarian cysts, simple lysis of adhesions, simple repair of hiatal hernia, etc.) is not customary and does not warrant additional reimbursement.
- J. Endoscopic Procedures**
When multiple endoscopic procedures are performed by the same practitioner at a single encounter, the major procedure is reimbursed at one hundred percent (100%). If a secondary procedure is performed through the same opening/orifice, fifty percent (50%) is allowable as a multiple procedure.

However, diagnostic procedures during the same session and entry site are incidental to the major procedure.

K. Biopsy Procedures

A biopsy of the skin and another surgical procedure performed on the same lesion on the same day must be billed as one procedure.

L. Repair of Nerves, Blood Vessels, and Tendons with Wound Repairs

The repair of nerves, blood vessels, and tendons is usually reported under the appropriate system. The repair of associated wounds is included in the primary procedure unless it qualifies as a complex wound, in which case modifier 51 may be applied. Simple exploration of nerves, blood vessels, and tendons exposed in an open wound is also considered part of the essential treatment of the wound closure and is not a separate procedure unless appreciable dissection is required.

M. Suture Removal

Billing for suture removal by the operating surgeon is not appropriate as this is considered part of the global fee.

N. Joint Manipulation Under Anesthesia

There is no charge for manipulation of a joint under anesthesia when it is preceded or followed by a surgical procedure on that same day by that surgeon. However, when manipulation of a joint is the scheduled procedure and it indicates additional procedures are necessary and appropriate, fifty percent (50%) of the manipulation may be allowed.

O. Supplies and Materials

Supplies and materials provided by the physician (e.g., sterile trays/drugs) over and above those usually included with the office visit may be listed separately using CPT code 99070 or specific HCPCS Level II codes.

P. Plastic and Metallic Implants

Plastic and metallic implants or non-autogenous graft materials supplied by the physician are to be reimbursed at cost.

Q. Aspirations and Injections

Puncture of a cavity or joint for aspiration followed by injection of a therapeutic agent is one procedure and should be billed as such.

R. Surgical Assistant

1. Physician surgical assistant — For the purpose of reimbursement, a physician who assists at surgery is reimbursed as a surgical assistant. Assistant surgeons should use modifier 80 and are allowed twenty percent (20%) of the maximum reimbursement allowance (MRA) for the procedure(s).
2. Registered Nurse Surgical Assistant
or Physician Assistant
 - a. A physician assistant, or registered nurses who have completed an approved first assistant training course, may be allowed a fee when assisting a surgeon in the operating room (O.R.).
 - b. The maximum reimbursement allowance for the physician assistant or the

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registered nurse first assistant (RNFA) is ten percent (10%) of the surgeon's fee for the procedure(s) performed.

c Under no circumstances will a fee be allowed for an assistant surgeon and a physician assistant or

RNFA at the same surgical encounter

d Registered nurses on staff in the O.R. of a hospital, clinic, or outpatient surgery center do not qualify for reimbursement as an RNFA

e CPT codes with modifier AS should be used to bill for physician assistant or RNFA services on a CMS-1500 form and should be submitted with the charge for the surgeon's services.

S. Operative Reports

An operative report must be submitted to the payer before reimbursement can be made for the surgeon's or assistant surgeon's services.

T. Needle Procedures

Needle procedures (lumbar puncture, thoracentesis, jugular or femoral taps, etc.) should be billed in addition to the medical care on the same day.

U. Therapeutic Procedures

Therapeutic procedures (injecting into cavities, nerve blocks, etc.) (CPT codes 20526–20610, 64400, 64450) may be billed in addition to the medical care for a new patient. (Use appropriate level of service plus injection.)

In follow-up cases for additional therapeutic injections and/or aspirations, an office visit is only indicated if it is necessary to re-evaluate the patient. In this case, a minimal visit may be listed in addition to the injection. Documentation supporting the office visit charge must be submitted with the bill to the payer. Reimbursement for therapeutic injections will be made according to the multiple procedure rules.

Trigger point injection is considered one procedure and reimbursed as such regardless of the number of injection sites. Two codes are available for reporting trigger point injections. Use 20552 for injection(s) of single or multiple trigger point(s) in one or two muscles or 20553 when three or more muscles are involved.

V. Anesthesia by Surgeon

In certain circumstances it may be appropriate for the attending surgeon to provide regional or general anesthesia. Anesthesia by the surgeon is considered to be more than local or digital anesthesia. Identify this service by adding modifier 47 to the surgical code. Only base anesthesia units are allowed. See the Anesthesia section.

W. Therapeutic/Diagnostic Injections

Injections are considered incidental to the procedure when performed with a related invasive procedure.

X. Intervertebral Biomechanical Device(s) and Use of Code 2285

Code 22851 describes the application of an intervertebral biomechanical device to a vertebral defect or interspace. Code 22851 should be listed in conjunction with a primary procedure without the use of modifier 51. The use of 22851 is limited to one instance per single interspace or single vertebral defect regardless of the number of devices applied and infers additional qualifying training.

experience, sizing, and/or use of special surgical appliances to insert the biomechanical device. Qualifying devices include manufactured synthetic or allograft biomechanical devices, or methyl methacrylate constructs, and are not dependant on a specific manufacturer, shape, or material of which it is constructed. Qualifying devices are machine cut to specific dimensions for precise application to an intervertebral defect. (For example, the use of code 22851 would be appropriate during a cervical arthrodesis (22554) when applying a synthetic alloy cage, a threaded bone dowel, or a machine cut hexahedron cortical, cancellous, or corticocancellous allograft biomechanical device. Surgeons utilizing generic non-machined bony allografts or autografts are referred to code sets 20930–20931, 20936–20938 respectively.)

- Y Intra-operative neurophysiologic monitoring (e.g. SSEP, MEP, BAEP, TES, DEP, VEP). All intra-operative neurophysiologic monitoring requires pre-authorization. Reimbursement for intra-operative neurophysiologic monitoring will not be allowed in the following cases, unless mutually agreed to by the payer and the provider:
1. neuromuscular junction testing of each nerve during intraoperative monitoring;
 2. intraoperative monitoring during peripheral nerve entrapment releases, such as carpal release, ulnar nerve transposition at the elbow, and tarsal tunnel release;
 3. during decompression of cervical nerve roots without myelopathy;
 4. during placement of cervical instrumentation absent evidence of myelopathy;
 5. during lumbar discectomy for radiculopathy; or
 6. during lumbar decompression for treatment of stenosis without the need for instrumentation.

II. AMBULATORY SURGERY CENTERS

A. Definition

For purposes of this section of the Fee Schedule, "ambulatory surgery center" means an establishment with an organized medical staff of physicians; with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; with continuous physicians and registered nurses on site or on call; which provides services and accommodations for patients to recover for a period not to exceed twenty-three (23) hours after surgery. An ambulatory surgery center may be a freestanding facility or may be attached to a hospital facility. For purposes of Workers' Compensation reimbursement to ASCs, the facility must be an approved Medicare ASC.

B. Coding and Billing Rules

1. Facility fees for ambulatory surgery must be billed on the UB-04 form.
2. The CPT/HCPCS code(s) of the procedure(s) performed determines the reimbursement for the facility fee. Report all procedures performed.
3. If more than one surgical procedure is furnished in a single operative encounter, the multiple procedure rule applies. The primary procedure is reimbursed at one hundred percent (100%) of the maximum reimbursable allowance (MRA), the second and subsequent procedures are reimbursed at fifty percent (50%) of the MRA.
4. If the billed total for an outpatient surgical encounter is less than the ASC MRA, the lesser of the charges is paid to the facility.
5. The payment rate for an ASC surgical procedure includes all facility services directly related to the procedure performed on the day of surgery. Facility services include:
 - * Nursing and technician services

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- Use of the facility
 - Drugs, biologicals, surgical dressings, splints, casts and equipment directly related to the provision of the surgical procedure
 - Materials for anesthesia
 - Administration, record keeping and housekeeping items and services
6. Separate payment is not made for the following services that are directly related to the surgery:
- Pharmacy
 - Medical/surgical supplies
 - Sterile supplies
 - Operating room services
 - Anesthesia
 - Ambulatory surgical care
 - Recovery room
 - Treatment or Observation room
7. Facility fees do not include physician services, x-rays, diagnostic procedures, laboratory procedures, CRNA or anesthesia physician services, prosthetic devices, ambulance services, braces, artificial limbs or DME for use in the patient's home. These items will be reimbursed according to Fee Schedule MRA or HCPCS MRA, whichever is appropriate.
- C. Facility Fee Reimbursement for ASCs
1. The Mississippi Worker's Compensation Commission has adopted the Medicare ASC Payment Groups for classifying payment of facility fees for ambulatory surgery. The specific rates and groupings are more fully explained in the section on Inpatient and Outpatient Care Rules.
 2. The ASC payment rate has been added to the CPT code listing of fees in the Surgery section of the Fee Schedule. The column lists the total approved facility fee for that particular CPT code.
 3. The facility fees will be paid for medically necessary services only. All ambulatory elective procedures must be precertified according to the rules and guidelines of the Fee Schedule.
 4. Procedures not assigned an ASC facility fee will be reimbursed according to the lesser of total billed charges or usual and customary rates.

III. MULTIPLE PROCEDURES

A. Multiple Procedure Reimbursement Rule

Multiple procedures performed during the same operative session at the same operative site are reimbursed as follows:

- One hundred percent (100%) of the allowable fee for the primary procedure
- Fifty percent (50%) of the allowable fee for the second and subsequent procedures

B. Bilateral Procedure Reimbursement Rule

Physicians and staff are sometimes confused by the definition of bilateral. Bilateral procedures are identical procedures (i.e., use the same CPT code) performed on the same anatomic site but on opposite sides of the body. Furthermore, each procedure should be performed through its own separate incision to qualify as bilateral. For example, open reductions of bilateral fractures of the mandible treated through a common incision would not qualify under the definition of bilateral and

would be reimbursed according to the multiple procedure rule. Medicare's accepted method of billing bilateral services is to list the procedure once and add modifier 50. Mississippi is adopting this same policy. Refer to the example below.

69300 50 Otoplasty, protruding ear

Place a "2" in the UNITS column of the CMS-1500 claim form so that payers are aware that two procedures were performed. List the charge as one hundred fifty percent (150%) of your normal charge. Reimbursement shall be at one hundred fifty percent (150%) of the amount allowed for a unilateral procedure(s). For example, if the allowable for a unilateral surgery is one hundred dollars (\$100.00) and it is performed bilaterally, reimbursement shall be one hundred fifty dollars (\$150.00). However, if the procedure description states "bilateral," reimbursement shall be as listed in the Fee Schedule since the fee was calculated for provision of the procedure bilaterally.

C. Multiple Procedures—Different Areas Rule

When multiple surgical procedures are performed in different areas of the body during the same operative sessions and the procedures are unrelated (e.g., abdominal hernia repair and a knee arthroscopy), the multiple procedure reimbursement rule will apply independently to each area. Modifier 51 must be added.

D. Multiple Procedure Billing Rules

1. The primary procedure, which is defined as the procedure with the highest RVU, must be billed with the applicable CPT code.
2. The second or lesser or additional procedure(s) must be billed by adding modifier 51 to the codes, unless the procedure(s) is exempt from modifier 51 or qualifies as an add-on code.

IV. REPAIR OF WOUNDS

A. Definitions

Wound repairs are classified as simple, intermediate, or complex:

1. **Simple repair.** Simple repair is repair of superficial wounds involving primarily epidermis and dermis or subcutaneous tissues without significant involvement of deeper structures and simple one-layer closure/suturing. This includes local anesthesia and chemical or electrocauterization of wounds not closed.
2. **Intermediate repair.** Intermediate repair is repair of wounds that requires layered closure of one or more of the subcutaneous tissues and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure. Single-layer closure of heavily contaminated wounds that require extensive cleaning or removal of particulate matter also constitutes intermediate repair.
3. **Complex repair.** Complex repair is repair of wounds requiring more than layered closure, scar revision, debridement (e.g., traumatic lacerations or avulsions), extensive undermining, slants or retention sutures. It may include creation of the defect and necessary preparation for repairs or the debridement and repair of complicated lacerations or avulsions.

B. Reporting

The following instructions are for reporting services at the time of the wound repair:

1. The repaired wound(s) should be measured and recorded in centimeters, whether curved, angular, or stellate.

2. When multiple wounds are repaired, add together the lengths of those in the same classification (see above) and anatomical grouping and report as a single item. When more than one classification of wound is repaired, list the more complicated as the primary procedure and the less complicated as the secondary procedure using modifier 51.
3. Debridement is considered a separate procedure only when gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue are removed, or when debridement is carried out separately without immediate primary closure (extensive debridement of soft tissue and/or bone).
4. Report involvement of nerves, blood vessels, and tendons under the appropriate system (nervous, musculoskeletal, etc.) for repair. The repair of these wounds is included in the fee for the primary procedure unless it qualifies as a complex wound, in which case modifier 51 applies.
5. Simple ligation of vessels in an open wound is considered part of any wound closure, as is simple exploration of nerves, blood vessels, or tendons.
6. Adjacent tissue transfers, flaps and grafts include such procedures as Z-plasty, W-plasty, V-4-plasty or rotation flaps. Reimbursement is based on the size of the defect. Closing the donor site with a skin graft is considered an additional procedure and will be reimbursed in addition to the primary procedure. Excision of a lesion prior to repair by adjacent tissue transfer is considered "bundled" into the tissue transfer procedure and is not reimbursed separately.
7. Wound exploration codes should not be billed with codes that specifically describe a repair to major structure or major vessel. The specific repair code supersedes the use of a wound exploration code.

V. MUSCULOSKELETAL SYSTEM

A. Casting and Strapping

This applies to severe muscle sprains or strains that require casting or strapping.

1. Initial (new patient) treatment for soft tissue injuries must be billed under the appropriate office visit code.
2. When a cast or strapping is applied during an initial visit, supplies and materials (e.g., stockinet, plaster, fiberglass, ace bandages) may be itemized and billed separately using the appropriate HCPCS Level II code.
3. When initial casting and/or strapping is applied for the first time during an established patient visit, reimbursement may be made for the itemized supplies and materials in addition to the appropriate established patient visit.
4. Replacement casts or strapping provided during a follow-up visit (established patient) include reimbursement for the replacement service as well as the removal of casts, splints, or strapping. Follow-up visit charges may be reimbursed in addition to replacement casting and strapping only when additional significantly identifiable medical services are provided. Office notes should substantiate medical necessity of the visit. Cast supplies may be billed using the appropriate HCPCS Level II code and reimbursed separately.

B. Fracture Care

1. Fracture care is a global service. It includes the examination, restoration or stabilization of the fracture, application of the first cast, and cast removal. Casting material is not considered part of the global package and may be reimbursed separately. It is inappropriate to bill an office visit since the reason for the encounter is for fracture care. However, if the patient requires surgical intervention, additional reimbursement can be made for the appropriate E/M code to properly evaluate the patient for surgery. Use modifier 57 with the E/M code.

2. Reimbursement for fracture care includes the application and removal of the first cast or traction device only. Replacement casting during the period of follow-up care is reimbursed separately.
3. The phrase "with manipulation" describes reduction of a fracture.
4. Re-reduction of a fracture performed by the primary physician may be identified by the addition of modifier 76 to the usual procedure code to indicate "repeat procedure" by the same physician.
5. The term "complicated" appears in some musculoskeletal code descriptions. It implies an infection occurred or the surgery took longer than usual. Be sure the medical record documentation supports the "complicated" descriptor to justify reimbursement.

C. Bone, Cartilage, and Fascia Grafts

1. Reimbursement for obtaining autogenous bone, cartilage or fascia grafts, or other tissue through separate incisions is made only when the graft is not described as part of the basic procedure.
2. Tissue obtained from a cadaver for grafting must be billed using code 99070 and accompanied by a report in order to ensure an equitable reimbursement by the payer.

D. Arthroscopy

Note: Surgical arthroscopy always includes a diagnostic arthroscopy. Only in the most unusual case is an increased fee justified because of increased complexity of the intra-articular surgery performed.

1. Diagnostic arthroscopy should be billed at fifty percent (50%) when followed by open surgery.
2. Diagnostic arthroscopy is not billed when followed by arthroscopic surgery.
3. If there are only minor findings that do not confirm a significant preoperative diagnosis, the procedure should be billed as a diagnostic arthroscopy.

E. Arthrodesis Procedures

Many revisions have occurred in CPT coding for arthrodesis procedures. References to bone grafting and fixation are now procedures which are listed and reimbursed separately from the arthrodesis codes.

To help alleviate any misunderstanding about when to code a discectomy in addition to an arthrodesis, the statement "including minimal discectomy" to prepare interspace has been added to the anterior interbody technique. If the disk is removed for decompression of the spinal cord, the decompression should be coded and reimbursed separately.

F. External Spinal Stimulators Post Fusion

1. The following criteria is established for the medically accepted standard of care when determining applicability for the use of an external spinal stimulator. However, the medical necessity should be determined on a case-by-case basis.
 - a. Patient has had a previously failed spinal fusion, and/or
 - b. Patient is scheduled for revision or repair of pseudoarthrosis, and/or
 - c. The patient smokes greater than a pack of cigarettes per day and is scheduled for spinal fusion.
2. The external spinal stimulator is not approved by the Mississippi Workers' Compensation Commission for use in primary spinal fusions.
3. The external spinal stimulator will be reimbursed by report (BR).
4. Precertification is required for use of the external spinal stimulator.

G. Carpal Tunnel Release

The following intraoperative services are included in the global service package for carpal tunnel release and should not be reported separately and do not warrant additional reimbursement.

- Surgical approach
- Isolation of neurovascular structures
- Video imaging
- Stimulation of nerves for identification
- Application of dressing, splint, or cast
- Tenolysis of flexor tendons
- Flexor tenosynovectomy
- Excision of lipoma of carpal canal
- Exploration of incidental release of ulnar nerve
- Division of transverse carpal ligament
- Use of endoscopic equipment
- Placement and removal of surgical drains or suction device
- Closure of wound

VI. BURNS, LOCAL TREATMENT

A. Degree of Burns

- 1 Code 16000 must be used when billing for treatment of first degree burns when no more than local treatment of burned surfaces is required.
- 2 Codes 16020–16030 must be used when billing for treatment of partial-thickness burns only.
- 3 The claim form must be accompanied by a report substantiating the services performed.
- 4 Major debridement of foreign bodies, grease, epidermis, or necrotic tissue may be billed separately under codes 11000–11001. Modifier 51 does not apply.

B. Percentage of Total Body Surface Area

The following definitions apply to codes 16020–16030:

- 1 "Small" means less than five percent (5%) of the total body surface area
- 2 "Medium" means whole face or whole extremity or five to ten percent (5%–10%) of the total body surface area
- 3 "Large" means more than one extremity or greater than ten percent (10%) of the total body surface area

C. Reimbursement

- 1 To identify accurately the proper procedure code and substantiate the descriptor for billing, the exact percentage of the body surface involved and the degree of the burn must be specified on the claim form submitted or by attaching a special report. Claims submitted without this specification will be returned to the physician for this additional information.
- 2 Hospital visits, emergency room visits, or critical care visits provided by the same physician on the same day as the application of burn dressings will be reimbursed as a single procedure at the highest level of service

VII. NERVE BLOCKS

A. Diagnostic or Therapeutic

1. Please refer to the Pain Management section for guidelines and reimbursement of nerve blocks.
2. Medications such as steroids, pain medication, etc., may be separately billed using the appropriate HCPCS Level II code.
 - a. The name of the medication(s), dosage, and volume must be identified.
 - b. Medication will be reimbursed according to fees listed in the HCPCS section. If not listed in HCPCS, reimbursement will be according to the Pharmacy section in the General Guidelines.

B. Anesthetic

When a nerve block for anesthesia is provided by the operating room surgeon, the procedure codes listed in the Anesthesia section must be followed.

VIII. MODIFIERS

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance should be identified by the addition of the appropriate modifier code. The modifier may be reported by a two-digit number placed after the usual procedure number and separated by a hyphen. If more than one modifier is used, place the multiple modifiers code 99 immediately after the procedure code. This indicates that one or more additional modifier codes follow. Modifiers commonly used in surgery are as follows:

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.

Mississippi's note: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement.

26 Professional Component

Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

32 Mandated Services

Services related to mandated consultation and/or related services (e.g., third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

47 Anesthesia by Surgeon

Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) Note: Modifier 47 would not be used as a modifier for the anesthesia procedures 00100–01999.

Mississippi's note: Reimbursement is made for base units only.

50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed during the same operative session should be identified by adding modifier 50 to the appropriate five-digit code.

51 Multiple Procedures

When multiple procedures, other than E/M services, physical medicine and rehabilitation services, or provision of supplies (e.g., vaccines),

are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes (see the applicable CPT book appendix).

Mississippi's note: This modifier should not be appended to designated "modifier 51 exempt" codes as specified in the most current CPT book.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 Discontinued Procedure

Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.

54 Surgical Care Only

When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

55 Postoperative Management Only

When one physician performed the postoperative management and another physician performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

56 Preoperative Management Only

When one physician performed the preoperative care and evaluation and another physician performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

57 Decision for Surgery

An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. Note: For treatment of a problem that requires a return to the operation or procedure room, see modifier 78.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures or services other than E/M services, that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

62 Two Surgeons

When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code; if an additional procedure(s) (including an add-on procedure(s)) is performed during the same surgical session, a separate code(s) may be reported with modifier 62 added. Note: If a co-surgeon acts as an assistant in the performance of an additional procedure(s) during the same surgical session, the service(s) may be reported using a separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

66 Surgical Team

Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel and various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of modifier 66 to the basic procedure number used for reporting services.

76 Repeat Procedure by Same Physician

It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

77 Repeat Procedure by Another Physician

The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.

78 Return to the Operating Room for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first and requires the use of the operating room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period

The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

80 Assistant Surgeon

Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

Mississippi's note: Reimbursement is twenty percent (20%) of the maximum reimbursement allowance.

81 Minimum Assistant Surgeon

Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.

Mississippi's note: Physician reimbursement is ten percent (10%) of the allowable.

82 Assistant Surgeon (when qualified resident surgeon not available)

The unavailability of a qualified resident surgeon is prerequisite for use of modifier 82 appended to the unusual procedure code number(s).

90 Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.

99 Multiple Modifiers

Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

AS Assistant At Surgery Services Provided By Registered Nurse First Assistant, Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist

Assistant at surgery services provided by a Registered Nurse First Assistant (RNFA), Physician Assistant, Nurse Practitioner or Clinical Nurse Specialist are identified by adding modifier AS to the listed applicable surgical procedures. The use of the AS modifier is appropriate for any code that otherwise is reimbursable for a physician assisting a surgeon in the operating room.

Mississippi's note: Modifier AS reimbursement is ten percent (10%) of the allowable.

IX. MODIFIERS APPROVED FOR AMBULATORY SURGERY CENTER (ASC) HOSPITAL OUTPATIENT USE**25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service**

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (See Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

27 Multiple Outpatient Hospital E/M Encounters on the Same Date

For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (e.g., hospital emergency department, clinic). Note: This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient evaluation and management services provided by the same physician on the same date and performed in multiple outpatient setting(s) (e.g., hospital emergency department, clinic), see Evaluation and Management, Emergency Department, or Preventive Medicine Services codes.

50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five digit code.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use)

58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. Note: For treatment of a problem that requires a return to the operating or procedure room, see modifier 78.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures or services other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

73 Discontinued Out-Patient Hospital/ Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of modifier 73. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

74 Discontinued Out-Patient Hospital/ Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc). Under these circumstances, the procedure started but terminated can be reported by its usual

procedure number and the addition of modifier 74. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

76 Repeat Procedure by Same Physician

It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

77 Repeat Procedure by Another Physician

The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.

78 Return to the Operating Room for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period

The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

91 Repeat Clinical Diagnostic Laboratory Test

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

Pathology and Laboratory

I. GUIDELINES

A. Pathology Services

Services in pathology and laboratory are provided by the pathologist, or by the technologist, under responsible supervision of a physician.

B. Separate or Multiple Procedures

It is appropriate to designate multiple procedures rendered on the same date by separate entries.

C. Unlisted Service or Procedures

A service or procedure may be provided that is not listed in this fee schedule. When reporting such a service or procedure, the appropriate unlisted procedure code may be used to indicate the service, identifying it by special report as discussed below. The unlisted procedures and accompanying codes for Pathology and Laboratory are as follows:

81099	Unlisted urinalysis procedure
84999	Unlisted chemistry procedure
85999	Unlisted hematology and coagulation procedure
86849	Unlisted immunology procedure
86999	Unlisted transfusion medicine procedure
87999	Unlisted microbiology procedure
88099	Unlisted necropsy (autopsy) procedure
88199	Unlisted cytopathology procedure
88299	Unlisted cytogenetic study
88399	Unlisted surgical pathology procedure
89240	Unlisted miscellaneous pathology test

D. Special Report

A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service. Additional items that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care. This report does not command a separate fee for completion.

Mississippi Workers' Compensation Medical Fee Schedule

E. By Report (BR)

"BR" in the Amount column indicates services that are too new, unusual, or variable in the nature of their performance to permit the assignment of a definable fee. Such services should be substantiated by documentation submitted with the bill. Sufficient information should be included to permit proper identification and a sound evaluation. If the service is justified by the report, the actual charge shall be paid in full, unless the payer has evidence that the actual charge exceeds the usual and customary charge for such service.

F. Facility Fee

The Facility Fee is the Amount increased by ten percent (10%).

II. GENERAL INFORMATION AND INSTRUCTIONS

A. Panel Tests

The billing for panel tests must include documentation listing the tests in the panel. When billing for panel tests (80048-80076), use the code number corresponding to the appropriate panel test. These tests will not be reimbursed separately.

The panel components do not preclude the performance of other tests not listed in the panel. If other laboratory tests are performed in conjunction with a particular panel, the additional tests may be reported separately in addition to the panel.

B. Handling and Collection Process

1. In collecting a specimen, the cost for collection is covered by the technical component when the lab test is conducted at that site. No separate collection or handling fee for this purpose will be reimbursed.
2. When a specimen must be sent to a reference laboratory, the cost of specimen collection is covered in a collection fee. This charge is only allowed when a reference laboratory is used, and modifier 90 must be used.

C. Global, Professional, and Technical Components

Some procedures in the Pathology and Laboratory section are considered global fees and do not qualify for a separate technical (TC) or professional (PC) component. Some procedures are listed with a PC fee in addition to the global fee. For procedures listed with a PC fee, the TC reimbursement rate is calculated by subtracting the PC amount from the total amount.

Whereas these guidelines are written to be all-inclusive, there are instances when the reviewer must make an informed decision regarding the PC/TC reimbursements. Request for PC reimbursement will only be considered if:

- The physician performs the procedure or reviews the results
- A written report, not a computer generated report, is submitted with the request for payment

III. MODIFIERS

Listed services and procedures may be modified under certain circumstances. When applicable, the modifying circumstances should be identified by the addition of the appropriate modifier code. The modifier may be reported by a two-digit number placed after the usual procedure number and separated by a hyphen. If more than one modifier is used, place the multiple modifiers code 99 immediately after the procedure code. This indicates that one or more additional modifier codes will follow. Modifiers commonly used in pathology and laboratory are as follows:

22 Increased Procedural Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.

Mississippi's note: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement.

26 Professional Component

Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component (HCPCS Level II Modifier)

Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

Mississippi's note: The technical component is calculated by subtracting the PC Amount from the Amount for the reimbursement.

32 Mandated Services

Services related to mandated consultation and/or related services (e.g., third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 Discontinued Procedure

Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures or services other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

90 Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.

91 Repeat Clinical Diagnostic Laboratory Test

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results, due to testing problems with specimens or equipment, or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when another code(s) describes a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for a laboratory test(s) performed more than once on the same day on the same patient.

92 Alternative Laboratory Platform Testing

When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701–86703). The test does not require permanent dedicated space; hence by its design it may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.

99 Multiple Modifiers

Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

Medicine Services

In addition to the general rules, this section applies to unique guidelines for medicine specialties. Physical medicine and rehabilitation guidelines, as well as chiropractic and osteopathic services, are listed in a separate section following Medicine Services.

I. GUIDELINES

A. Unlisted Services or Procedures

When a service or procedure is provided that is not specifically listed in the Fee Schedule, documentation must be submitted to substantiate the charge.

B. Multiple Procedures

It is appropriate to designate multiple procedures rendered on the same date by separate entries.

C. Separate Procedures

Some of the listed procedures are commonly carried out as an integral part of a total service and, as such, do not warrant a separate identification. When, however, such a procedure is performed independently of, and is not immediately related to other services, it may be listed as a "separate procedure." Thus, when a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be reported as a separate procedure.

D. By Report (BR) Procedures

"BR" in the Amount column indicates services that are too new, unusual, or variable in the nature of their performance to permit the assignment of a definable fee. Such services should be substantiated by documentation submitted with the bill. Sufficient information should be included to permit proper identification and a sound evaluation. If the service is justified by the report, the actual charge shall be paid in full, unless the payer has evidence that the actual charge exceeds the usual and customary charge for such service.

E. Special Report

A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort, and equipment necessary to provide the service. Additional items that may be included are complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow-up care.

F. Materials Supplied by Physician

Supplies and materials provided by the physician over and above those usually included with the office visit should be identified with CPT code 99070 or specific HCPCS Level II code. Reimbursement shall be limited to the Fee Schedule maximum reimbursement allowance (MRA) or the usual and customary rate for items not listed in this Fee Schedule.

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G. Audiological Function Tests

The audiometric tests (92551–92596) require use of calibrated electronic equipment. Other hearing tests (e.g., whisper voice or tuning fork) are considered part of the examination and not paid separately. All descriptors refer to testing of both ears.

H. Psychological Services

Payment for a psychiatric diagnostic interview includes history and mental status determination, development of a treatment plan when necessary, and the preparation of a written report that must be submitted with the required billing form.

Psychotherapy codes (90804–90857) must be billed under the CPT code most closely approximating the length of the session. The codes for individual therapy services designate whether the service includes medical evaluation. Only a psychiatrist (M.D. or D.O.) may bill for those codes that include medical evaluation (procedure codes 90805, 90807, 90809, 90811, 90813, 90815, 90817, 90819, 90822, 90824, 90827, 90829).

A service level adjustment factor is used to determine payment for psychotherapy when a provider other than a psychiatrist provides the service. In those instances, the reimbursement amount for the CPT code is paid at eighty-five percent (85%) of the maximum reimbursement allowance. This applies to psychologists, social workers, and counselors.

I. Electromyography (EMG)

Payment for EMG services includes the initial set of electrodes and all supplies necessary to perform the service. The physician may be paid for a consultation or new patient visit in addition to the EMG performed on the same day. When an EMG is performed on the same day as a follow up visit, payment may be made for the EMG only unless documentation supports the need for a medical service in addition to the EMG.

J. Manipulative Services

Chiropractic manipulative services, which are medicine services, will be discussed in the Physical Medicine section.

II. MODIFIERS

Listed services and procedures may be modified under certain circumstances. When applicable, identify the modifying circumstance by the addition of the appropriate modifier code, which may be reported by a two-digit number placed after the usual procedure number separated by a hyphen. If more than one modifier is used, place the multiple modifiers code 99 immediately after the procedure code. This indicates that one or more additional modifier codes will follow. Modifiers commonly used in Medicine Services are as follows:

22 Increased Procedure Services

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.

Mississippi's note: By definition, this modifier would be used in unusual circumstances only. Use of this modifier does not guarantee additional reimbursement.

26 Professional Component

Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component (HCPCS Level II Modifier)

Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

Mississippi's note: The technical component is calculated by subtracting the PC Amount from the Amount for the reimbursement.

32 Mandated Services

Services related to mandated consultation and/or related services (e.g., third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

51 Multiple Procedures

When multiple procedures, other than E/M services, physical medicine and rehabilitation services, or provision of supplies (e.g., vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes (see the applicable CPT book).

Mississippi's note: This modifier should not be appended to designated "modifier 51 exempt" codes as specified in the applicable CPT book.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 Discontinued Procedure

Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the wellbeing of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

55 Postoperative Management Only

When one physician performed the postoperative management and another physician performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

56 Preoperative Management Only

When one physician performed the preoperative care and evaluation and another physician performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

57 Decision for Surgery

An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged), b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. Note: For the treatment of a problem that requires a return to the operating or procedure room, see modifier 78.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures or services other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

76 Repeat Procedure by Same Physician

It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

77 Repeat Procedure by Another Physician

The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.

78 Return to the Operating Room for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period

The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

90 Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.

99 Multiple Modifiers

Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

Physical Medicine

I. SCOPE

A. Physical Medicine

Physical medicine is an integral part of the healing process for a variety of injured workers. Recognizing this, the Fee Schedule includes codes for physical medicine, modalities, procedures, tests, and measurements in the Physical Medicine section representing specific therapeutic procedures performed by licensed physicians, chiropractors, licensed physical therapists, and licensed occupational therapists.

B. Physical Medical Assessment

1. An assessment must be performed to determine if a patient will benefit from physical medicine therapy.
2. When a physician examines a patient and an assessment for physical medicine is performed, the billing for the office visit includes the physical medicine assessment.
3. Procedure code 97001 is to be used for an initial assessment by physical therapists. Code 97002 is to be used for re-evaluation of a patient by physical therapists. Procedure code 97003 is to be used for an initial assessment by occupational therapists. Code 97004 is to be used for re-evaluation of a patient by occupational therapists.

C. Plan of Care

1. An initial plan of care must be developed and filed with the payer regardless of whether therapy is provided by a physician or practicing therapist. The content of the plan of care, at a minimum, should contain
 - a. The specific therapies to be provided, including the frequency and duration of each
 - b. The estimated duration of the therapeutic regimen
 - c. The potential degree of restoration and measurable goals (e.g., potential restoration is good, poor, low, guarded)
2. The initial plan of care must be signed by the treating physician and submitted to the payer within fourteen (14) days of approval. Physicians are required to sign the plan of care for physical and/or occupational therapy. The physician's signature indicates approval of the therapy the patient is receiving and for the length of time established for the therapy.
3. The physician has the responsibility of providing documentation of medical necessity to the payer whenever there are questions regarding the extent of therapy being provided or the appropriateness of the therapy regimen.
4. A plan of care must be updated at least every thirty (30) days and submitted to the payer.
5. Preparation of a care plan does not warrant a separate fee.

D. Qualifications for Reimbursement

1. The patient's condition must have the potential for restoration of function.
2. The treatment must be prescribed by the authorized attending or treating physician.
3. The treatment must be specific to the injury and have the potential to improve the patient's condition.
4. The physician or therapist must be on-site during the provision of services.

II. REIMBURSEMENT

A. Guidelines

1. Visits for therapy may not exceed one visit per day without prior approval from the payer.
2. Therapy exceeding fifteen (15) visits or thirty (30) days, whichever comes first, must have prior authorization from the payer for continuing care. It must meet the following guidelines:
 - a. The treatment must be medically necessary.
 - b. Prior authorization may be made by telephone. Documentation should be made in the patient's medical record indicating the date and name of the payer representative giving authorization for the continued therapy.
3. Reimbursement is limited to no more than four (4) therapies concurrently at the same visit. In the event of multiple treatment areas, an additional four (4) therapies per treatment day may be allowed at the payer's discretion and with pre-authorization. In the event of multiple treatment areas, the second and subsequent areas are subject to the multiple procedure rule.
[In the pain management setting, no more than two (2) modalities and/or procedures may be used on a given day (e.g., heat/cold, ultrasound, diathermy, iontophoresis, TENS, electrical stimulation, muscle stimulation, etc.). No more than one (1) modality may be used concurrently.]
4. Payment for 97010, which reports application of hot or cold packs, is bundled into payment for other services. Separate reimbursement for hot and cold packs will not be allowed in the treatment of work-related injury/illness.
5. No more than four (4) 15-minute procedures and/or modalities will be reimbursed at each encounter without prior authorization.
6. Only one (1) work hardening or work conditioning program is reimbursed per injury.

B. Treatment Areas

1. Spinal areas are recognized as the following five distinct regions:
 - Cranial
 - Cervical
 - Thoracic
 - Lumbar
 - Sacral

Transitional areas of the spine are not recognized as distinctly different areas (e.g., cervicothoracic, lumbosacral).

2. Pelvis
3. Upper extremity (either left or right) is recognized as the following six distinct regions:

- Shoulder
- Upper arm
- Elbow
- Forearm
- Wrist
- Hand

4. Lower extremity (either left or right) is recognized as the following eight distinct regions:

- Hip
- Thigh
- Knee
- Calf
- Ankle
- Foot
- Rib cage
- Anterior trunk

C. Tests and Measurements

1. When two or more procedures from 95831 through 95852 are performed on the same day, reimbursement may not exceed the maximum reimbursement allowance (MRA) for procedure code 95834 Total evaluation of body, including hands.
2. Functional capacity evaluation (FCE) must have pre-authorization from the payer before scheduling the tests.
3. Reimbursement for extremity testing, muscle testing, and range of motion measurements (95831, 95832, 95833, 95834, 95851, 95852) will not be made more than once in a thirty (30) day period for the same body area. If a physician's order specifically indicates testing in more than one plane of motion, (e.g., flexion/extension and internal/external rotation), then each plane of motion test is reimbursable, but not more than once in a thirty (30) day period for that same body area. The multiple procedure rule would apply.

D. Fabrication of Orthotics

1. Procedure code 97760 must be billed for the professional services of a physician or therapist to fabricate orthotics.
2. Orthotics, prosthetics, and related supplies used may be billed under the appropriate HCPCS code. The maximum reimbursement allowance is listed in the DME and Other HCPCS Codes section of the Fee Schedule. For orthotics and supplies not listed in the DME and Other HCPCS Codes section, use CPT code 99070. Reimbursement may not exceed a twenty percent (20%) mark-up of the provider's cost and an invoice may be required by the payer before reimbursement is made.

E. Follow-up Examination of an Established Patient

A physician, physical therapist, or occupational therapist may charge and be reimbursed for a follow-up examination for physical therapy only if new symptoms present the need for re-examination and evaluation as follows:

1. There is a definitive change in the patient's condition
2. The patient fails to respond to treatment and there is a need to change the treatment plan

3. The patient has completed the therapy regimen and is ready to receive discharge instructions

III. WORK HARDENING RULES

- A. Work hardening programs are interdisciplinary, goal-specific, vocationally-driven treatment programs designed to maximize the likelihood of return to work through functional, behavioral, and vocational management.
- B. Not all claimants require these programs to reach a level of function that will allow successful return to work.
- C. Only those programs that meet all of the specific guidelines will be defined as work hardening programs.
- D. Programs will be reimbursed per the Fee Schedule after meeting all other requirements.
- E. Work hardening will be reimbursed for a maximum of four weeks with prior authorization from the payer. The payer may approve additional two-week increments if the patient demonstrates substantial improvement.
- F. For pre-admission criteria, all claimants must complete a preprogram assessment, including a functional capacity evaluation (FCE). The goal of the program is return to work, therefore, for all anticipated returns to previous employment or placement with a new employer, the following must be provided:
 1. Specific written critical job demands and/or job site analysis
 2. Verified written employment opportunities
- G. For the evaluation process, initial screening evaluation is performed to determine if the injured worker will benefit from a work hardening program. The outcome of this evaluation will be:
 1. Recommendation of release to return to work
 2. Acceptance into the program with an individual written rehabilitation plan stating specific goals and recommended services
 3. Rejection from program for specific reasons
 4. Referral back to the provider for medical evaluation
- H. The individualized work hardening plan must be supervised by a licensed physical or occupational therapist and/or physician within a therapeutic environment. Although some time is spent on a one-to-one basis, more than fifty percent (50%) of the time is self-monitored under the supervision of a physical or occupational therapist and/or physician. Recommended group size is no larger than five-to-one (5 patients to 1 therapist).
- I. Progress should be documented and reviewed to ensure continued progress.
- J. Simultaneous utilization of work conditioning and work hardening is not allowed. Prior authorization is required for either one of these services and requires documentation of specific goals and outcomes.
- K. Discharge criteria must be provided to all claimants in writing prior to initiation of treatment at the time program goals are determined.
- L. Voluntary discharge is achieved by:
 1. Meeting program goals
 2. Early return to work
 3. Acute or worsening medical condition
 4. The claimant declining further treatment
- M. Non-voluntary discharge may be necessary in cases of

1. Failure to comply with program policies
 2. Absenteeism
 3. Lack of demonstrable benefit from treatment
- N. Non-voluntary discharge requires written documentation of prior and repeated counseling of the claimant, and immediate notification of the employer, insurer, case manager, and treating and attending (if different) provider.
- O. Under all circumstances of voluntary and non-voluntary discharge, the claimant will return to the attending provider for release from the program.
- P. The attending provider must sign a release to return to work when the program goals are achieved.
- Q. The exit/discharge summary should delineate the person's
1. Present functional status and potential
 2. Functional status related to the targeted job, alternative occupations, or competitive labor market.
- R. For program evaluation, programs must provide insurers and referring providers with
1. Initial interdisciplinary team evaluation report
 2. Proposed treatment plan
 3. Progress reports at weekly intervals
 4. The opportunity to attend team meetings
 5. Final discharge summary report
- S. Fees for work hardening programs will be paid in accordance with the Fee Schedule, with written prior approval by the payer, utilizing the following guidelines:
1. In all cases, for both voluntary and non-voluntary discharge, payment is for the actual duration of treatment provided.
 2. Non-multi disciplinary work conditioning programs will be reimbursed utilizing existing physical therapy, occupational therapy, and physical medicine codes. CPT code 97545 (initial two hours) and code 97546 (each additional hour) are to be used to bill work hardening. CPT code 97545 is to be billed for the initial two hours of the work hardening program. This is a one-time charge. CPT code 97546 is to be used for billing each additional hour of the work hardening program after the initial two hours (indicated by code 97545).

IV. FUNCTIONAL CAPACITY EVALUATIONS

- A. The functional capacity evaluation (FCE) is utilized for the following purposes:
1. To determine the highest level of safe functionality and of maximal medical improvement.
 2. To provide a pre-vocational baseline of functional capabilities to assist in the vocational rehabilitation process.
 3. To objectively set restrictions and guidelines for return to work.
 4. To determine whether specific job tasks can be safely performed by modification of technique, equipment, or by further training.
 5. To determine whether additional treatment or referral to a work hardening program is indicated.
 6. To assess outcome at the conclusion of a work hardening program.

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B. General Requirements

1. The FCE may be prescribed only by a licensed physician, or may be required by the payer when indicated.
2. The FCE requires prior authorization by the payer.
3. The FCE should be billed using code 97750 Functional capacity evaluation.

V. TENS UNITS

- A. TENS (transcutaneous electrical nerve stimulation) must be provided under the attending or treating physician's prescription.
- B. Authorization from the payer must be sought before purchase or rental arrangements are made for a TENS unit. The payer has sole right of selection of vendors for rental or purchase of equipment, supplies, etc.

VI. SUPPLIES, EQUIPMENT, ORTHOTICS, AND PROSTHETICS

- A. Physicians and therapists must obtain authorization from the payer before purchase/rental of supplies, equipment, orthotics, and prosthetics costing more than fifty dollars (\$50.00) per item for workers' compensation patients. When submitting bills, include the appropriate HCPCS Level II code. Or, if there is not an appropriate HCPCS code, use CPT code 99070.
- B. The payer has sole right of selection of vendors.

VII. OTHER INSTRUCTIONS

- A. Charges will not be reimbursed for publications, books, or videocassettes unless prior approval of the payer is obtained.
- B. All charges for services must be clearly itemized by CPT code, and the state professional license number must be on the bill.
- C. The treating physician must approve and sign all physical capability/restriction forms for the work-related injury/illness. This form must be submitted to the payer within fourteen (14) working days of the release to work.
- D. Documentation may be required by the payer to substantiate the necessity for treatment rendered. Documentation to substantiate charges and reports of tests and measurements are included in the fee for the service and do not warrant additional reimbursement.
- E. When patients do not show measurable progress, the payer may request the physician discontinue the treatment or provide documentation to substantiate medical necessity.
- F. When physical medicine therapies are provided to more than one body area, modifier 51 must be added to the procedure code or codes billed for the additional body area and will be reimbursed according to the multiple procedure rule.
- G. Non-surgical debridement should be billed as CPT code 97597, 97598, or 97602.

VIII. BACK SCHOOLS

All back school programs shall require prior authorization from the payer. The payer and the back school program may agree upon the daily, weekly, or other time-based payment to be made for services.

provided to the injured/ill worker. This agreement shall supersede the use of this Physical Medicine section when calculating reimbursement, but it shall not exceed the usual and customary fee.

IX. MASSAGE THERAPY

Massage therapy requires prior authorization of the payer before treatment can be rendered. Medical necessity must be established prior to approval. Reimbursement must be arranged between the payer and provider.

X. CHIROPRACTIC MANIPULATIVE TREATMENT

Codes 98940 through 98943 are used to code chiropractic manipulative treatment. Like any other service, a spinal manipulation includes pre-evaluation and post-evaluation that would make it inappropriate to bill with an E/M service. However, if the patient's condition has deteriorated or an injury to another site has occurred, reimbursement can be made for an E/M service if documentation substantiates the additional service. Modifier 25 is added to an E/M service when a significant, separately identifiable E/M service is provided and documented as medically necessary.

XI. ELECTROMYOGRAM (EMG) AND NERVE CONDUCTION STUDY (NCS)

- A. Only a licensed physical medicine doctor or a neurologist is entitled to reimbursement for performing an Electromyogram (EMG) and/or a nerve conduction study (NCS).
- B. Reimbursement is not allowed under this Schedule for automated nerve conduction studies.
- C. Referral for an electromyogram and/or a nerve conduction study shall be at the discretion and direction of the physician in charge of care, and neither the payer nor the payer's agent may unilaterally or arbitrarily redirect the patient to another provider for these tests. The payer or the payer's agent may, however, discuss with the physician in charge of care appropriate providers for the conduct of these tests in an effort to reach an agreement with the physician in charge as to who will conduct an electromyogram and/or nerve conduction study in any given case.

XII. CHRONIC PAIN – INTER-DISCIPLINARY PAIN REHABILITATION PROGRAM

- A. The Inter-Disciplinary Pain Rehabilitation (IDPR) program is based on the biopsychosocial approach to managing chronic pain, and uses both physical medicine treatments as well as psychological treatments and therapy to manage the chronic pain patient. A goal oriented, team approach is used in an effort to reduce pain, improve functioning, and decrease the dependence on the health care system of persons with chronic pain. This is an outpatient program.
- B. Pre-authorization is required in order to utilize an inter-disciplinary pain rehabilitation program to treat the chronic pain patient. A specific IDPR program plan must be submitted to the payer as part of the pre-authorization process.
- C. The following guidelines shall be used to assist in pre-authorization, and concurrent review:
 - 1. Persons considered suitable candidates for an inter-disciplinary pain rehabilitation program are those
 - a. who are likely to benefit from the program design;

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b. whose symptoms are deemed by a pain management provider to constitute chronic pain syndrome; and

c. whose medical, psychological or other conditions do not prohibit participation in this program.

2 Mental Health Evaluation: an initial evaluation to determine the injured worker's readiness or suitability for this type of treatment may be performed prior to initiation of treatment. This evaluation is not considered part of the IDPR program and shall be billed separately.

3 Due to the nature and intensity of the program, both group and individual therapy may be part of the IDPR program. If the program plan for a particular patient includes individual psychotherapy, it shall be billed as part of the program, and not separately. If the program does not include psychotherapy services, such services may be billed separately, if used, subject to applicable pre-authorization requirements.

4 Psychological treatments which are part of the IDPR program may be rendered by a psychiatrist, psychologist, licensed counselor or licensed social worker.

5 The IDPR program shall always include a component designed to reduce the patient's dependence on and/or addiction to pain medications.

6 An individualized plan of treatment shall be supervised by a doctor within a therapeutic environment. Although some time is spent with a doctor on a one-to-one basis, more than 50% of the time may be spent in direct care under the supervision of the physical therapist, occupational therapist, mental health provider, or other licensed member of the IDPR team.

7 Program supervision shall be provided by a doctor who is trained and experienced in the treatment of patients with chronic pain syndrome. The program supervisor shall:

a. provide direct, on-site supervision of the daily pain management activities;

b. participate in the initial and final evaluation of the patient;

c. write the treatment plan for the patient, and write changes to the plan based on the patient's documented response to the treatment, and/or based on documented changes in the patient's condition;

d. direct the members of the IDPR team and review the patient's progress on a regular and consistent basis.

8 Participation in an IDPR program requires a minimum attendance of four (4) hours per day during the first week. The program shall not exceed eight (8) hours per day, except that workers who actually have experience working in a job for more than eight (8) hours per day may be allowed to participate for up to ten (10) hours per day, at the discretion of the program supervisor.

9 Daily treatment and patient response shall be documented and provided to the payer at least every two (2) weeks.

10 Discharge/exit criteria shall include but not be limited to:

a. the appropriate use of medication;

b. decreased intensity of subjective pain;

c. increased ability of the injured worker to manage pain;

- d. reduced health care use related to the chronic pain;
- e. return to work; and/or
- f. non-compliance with the program, or failure to obtain meaningful benefit after a reasonable period of time.

D. **Billing:** The IDPR program shall be billed using CPT 97799 ("unlisted physical medicine/rehabilitation service or procedure"), and appended with modifier "CP" to indicate chronic pain treatment. The total number of hours shall be indicated in the units column of the bill, or in some other conspicuous place on the bill. CARF accredited providers shall also add "CA" as an additional modifier.

E. **Reimbursement:** Reimbursement shall be as agreed to by the parties, or a maximum of \$125.00 per hour for CARF accredited providers. Providers without CARF accreditation shall be paid 80% of the maximum allowable fee for CARF accredited providers. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment shall be reimbursed if the time is equal to or greater than 8 minutes and less than 23 minutes.

XIII. Experimental or Investigational Procedures

Certain procedures or treatments are considered investigational or experimental for purposes of this Fee Schedule, and are not approved for reimbursement. These procedures or treatments include:

- A. VAX-D therapy.

Dental

Dental codes (D0120–D9999), also referred to as D codes, are a separate category of HCPCS Level II national codes that contain the complete *Current Dental Terminology* (CDT) code set, which is developed, maintained, and copyrighted by the American Dental Association (ADA).

CDT is updated every two years. The current edition is *CDT 2010*, which is the edition that has been used in this Fee Schedule.

Decisions regarding the modification, deletion, or addition of CDT codes are made by the ADA and not the national panel responsible for the administration of HCPCS Level II codes. The Department of Health and Human Services has an agreement with the ADA to include *CDT 2010* as a set of HCPCS Level II codes used to report dental services.

Durable Medical Equipment (DME), Orthotics, Prosthetics and Other HCPCS Codes

I. DEFINITION

HCPCS is an acronym for CMS's Healthcare Common Procedural Coding System. It is divided into two subsets. HCPCS Level I codes are CPT codes developed and maintained by the AMA. HCPCS Level II codes, with the exception of the dental codes (D0120–D9999), are developed and maintained by CMS and include codes for procedures, equipment, and supplies not found in the CPT book. This section of the Fee Schedule contains HCPCS Level II codes. (See the Dental section for dental codes.) HCPCS Level II codes that are excluded from the Fee Schedule are Physician Voluntary Reporting Program Codes (G8006–G9139), Alcohol/Drug Abuse Treatment Services (H0001–H2037), National Codes for State Medicaid Agencies (T1000–T5999, except T2001–T2007). These three sections are not included because there is no fee associated with the code (G8006–G9139) or the code was created for State Medicaid agencies (H0001–H2037, T1000–T5999) and no fee data is available.

Code categories included in this section are as follows:

Transportation Services including
Ambulance A0021–A0999

Medical/Surgical Supplies A4206–A8004

Administrative, Misc., and
Investigational A9150–A9999

Enteral/Parenteral Therapy B4034–B9999

Outpatient PPS C1300–C9728

Durable Medical Equipment
(DME) E0100–E8002

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Procedures/Professional Services (Temporary)	G0008–G3001
Drugs and Biologicals	J0120–J9999
K Codes (Temporary)	K0001–K0899
Orthotic Procedures	L0112–L4398
Prosthetic Procedures	L5000–L9900
Medical Services	M0064–M0301
Pathology and Laboratory Services	P2028–P9615
Q Codes (Temporary)	Q0035–Q9967
Diagnostic Radiology Services	R0070–R0076
Temporary National Codes (Non-Medicare)	S0012–S9999
Vision Services	V2020–V2799
Hearing Services	V5008–V5364

II. GUIDELINES

A Transportation Services Including Ambulance (A0021–A0999)

- 1 Transportation service codes include ground and air ambulance, nonemergency transportation (taxi, bus, automobile, wheelchair van), and ancillary transportation-related fees.
- 2 Modifiers are required when reporting transportation services. Modifiers are single digits used to identify origin and destination. The first modifier identifies the transport place of origin and the second modifier the destination. Origin and destination modifiers are as follows:
 - D Diagnostic or therapeutic site other than those identified in "P" or "H"
 - E Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility)
 - G Hospital-based dialysis facility (hospital or hospital-related)
 - H Hospital
 - I Site of transfer (for example, airport or helicopter pad) between types of ambulance
 - J Non-hospital-based dialysis facility
 - N Skilled nursing facility (SNF)
 - P Physician's office (includes HMO non-hospital facility, clinic, etc.)
 - R Residence

S Scene of accident or acute event

X Intermediate stop at physician's office enroute to the hospital (includes HMO non-hospital facility, clinic, etc.)

3. Transportation codes can also be found in the S and T codes. See S0207, S0208, S0209, S0215 and T2001–T2007.

B. Medical and Surgical Supplies (A4206–A8004)

1. A wide variety of medical, surgical, and some DME related supplies and services are represented in this section.
2. For rules related to DME supplies, accessories, maintenance, and repair, see G. Durable Medical Equipment below

C. Administrative, Miscellaneous, and Investigational (A9150–A9999)

1. These codes cover nonprescription drugs, exercise equipment, radiopharmaceutical diagnostic imaging agents, as well as other miscellaneous supplies.

D. Enteral and Parenteral Therapy (B4034–B9999)

1. This section covers enteral formulae, enteral medical supplies, parenteral nutrition solutions and supplies, and enteral and parenteral pumps.

E. Outpatient PPS (C1300–C9728)

1. These codes report drugs, biologicals, and devices used by hospitals
2. These codes are only used for facility (technical) services.

F. Durable Medical Equipment (DME) (E0100–E8002)

1. All durable medical equipment shall have prior authorization from the payer before obtaining the equipment. The payer has the choice of vendor for purchase or rental of DME.
2. If an injured/ill employee is receiving DME items for both compensable and non-compensable medical conditions, only those items that apply to the work related injury should be listed on claims and invoices submitted to the employer.
3. If the rental price for DME exceeds or equals the total purchase price, the employer shall purchase instead of renting equipment. The vendor shall make the payer aware of the price options.
4. The return of rented equipment is the dual responsibility of the injured worker and the DME supplier. The employer is not responsible for additional rental periods solely due to delay in equipment return.

G. Procedures/Professional Services (Temporary) (G0008–G3001)

1. G codes identify professional health care procedures and services that would otherwise be reported using CPT codes.
2. Procedures and professional services identified by G codes may have a corresponding CPT code. When both a G code and CPT code describe the same procedure, the CPT code is required for reporting purposes.
3. G codes also include procedures and professional services that do not currently have a valid CPT code. In such cases, the applicable G code should be used for reporting purposes.

Mississippi Workers' Compensation Medical Fee Schedule

H. Drugs and Biologicals (J0120–J9999)

1. These codes report drugs and biologicals that cannot be self administered and are typically administered by injection, infusion, or inhalation. Exceptions include oral immunosuppressive and oral chemotherapy drugs.
2. These codes report only the costs associated with provision of the drug. Administration including injection, infusion, or inhalation is reported separately using the applicable CPT code(s).
3. For oral anti-emetic drugs provided in conjunction with chemotherapy treatment, see Q0183–Q0181.
4. Additional codes for drugs and biologicals may be found in the Q codes and S codes.

I. Temporary Codes (K0001–K0899)

1. These codes are temporary codes used to report durable medical equipment that does not yet have a permanent national code.
2. For rules related to DME supplies, accessories, maintenance, and repair, see G. Durable Medical Equipment above.

J. Orthotic Procedures and Devices (L0112–L4398) and Prosthetic Procedures (L5000–L9900)

The payer shall only pay for orthotics and prosthetics prescribed by the treating physician for a compensable injury/illness. Prior authorization must be obtained from the payer.

K. Medical Services (M0064–M0301)

1. These codes are used to report office services, cellular therapy, prolotherapy, intragastric hypothermia, IV Chelation therapy, and fabric wrapping of an abdominal aneurysm.
2. These codes are rarely reported and may not be reimbursed as they represent services for which the therapeutic efficacy has not been established, the procedure is considered experimental, or the procedure has been replaced with a more effective treatment modality.

L. Pathology and Laboratory Services (P2028–P9615)

1. Included in this section are codes for chemistry and toxicology tests, pathology screening tests, microbiology tests, blood, and blood products.
2. Blood and blood product codes report the supply of the blood or blood product only.
3. The administration of blood or blood product is reported separately.
4. Code 36430 for transfusion of blood or blood components is reported only once per encounter, regardless of the number of units provided.

M. Temporary Codes (Q0035–Q9967)

1. These temporary codes were developed for reporting services and supplies that do not have a permanent national HCPCS code or CPT code. Included in this section are codes for:
 - a. Oral anti-emetic drugs
 - b. Casting supplies
 - c. Splint supplies
 - d. Low osmolar contrast
 - e. High osmolar contrast
 - f. Other supplies/services
2. Cast supplies and splints should be reported with the appropriate code from Q4001–Q4051. These codes report the cost of the supply only.

Durable Medical Equipment (DME), Orthotics, Prosthetics and Other HCPCS Codes

3. Cast supplies and splints are reported in addition to the CPT code for fracture management.
 4. Cast supplies and splints are reported in addition to CPT codes for application of the cast or splint.
 5. Refer to the CPT guidelines for rules related to reporting fracture management and cast application.
- N. Diagnostic Radiology Services (R0070–R0076)
1. These codes are used for transportation of portable x-ray and/or EKG equipment.
 2. Only a single reasonable transportation charge is allowed for each trip to a single location.
 3. When more than one patient receives x-ray or EKG services at the same location, the allowable transport charge is divided among all patients.
- O. Temporary National Codes (Non-Medicare) (S0012–S9999)
1. These codes were developed by the Blue Cross/Blue Shield Association (BCBSA) and the Health Insurance Association of America (HIAA) to report drugs, services, and supplies for which there are no CPT or HCPCS Level II codes, but for which codes are needed by the private sector to implement policies, program, or claims processing.
 2. See J codes for reporting rules related to drugs and biologicals.
 3. For the purposes of pain management, if the drugs used in the refill of the pain pump must be compounded, report the compounding service with code S9430 Pharmacy compounding and dispensing services. The compounding service shall be reimbursed at \$157.44 per individual refill. For purposes other than pain management, S9430 shall be reimbursed by report (BR).
- P. Vision, Hearing, and Speech-Language Pathology Services (V2020–V2799, V5008–V5364)
1. Vision services includes codes for reporting vision-related supplies, including spectacles, lenses, contact lenses, prostheses, intraocular lenses, and miscellaneous lenses.
 2. Hearing services includes codes for hearing tests and related supplies and equipment, speech-language pathology screenings, and repair of augmentative communicative systems.

III. MODIFIERS

HCPCS Level II modifiers are required for some supplies and services. Commonly reported HCPCS Level II modifiers include:

- | | |
|----|---|
| AU | Item furnished in conjunction with a urological, ostomy, or tracheostomy supply |
| AV | Item furnished in conjunction with a prosthetic device, prosthetic, or orthotic |
| AW | Item furnished in conjunction with a surgical dressing |
| KC | Replacement of special power wheelchair interface |
| NU | Purchased new equipment |
| RR | Rental equipment (listed amount is the per-month allowance) |
| UE | Purchased used equipment |

Inpatient Hospital and Outpatient Facility Payment Schedule and Rules

I. INPATIENT AND OUTPATIENT CARE RULES

A. Definition:

For purposes of this schedule, "inpatient" means being admitted to a hospital setting for twenty-four (24) hours or more. An inpatient admission does not require official admission to the hospital.

B. Billing and Reimbursement Rules for Inpatient Care:

1. Facilities must submit the bill for inpatient services within thirty (30) days after discharge. For those cases involving extended hospitalization, interim bills must be submitted every thirty (30) days.
2. Reimbursement for acute inpatient hospital services shall be the maximum reimbursement allowance fixed by the rules set forth in this section of the Fee Schedule, regardless of the total charge.
3. Non-covered charges include but are not necessarily limited to:
 - a. Convenience items;
 - b. Charges for services not related to the work injury/illness;
 - c. Services that were not certified by the payer or their representative as medically necessary.
4. When reviewing surgical claims, including for outlier consideration, the following apply:
 - a. Most operative procedures require cardiopulmonary monitoring either by the physician performing the procedure or an anesthesiologist/anesthetist. Because these services are integral to the operating room environment, they are considered as part of the OR fee and are not separately reimbursed, nor are they included separately in the total charge for outlier consideration:
 1. Cardiac monitors
 2. Oximetry
 3. Blood pressure monitor

4. Lasers
 5. Microscopes
 6. Video equipment
 7. Set up fees
 8. Additional CR staff
 9. Gowns
 10. Gloves
 11. Drapes
 12. Towels
 13. Mayo stand covers
 14. On-call or call-back fees
 15. After-hours fees
- b. Billing for surgery packs as well as individual items in the packs is not allowed and shall not be included in the total charge for outlier consideration.
- c. A majority of invasive procedures requires availability of vascular and/or airway access; therefore, the work associated with obtaining this access is included in the cost of the service, i.e., anesthesia—airway access is associated with general anesthesia and is included in the anesthesia charges.
- d. Recovery room and ICU rates include the charge for cardiac monitoring and oximeter. It is assumed the patient is placed in these special areas for monitoring and specialized care which is bundled into the special care rate. Call-back fees are not reimbursed for recovery room.
- e. Separate reimbursement is not allowed for setting up portable equipment at the patient's bedside.
- f. The following items do not qualify for separate reimbursement regardless of inpatient or outpatient status, and are not included in the total charge for outlier consideration:
1. Applicators, cotton balls, band-aides
 2. Syringes
 3. Aspirin
 4. Thermometers, blood pressure apparatus
 5. Water pitchers
 6. Alcohol preps
 7. Ice bags
5. Maximum reimbursement is set for the following line item charges:
- a. IV pump/daily – \$50.00
 - b. Venipuncture reimbursement is limited to \$4.25 per collection. A collection fee is not appropriate for finger stick, throat culture, or stool specimen collection
 - c. Pharmacy add-mixture/dispensing fee is limited to \$4.50 per mixture
- C. Implants, Durable Medical Equipment, and Supplies
Generally, durable medical equipment and supplies provided or administered in a hospital setting are not separately reimbursed since they are included in the payment reimbursement.

Unless otherwise specifically provided herein, implantables used in the inpatient setting are included in the applicable DRG reimbursement for inpatient treatment, and, therefore, the provider of inpatient services is not required to furnish the payer with an invoice for implantables.

For implantables used in the outpatient setting, reimbursement shall be made separately from the facility fee and all other charges, and the provider shall furnish a suitable invoice evidencing the cost of the implantable to the payer within sixty (60) days from the date of service the implantable is used. Upon receipt of this invoice, the payer shall pay the amount due within thirty (30) days thereafter.

Only the actual invoiced cost of the item(s), plus ten percent (10%), will be reimbursed. Tax, handling, and freight charges are included in the facilities invoiced cost and shall not be reimbursed separately.

D. Reimbursement Methodology

The inpatient maximum reimbursement allowable (MRA) totals are provided by DRG in this Fee Schedule. As of the effective date of this publication, the DRG maximum reimbursement allowable is based upon the 2009 CMS relative weights multiplied by the base rate as determined herein. Any DRGs outside of this Fee Schedule shall be reimbursed at seventy-five percent (75%) of charge. DRG MRAs represent payment in full, unless the outlier payment is applicable, or unless a contract between the payer and provider governs reimbursement, or unless otherwise specifically stated in this Fee Schedule.

1. DRG Payment is calculated by multiplying the Base Rate times the Relative Weight for the DRG.
2. The Base Rate for Mississippi is the current National Medicare Base Rate in effect as of the date of discharge, multiplied by two (2).
3. Common Medicare add-ons, such as for teaching hospitals (GME), DSH and Capital PPS, will not be allowed, and shall be considered as already included in the enhanced DRG Payment under this Fee Schedule.
4. All implantables shall be included in the applicable DRG reimbursement for inpatient treatment, and shall not be reimbursed separately in addition to the DRG payment.
5. Outlier Payments. To provide additional reimbursement for cases where the DRG payment is deemed inadequate by the Commission to cover the costs incurred by the facility, the Commission has established an outlier payment for high-cost cases.

The amount eligible for outlier reimbursement is equal to Total Charges minus DRG Payment minus Implantable Charges minus Non-Covered or Non-Qualified charges (as provided in Part I.B. above) minus the Outlier Threshold. The Outlier Threshold amount shall be specific to each facility and shall be equal to one-half (1/2) of the Medicare DRG outlier threshold in effect for each facility at the time of discharge.

6. Any amount determined to be eligible for additional outlier reimbursement shall be reimbursed at fifteen percent (15%) above the facility's cost for the outlier eligible charges. Cost is determined using the facility's cost-to-charge ratio, as determined by Medicare (CMS), which is in effect at the time of discharge. Outlier payment is figured by multiplying the eligible outlier amount by the cost-to-charge ratio, and then adding fifteen percent (15%) to compute the additional outlier payment due.

E. Instructions

The current CMS base rate payment and related files may be found by:

1. Going to www.cms.gov
2. Select the Medicare link (currently, upper left in the list)
3. Select Acute inpatient PPS (currently under Medicare Fee-for-Service Payment heading in the right-hand side column)
4. From this page, you can get either the rules or the data files.
5. The current base rate will be in the rules. To find it:

- a. Select IPPS Regulations and Notices in left-hand column.
 - b. Click on the year column so the most recent years are at the top.
 - c. Find "Hospital Inpatient Prospective Payment Systems and FY 2008 Rates" (The year will change annually. Remember, CMS inpatient is on the federal fiscal year, so the new year begins October 1 each year).
 - d. Click on the link for the year. Usually, there will be a Published/Draft option. The published option is as the rule appeared in the Federal Register.
 - e. Look for a table headlined: NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR. (The headline may be slightly different. Typically, this is one of the first tables in the document).
 - f. The wage index for Mississippi hospitals is less than 1.0. The full update amount should be used. Therefore, find the line reading: Final Rate for FY 2007 (after multiplying FY 2006 base rate by above factors) where the wage index is less than or equal to 1.0000.
Labor: \$3,094.17; Nonlabor: \$1,896.43
 - g. Adding those two amounts together produces \$4,990.60, which is the 2008 National Base Rate.
6. The hospital cost-to-charge ratio, used for reducing outliers to cost as well as the DRG relative weights, is found in the Inpatient Prospective Payment System data files from the page in Step 4 above.
- a. Click on Acute Inpatient Files for Download.
 - b. Sort by year so the most recent years are at the top.
 - c. The MS-DRG relative weight file will be Table 5. Note: Make sure you select the correct fiscal year as proposed files for next year may be in this list.
 - d. The cost to charge ratio will be in impact file for IPPS FY 2008 Final Rule November 2007.
 - e. After downloading, the impact file will be an Excel spreadsheet. CMS changes the column names from time to time, but the cost to charge ratio is in a column called OPCCR (Column Q in the 2008 version).
- F. Emergency Room Services
Emergency room facility fees, supplies, and treatment are reimbursed according to the Ambulatory Payment Classification system, as set forth herein under the heading "Ambulatory Surgery Center/Outpatient Facility Reimbursement." Radiology, lab, and physician services are reimbursed according to the Rules contained elsewhere in this Fee Schedule.
- G. Observation Services
1. Definition
Observation services are those services furnished by a hospital on the hospital's premises, and include use of a bed and periodic monitoring by a hospital's staff. The service must be reasonable and necessary to evaluate a patient's condition or to determine need for inpatient admission. To qualify for observation status, the patient needs observation due to an unforeseen circumstance or has a medical condition with a significant degree of instability.
 2. General Guidelines
 - a. Observation begins when the patient monitoring begins and ends when the order for discharge is written or given verbally by the physician.

- b. On rare occasions, an observation stay may be extended to forty-eight (48) hours. In such cases, medical necessity must be established and pre-authorization must be given for payment by the payer.
 - c. Services which are NOT considered necessary for observation are as follows:
 - 1. Services that are not reasonable and necessary for the diagnosis and treatment of the work related injury, but are provided for convenience of the patient, family, or physician.
 - 2. Any substitution of an outpatient observation for a medically appropriate inpatient admission.
 - 3. Services ordered as inpatient by the physician but billed as outpatient by the facility.
 - 4. Standing orders for observation following outpatient surgery.
 - 5. Test preparation for a surgical procedure.
 - 6. Continued care of a patient who has had a significant procedure as identified with OPPS indicator S or T.
 - d. Observation is not reimbursable for routine preparation furnished prior to an outpatient service or recovery after an outpatient service. Please refer to the criteria for observation services.
3. Billing and Reimbursement
- a. Observation status is billed at an hourly monitoring rate. The hourly rate is all inclusive with the exception of non-significant ancillary services.
 - b. Observation is billed at the rate of \$300.00 for the first three (3) hours and \$90.00 per hour thereafter. Laboratory and radiology are reimbursed according to the Fee Schedule payment limits.
 - c. Revenue code 782 is used to bill observation charges.
 - d. Observation services provided to a patient who is subsequently admitted as an inpatient should be included on the inpatient claim.
- H. Disputed Medical Charges; Abusive or Unfair Billing
- 1. Disputes over charges, fees, services, or other issues related to treatment under the terms of the Workers' Compensation Law shall be resolved in accordance with the Dispute Resolution Rules set forth elsewhere in this Fee Schedule.
 - 2. If the Commission determines that the charge amount for items substantially and consistently exceeds the facility's mark-up ratio, or if a facility's charges for other services or DRGs is substantially and consistently higher than the average charges made for the same services or DRGs by other facilities in the State, then the Commission may consider this to be an indication of abusive or unfair billing practices, and may order the facility in question to appear and show cause why penalties and other sanctions as allowed by Law should not be imposed on said facility for such abusive billing practices.
- For purposes of this provision, the mark-up ratio shall be the inverse of the facility's cost-to-charge ratio. The average charges by facilities for service or DRGs may be determined by reference to the publicly available Medpar file for Medicare inpatient admissions, with due consideration being given to the differences between the Medicare inpatient population and the workers' compensation inpatient population.

II. INPATIENT REHABILITATION FACILITIES (IRFs)

A. Inpatient Rehabilitation Facility Reimbursement Methodology

MWCC reimbursement for inpatient rehabilitation facilities (IRFs) will be based upon the CMS prospective payment system (PPS).

1. The MWCC Fee Schedule maximum reimbursement allowance for IRFs will be twice the IRF CMS pricer calculation, unless the payer and provider have a separate contract governing the reimbursement of services provided by an IRF.
2. The IRF reimbursement due under this Fee Schedule will be calculated using the CMS IRF pricer calculation in effect on the date of discharge.
3. The CMS IRF pricer is used only for facilities that have met the CMS qualifications for IRF.
4. Reimbursement for IRFs is not calculated using the DRG methodology.
5. The CMS IRF pricer is available at: http://www.cms.hhs.gov/PCPricer/06_IRF.asp

B. CMS Inpatient Rehabilitation Facility Reimbursement

Medicare regulations define inpatient rehabilitation facilities (IRFs) in the Code of Federal Regulations, Part 412, and subpart B. Medicare payments to IRFs are based on the IRF prospective payment system (PPS) under subpart P of part 412. The IRF must be currently accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), licensed by the State, and certified by Medicare as an IRF at the time the patient is treated.

The IRF must possess a Medicare/Medicaid provider number, or CMS Certification Number. The provider number consists of six digits. The first two digits indicate the state, 25 is for Mississippi, and the remaining four digits identify the facility as an IRF. The four digit suffix must be in the range of 3025–3099 for rehabilitation facilities, exempt units must have a T in the third position, e.g., 25TXXX. (<http://www.cms.hhs.gov/transmittals/downloads/R29SOMA.pdf>)

Unless governed by contract between payer and provider, or unless total billed charges are less, the reimbursement for an IRF under this Fee Schedule shall be the IRF PPS calculated rate multiplied by two. Other inpatient DRG or PPS calculations are not appropriate to use for IRF services. The IRF PPS rate is calculated using the formula for the current fiscal year, including outlier. The final calculation is published in the *Federal Register*, prior to October 1 of each year, or at <http://www.cms.hhs.gov/inpatientrehabfacpps/downloads/cms1551f.pdf>

IRF reimbursement is based upon the case mix group (CMG) to which the patient is assigned. MWCC will accept the CMG assigned by the Medicare CMG grouper. The CMG must be reported on the claim with revenue code 0024. This code indicates that this claim is being paid under the PPS and the revenue code can appear on a claim only once.

The *Federal Register* explains the formula for calculating the IRF PPS rate. The rates are calculated on case mix group (CMG) assignment from the combinations of ICD-9-CM codes with additional factors of labor share, wage index, rural adjustment (if applicable) and low income percentage (LIP) for a final adjusted IRF PPS reimbursement.

This calculated IRF PPS reimbursement is multiplied by two for the MWCC reimbursement rate.

Unadjusted IRF PPS (CMG Tier 1, 2, 3, or no comorbidities)

- x Labor Share (FY 2007 *Federal Register* Table 5)
- = Labor portion of federal payment

- x CBSA Based Wage Index (See Federal Register Table I, Jackson, MS)
- = Wage-Adjusted Amount
- + Non-labor amount (Unadjusted federal PPS less labor portion of federal payment)
- = Wage-adjusted federal payment
- x Rural Adjustment (See Federal Register)
- = Wage and rural adjusted federal payment
- + LIP adjustment (low income percentage based on disproportionate share hospital (DSH) calculation)
- = Wage, rural and LIP adjusted federal PPS payment rate
- x 2 (MWCC reimbursement adjustment)
- = MWCC IRF PPS adjusted payment

MWCC will use the Medicare Pricer which is available as a free download from (http://www.cms.hhs.gov/PCPricer/06_IRF.asp#TopOfPage) The Medicare pricer returns the payment rate specific to the facility.

Pricer returns the following information:

- *
- PS Return Code
- MSA /CBSA (effective October 1, 2005)
- Wage Index
- Average LOS
- Relative Weight
- Total Payment Amount
- PPS Federal Payment Amount
- Facility Specific Payment Amount
- Outlier Payment Amount
- Low-income Payment (LIP) Amount
- Teaching Amount (effective October 1, 2005)
- LOS
- Regular Days Used

- LTR Days Used
- Transfer Percentage
- Facility Specific Rate pre-blend
- Standard Payment Amount
- PPS federal amount pre-blend
- Facility costs
- Outlier threshold
- Submitted HIPPS/CMG code
- PPS Pricer CMG code
- Calculation version code

III. AMBULATORY SURGERY CENTER/OUTPATIENT FACILITY REIMBURSEMENT

A. Reimbursement for all hospital-based outpatient and freestanding ambulatory surgery center services shall be based on the Ambulatory Payment Classification (APC) system as developed by the Centers for Medicare and Medicaid Services (CMS) beginning January 1, 2008. The Base Rate effective from and after July 1, 2010 for payments made under this Schedule is \$91.19.

B. For implantables used in the outpatient setting, reimbursement shall be made separately from the facility fee and all other charges; the provider shall furnish a suitable invoice evidencing the cost of the implantable to the payer within sixty (60) days from the date of service. Upon receipt of this invoice, the payer shall pay the amount due within thirty (30) days thereafter. Implantables shall be reimbursed at payer cost plus ten percent (10%).

A "suitable invoice" is an acquisition invoice from the manufacturer that contains pricing information showing the actual cost of the implant(s) being billed, or, as in situations such as a bulk purchase, containing information from which the actual cost of the implant(s) can be readily determined. The invoice must be on company letterhead or other identifiable documentation from the implant manufacturer, not the hospital/facility, unless otherwise agreed to by the payer. Reimbursement is limited to 110% of the original manufacturer's invoice price.

C. All "C" status and "E" status codes shall be paid using a relative weight of twenty-three (23).

D. Status Code "N" items and services are packaged into APC rates, and are paid under OPPS; payment is packaged into payment for other services including outliers. Therefore, there is no separate APC payment. Status Code "P" (Partial hospitalization) is also paid under OPPS.

E. If more than one surgical procedure is furnished in a single operative encounter, the multiple procedure rule applies. The primary procedure is reimbursed at one hundred percent (100%) of the maximum reimbursable allowance (MRA), the second and subsequent procedures are reimbursed at fifty percent (50%).

F. Outlier Payments: In an effort to target outliers to high cost and complex cases where a very costly service could cause a facility to incur a significant financial loss, the following outlier payment formula is to be used to calculate the appropriate, additional reimbursement:

Step 1: Reduce charges to cost using the default cost to charge ratio. The current default cost to charge ratio for urban facilities is 0.244; the current default ratio for rural facilities is 0.192.

Step 2: Deduct implantable cost as it's paid separately. This is the cost of furnishing the service;

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Step 3: Test to see if outlier meets 1.75 condition: Is the number from Step 2 more than 1.75 times the ASC payment rate? If no, no outlier payment is due; if yes, proceed to Step 4.

Step 4: Test to see if outlier meets the \$2,175 threshold test: Add \$2,175 to the ASC payment rate, is the total more or less than the figure from Step 2 (the cost of furnishing the service)? If greater than the figure in Step 2, no outlier is due; if less than the figure in Step 2, proceed to Step 5.

$$\text{Step 5: Determine outlier payment} \quad \frac{\text{Cost} - (\text{ASC payment} \times 1.75)}{2}$$

OR:

$$(\text{Step 2 Amount} - \text{Step 3 Amount}) \div 2$$

EXAMPLE: As an example as how this might work, Hospital X, an urban facility, bills \$90,000 for CPT 23470 (reconstruct shoulder joint). We will assume there is a \$2,500-cost implantable device used and that MWCC payment is \$10,830.

Step 1: Reduce charges to cost using the default cost to charge ratio:

$$\$90,000 \times 0.244 = \$21,960$$

Step 2: Deduct implantable cost as it's paid separately:

$$\$21,960 - \$2,500 = \$19,460$$

Step 3: Test to see if outlier meets 1.75 condition:

$$\$10,830 \times 1.75 = \$18,952$$

Is \$19,460 > \$18,952? Yes, it is more than 1.75 times the payment.

Step 4: Test to see if outlier meets the \$2,175 test:

$$\$10,830 + \$2,175 = \$13,005$$

Is \$19,460 > \$13,005? Yes, it is more than \$2,175.

Step 5: Determine outlier payment:

$$\frac{\text{Cost} - (\text{ASC payment} \times 1.75)}{2}$$

$$\frac{\$19,460 - (\$10,830 \times 1.75)}{2} = \$254$$

The outlier payment in this case would be \$254.

