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

SUBCHAPTER C. Medical Fee Guidelines
28 TAC §134.203 and §134.2047. TEXT.

Subchapter A. Medical Reimbursement Policies
§134.1. Medical Reimbursement.
(a) “Maximum allowable reimbursement” (MAR), when used in this chapter, is defined as the maximum amount payable to a health care provider in the absence of a contractual fee arrangement that is consistent with §413.011 of the Labor Code, and Division rules.
(b) Medical reimbursement for health care services provided to injured employees subject to a workers' compensation health care network established under Insurance Code Chapter 1305 shall be made in accordance with the provisions of Insurance Code Chapter 1305, except as provided in subsections (c) and (d) of this section.
(c) Examinations conducted pursuant to Labor Code §§408.004, 408.0041, and 408.151 shall be reimbursed in accordance with §134.204 of this chapter (relating to Medical Fee Guideline for Workers’ Compensation Specific Services).
(d) Examinations conducted pursuant to Labor Code §408.0042 shall be reimbursed in accordance with §126.14 of this title (relating to Treating Doctor Examination to Define the Compensable Injury).
(e) Medical reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with:
(1) the Division's fee guidelines;
(2) a negotiated contract; or
(3) in the absence of an applicable fee guideline or a negotiated contract, a fair and reasonable reimbursement amount as specified in subsection (f) of this section.
(f) Fair and reasonable reimbursement shall:
(1) be consistent with the criteria of Labor Code §413.011;
(2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and
(3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available.
(g) The insurance carrier shall consistently apply fair and reasonable reimbursement amounts and maintain, in reproducible format, documentation of the insurance carrier's methodology(ies) establishing fair and reasonable reimbursement amounts. Upon request of the Division, an insurance carrier shall provide copies of such documentation.
§134.2. Incentive Payments for Workers’ Compensation Underserved Areas.
(a) When required by Division rule, an incentive payment shall be added

to the maximum allowable reimbursement (MAR) for services performed in a designated workers' compensation underserved area.

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

* The amended rule and new rules are adopted under the Labor Code §§408.021, 413.002, 413.007, 413.011, 413.012, 413.0511, 408.0252, 413.013, 413.014, 413.015, 413.016, 413.017, 413.019, 413.031; 402.0111, and 402.061. Section 408.021 entitles an injured employee who sustains a compensable injury to all health care reasonably required by the nature of the injury as and when needed. Section 413.002 requires the Division to monitor health care providers, insurance carriers and claimants to ensure compliance with rules adopted by the Commissioner of workers' compensation, including fee guidelines. Section 413.007 sets out information to be maintained by the Division for use by the Commissioner and the Division in adopting medical policies, fee guidelines, and rules. Section 413.011 mandates that the Division, by rule, establish medical policies and guidelines. Section 413.012 requires the Division to review and revise the medical policies and fee guidelines at least every two years to reflect fair and reasonable fees. Section 413.0511 requires the Medical Advisor to make recommendations regarding the adoption of rules and policies to develop, maintain, and review guidelines as provided by §413.011. Section 408.0252 allows the Commissioner of workers' compensation to identify areas of the state in which access to health care provides is less available and adopt appropriate standards, guidelines, and rules regarding the delivery of health care in those areas. Section 413.013 requires the Division by rule to establish programs related to health care treatments and services for dispute resolution, monitoring, and review. Section 413.014 requires preauthorization by the insurance carrier for specified health care treatments and services. Section 413.015 requires insurance carriers to pay charges for medical services as provided in the statute and requires that the Division ensure compliance with the medical policies and fee guidelines through audit and review. Section 413.016 provides for refund of payments made in violation of the medical policies and fee guidelines. Section 413.017 provides a presumption of reasonableness for medical services fees that are consistent with the medical policies and fee guidelines. Section 413.019 provides for payment of interest on delayed payments refunds or overpayments.

Section 413.031 provides for procedures for medical dispute resolution. Section 402.00111 provides that the Commissioner of workers' compensation shall exercise all executive authority, including rulemaking authority, under the Labor Code and other laws of this state. Section 402.061 provides that the commissioner of workers' compensation has the authority to adopt rules as necessary to implement and enforce the Texas Workers' Compensation Act.

Subchapter C. Medical Fee Guidelines

§134.203. Medical Fee Guideline for Professional Services.

(a) Applicability of this rule is as follows:

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

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

(B) prescription drugs or medicine;

(C) dental services;

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

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

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

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

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

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

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

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

(8) Whenever a component of the Medicare program is revised,

use of the revised component shall be required for compliance with Division rules, decisions, and orders for professional services rendered on or after the effective date, or after the effective date or the adoption date of the revised component, whichever is later.
(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following:
(1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.
(2) A 10 percent incentive payment shall be added to the maximum allowable reimbursement (MAR) for services outlined in subsections (c) – (f) and (h) of this section that are performed in designated workers' compensation underserved areas in accordance with §134.2 of this title (relating to Incentive Payments for Workers' Compensation Underserved Areas).
(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.
(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007.
(d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows:
(1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule;
(2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or
(3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section.
(e) The MAR for pathology and laboratory services not addressed in

subsection (c)(1) of this section or in other Division rules shall be determined as follows:
(1) 125 percent of the fee listed for the code in the Medicare Clinical Fee Schedule for the technical component of the service; and,
(2) 45 percent of the Division established MAR for the code derived in paragraph (1) of this subsection for the professional component of the service.
(f) For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement).
(g) When there is a negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the negotiated or contracted amount that applies to the billed services.
(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the:
(1) MAR amount;
(2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or
(3) fair and reasonable amount consistent with the standards of §134.1 of this title.
(i) Health care providers (HCPs) shall bill their usual and customary charges using the most current Level I (CPT codes) and Level II HCPCS codes. HCPs shall submit medical bills in accordance with the Labor Code and Division rules.
(j) Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS codes. Division-specific modifiers are identified and shall be applied in accordance with §134.204(n) of this title (relating to Medical Fee Guideline for Workers' Compensation Specific Services). When two or more modifiers are applicable to a single CPT code, indicate each modifier on the bill.
§134.204. Medical Fee Guideline for Workers' Compensation Specific Services.
(a) Applicability of this rule is as follows:
(1) This section applies to workers' compensation specific codes, services and programs provided in the Texas workers' compensation system, other than:
(A) professional medical services described in §134.203 of this title (relating to Medical Fee Guideline for Professional Services);
(B) prescription drugs or medicine;
(C) dental services;
(D) the facility services of a hospital or other health care facility; and
(E) medical services provided through a workers' compensation health care network certified pursuant to Insurance Code Chapter 1305, except as provided in §134.1 of this title and Insurance Code Chapter 1305.

(2) This section applies to workers' compensation specific codes, services and programs provided on or after March 1, 2008.
(3) For workers' compensation specific codes, services and programs provided between August 1, 2003 and March 1, 2008, §134.202 of this title (relating to Medical Fee Guideline) applies.
(4) For workers' compensation specific codes, services and programs provided prior to August 1, 2003, §134.201 of this title (relating to Medical Fee Guideline for Medical Treatments and Services Provided under the Texas Workers' Compensation Act) and §134.302 of this title (relating to Dental Fee Guideline) apply.
(5) Specific provisions contained in the Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the Centers for Medicare and Medicaid Services (CMS) in administering the Medicare program. Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies.
(b) Payment Policies Relating to coding, billing, and reporting for workers' compensation specific codes, services, and programs are as follows:
(1) Billing. Health care providers (HCPs) shall bill their usual and customary charges using the most current Level I (CPT codes) and Level II Healthcare Common Procedure Coding System (HCPCS) codes. HCPs shall submit medical bills in accordance with the Labor Code and Division rules.
(2) Modifiers. Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS codes. Where HCPCS modifiers apply, carriers shall treat them in accordance with Medicare and Texas Medicaid rules. Additionally, Divisionspecific modifiers are identified in subsection (n) of this section. When two or more modifiers are applicable to a single HCPCS code, indicate each modifier on the bill.
(3) Incentive Payments. A 10 percent incentive payment shall be added to the maximum allowable reimbursement (MAR) for services outlined in subsections (d), (e), (g), (i), (j), and (k) of this section that are performed in designated workers' compensation underserved areas in accordance with §134.2 of this title (relating to Incentive Payments for Workers' Compensation Underserved Areas).
(c) When there is a negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the negotiated or contracted amount that applies to the billed services.
(d) When there is no negotiated or contracted amount that complies with §413.011 of the Labor Code, reimbursement shall be the least of the:
(1) MAR amount;
(2) health care provider's usual and customary charge, unless

directed by Division rule to bill a specific amount; or
(3) fair and reasonable amount consistent with the standards of §134.1 of this title (relating to Medical Reimbursement).
(e) Case Management Responsibilities by the Treating Doctor is as follows:
(1) Team conferences and telephone calls shall include coordination with an interdisciplinary team.
(A) Team members shall not be employees of the treating doctor.
(B) Team conferences and telephone calls must be outside of an interdisciplinary program. Documentation shall include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in a phone call.
(2) Team conferences and telephone calls should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee.
(3) Contact with one or more members of the interdisciplinary team more often than once every 30 days shall be limited to the following:
(A) coordinating with the employer, employee, or an assigned medical or vocational case manager to determine return to work options;
(B) developing or revising a treatment plan, including any treatment plans required by Division rules;
(C) altering or clarifying previous instructions; or
(D) coordinating the care of employees with catastrophic or multiple injuries requiring multiple specialties.
(4) Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows:
(A) CPT Code 99361.
(i) Reimbursement to the treating doctor shall be $113. Modifier “W1” shall be added.
(ii) Reimbursement to the referral HCP shall be $28 when a HCP contributes to the case management activity.
(B) CPT Code 99362.
(i) Reimbursement to the treating doctor shall be $198. Modifier “W1” shall be added.
(ii) Reimbursement to the referral HCP shall be $50 when a HCP contributes to the case management activity.
(C) CPT Code 99371.
(i) Reimbursement to the treating doctor shall be $18. Modifier “W1” shall be added.
(ii) Reimbursement to a referral HCP contributing to this case management activity shall be $5.

(D) CPT Code 99372.
(i) Reimbursement to the treating doctor shall be $46.
Modifier “W1” shall be added.
(ii) Reimbursement to the referral HCP contributing to
this case management activity shall be $12.
(E) CPT Code 99373.
(i) Reimbursement to the treating doctor shall be $90.
Modifier “W1” shall be added.
(ii) Reimbursement to the referral HCP contributing to
this case management action shall be $23.
(f) To determine the MAR amount for home health services provided through a licensed home health agency, the MAR shall be 125 percent of the published Texas Medicaid fee schedule for home health agencies.
(g) The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier “FC.” FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required. FCEs shall include the following elements:
(1) A physical examination and neurological evaluation, which include the following:
(A) appearance (observational and palpation);
(B) flexibility of the extremity joint or spinal region (usually observational);
(C) posture and deformities;
(D) vascular integrity;
(E) neurological tests to detect sensory deficit;
(F) myotomal strength to detect gross motor deficit; and
(G) reflexes to detect neurological reflex symmetry.
(2) A physical capacity evaluation of the injured area, which includes the following:
(A) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and
(B) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative database. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes.
(3) Functional abilities tests, which include the following:
(A) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);
(B) hand function tests that measure fine and gross motor

coordination, grip strength, pinch strength, and manipulation tests using measuring devices;
(C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and
(D) static positional tolerance (observational determination of tolerance for sitting or standing).
(h) The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier.
(1) Accreditation by the CARF is recommended, but not required.
(A) If the program is CARF accredited, modifier “CA” shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR.
(B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR.
(2) For Division purposes, General Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Conditioning.
(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier “WC.” Each additional hour shall be billed using CPT Code 97546 with modifier “WC.” CARF accredited Programs shall add “CA” as a second modifier.
(B) Reimbursement shall be $36 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.
(3) For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening.
(A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier “WH.” Each additional hour shall be billed using CPT Code 97546 with modifier “WH.” CARF accredited Programs shall add “CA” as a second modifier.
(B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes.

(4) The following shall be applied for billing and reimbursement of Outpatient Medical Rehabilitation Programs.
(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier “MR” for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add “CA” as a second modifier.
(B) Reimbursement shall be $90 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.
(5) The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs.
(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier “CP” for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add “CA” as a second modifier.
(B) Reimbursement shall be $125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes.
(i) The following shall apply to Designated Doctor Examinations.
(1) Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and shall be billed and reimbursed as follows:
(A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier “W5” is the first modifier to be applied when performed by a designated doctor;
(B) Attainment of maximum medical improvement shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier “W5” is the first modifier to be applied when performed by a designated doctor;
(C) Extent of the employee’s compensable injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier “W6;”
(D) Whether the injured employee’s disability is a direct result of the work-related injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier “W7;”
(E) Ability of the employee to return to work shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier “W8”; and
(F) Issues similar to those described in subparagraphs (A) - (E) of this paragraph shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier “W9.”
(2) When multiple examinations under the same specific Division order are performed concurrently under paragraph (1)(C) - (F) of this subsection:

(A) the first examination shall be reimbursed at 100 percent of the set fee outlined in subsection (k) of this section;
(B) the second examination shall be reimbursed at 50 percent of the set fee outlined in subsection (k) of this section; and
(C) subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in subsection (k) of this section.
(j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:
(1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include:
(A) the examination;
(B) consultation with the injured employee;
(C) review of the records and films;
(D) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and,
(E) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Act and Division rules in Chapter 130 of this title (relating to Impairment and Supplemental Income Benefits).
(2) An HCP shall only bill and be reimbursed for an MMI/IR examination if the doctor performing the evaluation (i.e., the examining doctor) is an authorized doctor in accordance with the Act and Division rules in Chapter 130 of this title.
(A) If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier “NM” shall be added.
(B) If the examining doctor determines MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not warranted and only the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection.
(C) If the examining doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed in accordance with paragraphs (3) and (4) of this subsection.
(3) The following applies for billing and reimbursement of an MMI evaluation.
(A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier.
(i) Reimbursement shall be the applicable established patient office visit level associated with the examination.
(ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office

visit.
(B) If the treating doctor refers the injured employee to another doctor for the examination and certification of MMI (and IR); and, the referral examining doctor has:
(i) previously been treating the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(A) of this subsection; or,
(ii) not previously treated the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(C) of this subsection.
(C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350.
(4) The following applies for billing and reimbursement of an IR evaluation.
(A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form.
(B) When multiple IRs are required as a component of a designated doctor examination under §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings), the designated doctor shall bill for the number of body areas rated and be reimbursed $50 for each additional IR calculation. Modifier “MI” shall be added to the MMI evaluation CPT code.
(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
(i) Musculoskeletal body areas are defined as follows:
(I) spine and pelvis;
(II) upper extremities and hands; and,
(III) lower extremities (including feet).
(ii) The MAR for musculoskeletal body areas shall be as follows.
(I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.
(II) If full physical evaluation, with range of motion, is performed:
(-a-) $300 for the first musculoskeletal body area; and
(-b-) $150 for each additional musculoskeletal body area.
(iii) If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier “WP.” Reimbursement shall be 100 percent of the total MAR.
(iv) If, in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent

Impairment), the examining doctor performs the MMI examination and assigns the IR, but does not perform the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the examining doctor shall bill using the appropriate MMI CPT code with CPT modifier “26.” Reimbursement shall be 80 percent of the total MAR.
(v) If a HCP, other than the examining doctor,
performs the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the HCP shall bill using the appropriate MMI CPT code with modifier “TC.” In accordance with §130.1 of this title, the HCP must be certified. Reimbursement shall be 20 percent of the total MAR.
(D) Non-musculoskeletal body areas shall be billed and
reimbursed using the appropriate CPT code(s) for the test(s) required for the assignment of IR.
(i) Non-musculoskeletal body areas are defined as
follows:
(I) body systems;
(II) body structures (including skin); and,
(III) mental and behavioral disorders.
(ii) For a complete list of body system and body
structure non-musculoskeletal body areas, refer to the appropriate AMA Guides.
(iii) When the examining doctor refers testing for nonmusculoskeletal
body area(s) to a specialist, then the following shall apply:
(I) The examining doctor (e.g., the referring
doctor) shall bill using the appropriate MMI CPT code with modifier “SP” and indicate one unit in the units column of the billing form. Reimbursement shall be $50 for incorporating one or more specialists' report(s) information into the final assignment of IR. This reimbursement shall be allowed only once per examination.
(II) The referral specialist shall bill and be
reimbursed for the appropriate CPT code(s) for the tests required for the assignment of IR. Documentation is required.
(iv) When there is no test to determine an IR for a
non-musculoskeletal condition:
(I) The IR is based on the charts in the AMA
Guides. These charts generally show a category of impairment and a range of percentage ratings that fall within that category.
(II) The impairment rating doctor must
determine and assign a finite whole percentage number rating from the range of percentage ratings.
(III) Use of these charts to assign an IR is
equivalent to assigning an IR by the DRE method as referenced in subparagraph (C)(ii)(I) of this paragraph.
(v) The MAR for the assignment of an IR in a nonmusculoskeletal
body area shall be $150.
(5) If the examination for the determination of MMI and/or the
assignment of IR requires testing that is not outlined in the AMA Guides, the

appropriate CPT code(s) shall be billed and reimbursed in addition to the fees outlined in paragraphs (3) and (4) of this subsection.

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

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

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

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

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

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

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

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

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

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

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

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

examination is performed.
(8) SP, Specialty Area - This modifier shall be added to the appropriate MMI CPT code when a specialty area is incorporated into the MMI report.
(9) TC, Technical Component - This modifier shall be added to the CPT code when the technical component of a procedure is billed separately.
(10) VR, Review report - This modifier shall be added to CPT Code 99455 to indicate that the service was the treating doctor's review of report(s) only.
(11) V1, Level of MMI for Treating Doctor - This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to a "minimal" level.
(12) V2, Level of MMI for Treating Doctor - This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to "self limited or minor" level.
(13) V3, Level of MMI for Treating Doctor - This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to "low to moderate" level.
(14) V4, Level of MMI for Treating Doctor - This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to "moderate to high severity" level and of at least 25 minutes duration.
(15) V5, Level of MMI for Treating Doctor - This modifier shall be added to CPT Code 99455 when the office visit level of service is equal to "moderate to high severity" level and of at least 45 minutes duration.
(16) WC, Work Conditioning - This modifier shall be added to CPT Code 97545 to indicate work conditioning was performed.
(17) WH, Work Hardening - This modifier shall be added to CPT Code 97545 to indicate work hardening was performed.
(18) WP, Whole Procedure - This modifier shall be added to the CPT code when both the professional and technical components of a procedure are performed by a single HCP.
(19) W1, Case Management for Treating Doctor - This modifier shall be added to the appropriate case management billing code activities when performed by the treating doctor.
(20) W5, Designated Doctor Examination for Impairment or Attainment of Maximum Medical Improvement – This modifier shall be added to the appropriate examination code performed by a designated doctor when determining impairment caused by the compensable injury and in attainment of maximum medical improvement.
(21) W6, Designated Doctor Examination for Extent - This modifier shall be added to the appropriate examination code performed by a designated doctor when determining extent of the employee's compensable injury.
(22) W7, Designated Doctor Examination for Disability - This modifier shall be added to the appropriate examination code performed by a designated doctor when determining whether the injured employee's disability is a direct result of the work-related injury.

(23) W8, Designated Doctor Examination for Return to Work - This modifier shall be added to the appropriate examination code performed by a designated doctor when determining the ability of employee to return to work.
(24) W9, Designated Doctor Examination for Other Similar Issues - This modifier shall be added to the appropriate examination code performed by a designated doctor when determining other similar issues.
8. CERTIFICATION. This agency certifies that the adopted sections have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.
Issued at Austin, Texas, on _____, 2007.

_____
Norma Garcia
General Counsel
Texas Department of Insurance,
Division of Workers' Compensation
IT IS THEREFORE THE ORDER of the Commissioner of Workers' Compensation that the amendments to §134.1 and the new §§134.2, 134.203, and 134.204 specified herein, concerning medical fee guidelines, are adopted.
AND IT IS SO ORDERED.

_____
ALBERT BETTS
COMMISSIONER OF WORKERS' COMPENSATION
TEXAS DEPARTMENT OF INSURANCE
ATTEST:

_____
Norma Garcia
General Counsel
COMMISSIONER'S ORDER NO._____