ARKANSAS REGISTER

099

Transmittal Sheet

Sharon Priest
Secretary of State
State Capitol Rm. 026
Little Rock, Arkansas 72201-1094

For Office Use Only: Effective Date 5/5/00 Code Number 099.00.00-001

Name of Agency Arkansas Workers' Compensation Commission

Department Medical Cost Containment Program - Rule 30 (Amended)

Contact Person Julie Benafield Bowman - Chief Executive Officer

Statutory Authority for Promulgating Rules Ark. Code Ann. 11-9-205

	Date
☐ Emergency — Intended Effective Date	
Legal Notice Published	Feb. 11, 200(
☐ 10 Days After Filing	
Final Date for Public Comment	March 27, 200(
☒ Other : Twenty (20) days after adoption by Commission per ACA 11-9-205	
Reviewed by Legislative Council (Rules & Regs) (Agenda)	05-04-200(
Adopted by State Agency	April 25, 20(

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted In Compliance with Act 434 of 1967 As Amended.

Julie Benafield Bowman
Signature

501-682-3930
Phone Number

Chief Executive Officer
Title

April 25, 2000
Date

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SECRETARY OF STATE
STATE OF ARKANSAS

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RULE 30

MEDICAL COST CONTAINMENT PROGRAM

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RULE 30

MEDICAL COST CONTAINMENT PROGRAM

I. GENERAL PROVISIONS

Pursuant to Ark. Code Ann. § 11-9-517 (Repl. 1996) the following rule is hereby established in order to implement a medical cost containment program.

A. Scope

1. This rule does all of the following:
   a. Establishes procedures by which the employer shall furnish, or cause to be furnished, to an employee who receives a personal injury arising out of and in the course of employment, reasonable and necessary medical, surgical, and hospital services and medicines, or other attendance or treatment recognized by the laws of the state as legal, when needed. The employer shall also supply to the injured employee dental services, crutches, artificial limbs, eyes, teeth, eyeglasses, hearing apparatus, and other appliances necessary to cure, so far as reasonably and necessarily possible, and relieve from the effects of the injury.
   b. Establishes schedules of maximum fees by a health facility or health care provider for such treatment or attendance, service, device, apparatus, or medicine.
   c. Establishes procedures by which a health care provider shall be paid the lesser of (1) the provider's usual charge, or (2) the maximum fee established under this rule, or (3) the MCO/PPO contracted price, where applicable.
   d. Provides for the identification of utilization of health care and health services above the usual range of utilization for such services, based on medically accepted standards, and provides for acquiring by a carrier and by the Medical Cost Containment Division (MCCD) of the necessary records, medical bills, and other information concerning any health care or health service under review.
   e. Establishes a system for the evaluation by a carrier of the appropriateness in terms of both the level of and the quality of health care and health services provided to injured employees, based upon medically accepted standards.
   f. Authorizes carriers to withhold payment from, or recover payment from, health facilities or health care providers which

have made excessive charges or which have required unjustified and/or unnecessary treatment, hospitalization, or visits.

g. Provides for the review by the Commission of the records and medical bills of any health facility or health care provider which has been determined not to be in compliance with this rule or to be requiring unjustified and/or unnecessary treatment, hospitalization or office visits.

h. Establishes that when a health care facility or health care provider provides health care or health care service that is not usually associated with, is longer in duration than, is more frequent than, or extends over a greater number of days than that health care or service usually does with the diagnosis or condition for which the patient is being treated, the health care provider may be required by the carrier to explain the necessity in writing.

i. Provides for the implementation of the MCCD review and decision responsibility. The rule and definitions are not intended to supersede or modify the workers' compensation laws, the administrative rules of the Commission, or court decisions interpreting the laws or the Commission's administrative rules.

j. Provides for the certification of carriers determined to be in compliance with the criteria and standards established by this rule in their utilization review of services and charges by health care facilities and health care providers

k. Establishes maximum fees for depositions/witnesses.

l. Establishes maximum fees for medical reports.

m. Provides for uniformity of billing for provider services.

n. Establishes the effective date for implementation of Rule 30.

o. Adopts by reference as part of this rule the Medical Fee Schedule and any amendments to that fee schedule.

p. Establishes procedures for balance billing.

q. Establishes procedures for reporting of medical claims.

r. Establishes procedures for obtaining medical services by out-of-state providers.

s. Establishes procedures for preauthorization of nonemergency hospitalizations, transfers between facilities, and outpatient services expected to exceed $1000.00 in billed charges for a single date of service by a provider. (See Arkansas Workers' Compensation Commission Inpatient Hospital Fee Schedule Part III.)

2. An independent medical examination performed to evaluate legal liability of a case, or for purposes of litigation of a case, shall be exempt from this rule.

B. Procedure Codes

1. Services must be coded with valid procedure or supply codes of the *Health Care Financing Administration Common Procedure Coding System* (HCPCS). Procedure codes used in Rule 30 were developed and copyrighted by the American Medical Association.
2. The most current edition of the *Current Procedural Terminology* (CPT) should be used for Rule 30 Guidelines.

C. Procedures For Which Codes Are Not Listed

1. If a procedure is performed which is not listed in the Medicare *Resource Based Relative Value Scale* (RBRVS), the health care provider must use an appropriate CPT procedure code. The provider must submit an explanation, such as copies of operative reports, consultation reports, progress notes, office notes or other applicable documentation, or description of equipment or supply (when that is the charge).
2. The CPT contains procedure codes for unlisted procedures. These codes should only be used when there is no procedure code which accurately describes the service rendered. A special report is required as these services are reimbursed **BR (By Report)**.
3. Reimbursement by the carrier for BR procedures should be based upon the carrier's review of the submitted documentation, the recommendations from the carrier's medical consultant, and the carrier's review of the prevailing charges for similar services as identified by the carrier based on data which is representative of Arkansas charges.

D. Modifier Codes

1. Modifiers listed in the CPT shall be added to the procedure code when the service or procedure has been altered from the basic procedure described by the descriptor.
2. The use of modifiers does not imply or guarantee that a provider will receive reimbursement as billed. Reimbursement for modified services or procedures must be based on documentation of reasonableness and necessity and must be determined on a case-by-case basis.

3. When Modifier 21, 22, or 25 is used, a report explaining the medical necessity of the situation must be submitted to the carrier. It is not appropriate to use Modifier 21, 22, or 25 for routine billing.

E. Total Procedures Billed Separately

Certain diagnostic procedures (neurologic testing, radiology and pathology procedures, etc.) may be performed by two separate entities who also bill separately for the professional and technical components. When this occurs, the total reimbursement must not exceed the maximum medical fee schedule allowable for the 5-digit procedure code listed.

1. When billing for the professional component only, Modifier 26 must be added to the appropriate 5-digit procedure code.
2. When billing for the technical component only, Modifier 27 or TC (Technical Component) must be added to the appropriate 5-digit code.

F. Definitions

As used in this rule:

1. "Act" means the Ark. Code Ann. § §11-9-101, et seq. (Repl. 1996).
2. "Adjust" means that a carrier or a carrier's agent reduces a health care provider's request for payment such as:
   a. Applies the AWCC maximum fee;
   b. Applies an agreed upon discount to the provider's usual charge;
   c. Adjusts to a reasonable amount when the maximum fee is by report;
   d. Recodes a procedure;
   e. Reduces payment as a result of utilization review.
3. "Appropriate care" means health care that is suitable for a particular person, condition, occasion, or place.
4. "Bill" means a request by a provider submitted to a carrier for payment for health care services provided in connection with a covered injury or illness.
5. "Bill adjustment" means a reduction of a fee on a provider's bill.
6. "BR" (By Report) means that the procedure is not assigned a maximum fee and requires a written description. The description shall be included on the bill or attached to the bill and shall include the following information, as appropriate:
   a. Copies of operative reports.
   b. Consultation reports.
   c. Progress notes.
   d. Office notes or other applicable documentation.
   e. Description of equipment or supply (when that is the charge).

7. "Carrier" means any stock company, mutual company, or reciprocal or interinsurance exchange or self-insured employer authorized to write or carry on the business of workers' compensation insurance in this state; whenever required by the context, the term 'carrier' shall be deemed to include duly qualified self-insureds or self-insured groups.
8. "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.
9. "Case record" means the complete health care record maintained by the carrier pertaining to a covered injury or illness occurring on a specific date, and includes the circumstances or reasons for seeking health care; the supporting facts and justification for initial and continual receipt of health care; all bills filed by a health care service provider; and actions of the carrier which relate to the payment of bills filed in connection with a covered injury or illness.
10. "Commission" means the Arkansas Workers' Compensation Commission.
11. "Complete procedure" means a procedure containing a series of steps which are not to be billed separately.
12. "Consultant service" means; in regard to the health care of a covered injury and illness; an examination, evaluation, and opinion rendered by a specialist when requested by the authorized treating practitioner or by the employee; and which includes a history, examination, evaluation of treatment, and a written report. If the consulting practitioner assumes responsibility for the continuing care of the patient, subsequent service(s) cease(s) to be a consultant service.
13. "Covered injury or illness" means an injury or illness for which treatment is mandated.
14. "Critical care" *See* most current ***CPT***.
15. "Day" means calendar day.
16. "Diagnostic procedure" means a service which aids in determining the nature and cause of a disease or injury.
17. "Dispute" means a disagreement between a carrier or a carrier's agent and a health care provider on the application of this rule.
18. "DRG" (Diagnosis Related Group) means one of the classifications of diagnoses in which patients demonstrate similar resource consumption and length of stay patterns.
19. "Durable medical equipment" is equipment which (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) generally is not useful to a person in the absence of illness or injury, and (4) is appropriate for use in the home.
20. "Established patient" *See* most current ***CPT***.
21. "Expendable medical supply" means a disposable article which is needed in quantity on a daily or monthly basis.

22. "Focused review" means the evaluation of a specific health care service or provider to establish patterns of use and dollar expenditures.
23. "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 allowable payment, but does not include care for complications.
24. "Follow-up days" means the days of care following a surgical procedure which are included in the procedure's maximum allowable payment, but does not include care for complications.
25. "Follow-up visits" means the number of office visits following a surgical procedure which are included in the procedure's maximum allowable payment, but does not include care for complications.
26. "Health care organization" means a group of practitioners or individuals joined together to provide health care services and includes, but is not limited to, a freestanding surgical outpatient facility, health maintenance organization, an industrial or other clinic, an occupational health care center, a home health agency, a visiting nurse association, a laboratory, a medical supply company, or a community mental health center.
27. "Health care review" means the review of a health care case or bill, or both, by a carrier, or the carrier's agent.
28. "Inappropriate health care" means health care that is not suitable for a particular person, condition, occasion, or place.
29. "Incidental surgery" means a surgery performed through the same incision, on the same day, by the same doctor, and not related to the diagnosis.
30. "Independent medical examination" means an examination and evaluation conducted by a practitioner different from the practitioner providing care.
31. "Independent procedure" means a procedure which may be carried out by itself, separate and apart from the total service that usually accompanies it.
32. "Inpatient services" mean services rendered to a person who is formally admitted to a hospital or whose length of stay exceeds 23 hours.
33. "Institutional services" mean all non-physician services rendered within the institution by an agent of the institution.

34. "Maximum allowable payment" means the maximum fee for a procedure established by this rule or the provider's usual and customary charge, whichever is less, except as otherwise might be specified.
35. "Maximum fee" means the maximum allowable fee for a procedure established by this rule.
36. "Medical admission" means any hospital admission where the primary services rendered are not surgical, psychiatric, or rehabilitative in nature.
37. "Medical only case" means a case which does not involve lost work time.
38. "Medically accepted standard" means a measure which is set by a competent authority as the rule for evaluating quantity or quality of health care or health care services and which may be defined in relation to any of the following:
    a. Professional performance.
    b. Professional credentials.
    c. The actual or predicted effects of care.
    d. The range of variation from the norm.
39. "Medically appropriate care" means health care that is suitable for a particular person, condition, occasion, or place.
40. "Medical supply" means either a piece of durable medical equipment or an expendable medical supply.
41. "Modifier code" means a 2-digit number used in conjunction with the procedure code to describe unusual circumstances which arise in the treatment of an injured or ill employee.
42. "New patient" means a patient who is new to the provider for a particular covered injury or illness and who needs to have medical and administrative records established.
43. "Operative report" means the practitioner's written description of the surgery and includes all of the following:
    a. A preoperative diagnosis.
    b. A postoperative diagnosis.
    c. A step-by-step description of the surgery.
    d. An identification of problems which occurred during surgery.
    e. The condition of the patient, when leaving the operating room, the practitioner's office, or the health care organization.
44. "Optometrist" means an individual licensed to practice optometry.
45. "Optometry" shall be defined according to Ark. Code Ann. § 17-89-101.

46. "Orthotic equipment" means an orthopedic apparatus designed to support, align, prevent, correct deformities, or improve the function of a movable body part.
47. "Orthotist" means a person skilled in the construction and application of orthotic equipment.
48. "Outpatient service" means a service provided by the following, but not limited to, types of facilities: physicians' offices and clinics, hospital emergency rooms, hospital outpatient facilities, community mental health centers, outpatient psychiatric hospitals, outpatient psychiatric units, and freestanding surgical outpatient facilities.
49. "Package" means a surgical procedure that includes but is not limited to all of the following components:
    a. The operation itself.
    b. Local infiltration.
    c. Topical anesthesia when used.
    d. The normal, uncomplicated follow-up care/visits. This includes a standard postoperative period of 30 days, except, CPT starred * procedures.
50. "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.
51. "Practitioner" means a person licensed, registered, or certified as an audiologist, doctor of chiropractic, doctor of dental surgery, doctor of medicine, doctor of osteopathy, doctor of podiatry, doctor of optometry, nurse, nurse anesthetist, nurse practitioner, occupational therapist, orthotist, pharmacist, physical therapist, physician's assistant, prosthetist, psychologist, or other person licensed, registered, or certified as a health care professional.
52. "Primary procedure" means the therapeutic procedure most closely related to the principle diagnosis.
53. "Procedure" means a unit of health service.
54. "Procedure code" means a 5-digit numerical sequence or a sequence containing an alpha or alphas and followed by three or four digits, which identifies the service performed and billed.
55. "Properly submitted bill" means a request by a provider for payment of health care services submitted to a carrier on the appropriate forms which are completed pursuant to this rule. Properly submitted bills shall include appropriate documentation as required by this rule.
56. "Prosthesis" means an artificial substitute for a missing body part.
57. "Prosthetist" means a person skilled in the construction and application of a prosthesis.
58. "Provider" means a facility, health care organization, or a practitioner.

59. "Reasonable amount" means a payment based upon the amount generally paid in the state for a particular procedure code using data available from but not limited to the provider, the carrier, or the Arkansas Workers' Compensation Commission.
60. "Reject" means that a carrier or a carrier's agent denies payment to a provider or denies a provider's request for reconsideration.
61. "Secondary procedure" means a surgical procedure which is performed to ameliorate conditions that are found to exist during the performance of a primary surgery and which is considered an independent procedure that may not be performed as a part of the primary surgery or for the existing condition.
62. "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.
63. "Specialist service" means, in regard to the health care of a covered injury and illness, the treatment by a specialist, when requested by the treating practitioner, carrier, or by the employee, and includes a history, an examination, evaluation of medical data, treatment, and a written report.
64. "Stop-Loss Payment (SLP)" means an independent method of payment for an unusually costly or lengthy stay.
65. "Stop-Loss Reimbursement Factor (SLRF)" means a factor established by the Commission to be used as a multiplier to establish a reimbursement amount when total hospital charges have exceeded specific stop-loss thresholds.
66. "Stop-Loss Threshold (SLT)" means a threshold of charges established by the Commission, beyond which reimbursement is calculated by multiplying the applicable stop-loss reimbursement factor times the total charges identifying that particular threshold.
67. "Surgical admission" means any hospital admission where the primary services rendered are not medical, psychiatric or rehabilitative in nature.
68. "Transfer between facilities" means to move or remove a patient from one facility to another for a purpose related to obtaining or continuing medical care. It may or may not involve a change in the admittance status of the patient, i.e., patient transported from one facility to another to obtain specific care, diagnostic testing, or other medical services not available in the facility in which the patient has been admitted. Includes costs related to transportation of patient to obtain medical care.

69. "Usual and customary charge" means a particular provider's average charge for a procedure to all payment sources, and includes itemized charges previously billed separately which are included in the package for that procedure as defined by this rule.
70. "Wage loss case" means a case that involves the payment of wage loss compensation.
71. "Workers' Compensation Standard Per Diem Amount (SPDA)" means a standardized per diem amount established for the reimbursement of hospitals for services rendered.

G. Information Program Regarding Rule

The Medical Cost Containment Division shall institute an ongoing information program regarding this rule for providers, carriers, and employers. The program shall include, at a minimum, informational sessions throughout the state, as well as the distribution of appropriate information materials.

H. Independent Medical Examination to Evaluate Medical Aspects of Case

1. An independent medical examination 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. This service may be necessary in order to make a judgment regarding the current status of the injured or ill worker, or to determine the need for further health care.
2. An independent medical examination, performed to evaluate the medical aspects of a case, shall be billed using the independent medical examination procedure code 99199 (BR), and shall include the practitioner's time only. The office visit charge is included with the code 99199 and may not be billed separately.
3. Any laboratory procedure, x-ray procedure, and any other test which is needed to establish the worker's ability to return to work shall be identified by the appropriate procedure code established by this rule.

I. Payment

1. Reimbursement for health care services shall be the lesser of (a) the provider's usual charge, or (b) the maximum fee calculated according to the AWCC Official Fee Schedule (and/or any amendments to that fee schedule), or (c) the MCO/PPO contracted price, where applicable. A licensed provider shall receive no more than the maximum allowable payment, in accordance with this rule, for appropriate health care services rendered to a person who is entitled to health care service.

2. The Medicare RBRVS is adopted by reference as part of this rule. The Medicare RBRVS is distributed by the Office of the Federal Register and is also available on the Internet.
3. When extraordinary services resulting from severe head injuries, major burns, and severe neurologic injuries or any injury requiring an extended period of intensive care are required, a greater fee may be allowed up to 150% of the fee schedule. Such cases should be billed with modifier 21 or 22 (for CPT coded procedures) and should contain a detailed written description of the extraordinary service rendered and the need therefor.
4. Billing for provider services shall be submitted on the forms approved by the Commission: UB-92 and HFCA-1500.
5. A carrier shall not make a payment for a service unless all required review activities pertaining to that service are completed.
6. A carrier's payment shall reflect any adjustments in the bill made through the carrier's utilization review program.
   a. A carrier must provide an explanation of medical benefits to a health care provider whenever the carrier's reimbursement differs from the amount billed by the provider.
   b. A provider shall not attempt to collect from the injured employee, employer, or carrier any amounts reduced by the carrier pursuant to this rule.
7. A carrier shall date stamp medical bills and reports upon receipt and shall pay an undisputed and properly submitted bill within 30 days of receipt. Any carrier not paying an undisputed and properly submitted bill within 30 days of receipt shall be assessed a penalty of 18%, upon a determination by MCCD.
8. When a carrier disputes a bill or portion thereof, the carrier shall pay the undisputed portion of the bill within 30 days of receipt of a properly submitted bill. Any carrier not paying an undisputed portion of the bill within 30 days of receipt can be assessed a penalty of 18% on the undisputed portion of the bill, upon a determination by MCCD.
9. Any penalty for late payment will be assessed by the Medical Cost Containment Division after an Administrative Review has been conducted. The penalty is payable to the medical provider.
10. Billings not submitted on the proper form may be returned to the provider for correction and resubmission. If a carrier returns such billings, it must do so within 20 days of receipt of the bill. The number of days between the date the carrier returns the billing to the provider and the date the carrier receives the corrected billing, shall not apply toward the 30 days within which the carrier is required to make payment.

J. Reimbursement for Employee-Paid Services

Notwithstanding any other provision of this rule, if an employee has personally paid for a health care service and at a later date a carrier is determined to be responsible for the payment, then the employee shall be fully reimbursed by the carrier.

K. Recovery of Payment

1. Nothing in this rule shall preclude the recovery of payment for services and bills which may later be found to have been medically paid at an amount which exceeds the maximum allowable payment. This also includes payments reimbursed to an employee pursuant to Sub-Section J above.
2. A carrier may recover a payment to a provider, whether by an employee or a carrier, if the carrier requests the provider for the recovery of the payment, with a statement of reasons for the request, within one one year of the date of payment.
3. Within 30 days of receipt of the carrier's request for recovery of the payment, the provider shall do either of the following:
   a. If in agreement with the request, refund the payment to the carrier.
   b. If not in agreement with the request, supply the carrier with a written detailed statement of the reasons for its disagreement, along with a refund of the portion, if any, of the payment that the provider agrees should be refunded.
4. If the carrier does not accept the reason for disagreement supplied by the provider, the carrier may file a request for Administrative Review, within 30 days of receipt of the provider's statement of disagreement. The request for review shall be filed with the Administrator of the Cost Containment Division and the carrier shall supply a copy to the provider.
5. If, within 60 days of the carrier's request for recovery of a payment, the carrier does not receive either a full refund of the payment or a statement of disagreement, then, at the option of the carrier, the carrier may do either or both of the following:
   a. File a request for Administrative Review, of which the carrier shall supply a copy to the provider.
   b. Reduce the payable amount on the provider's subsequent bills (in the case in question or any other case) to the extent of the request for recovery of payment.
6. If, within 30 days of a final order of any decision of the Commission a provider does not pay in full any refund ordered, the carrier may reduce the payable amount on the provider's subsequent bills to the extent of the request for recovery of payment plus, an additional 18%.

L. Amounts in Excess of Fees

The provider shall not bill the employee, employer, or carrier for any amount for health care services provided for the treatment of a covered injury or illness when that amount exceeds the maximum allowable payment established by this rule.

M. Missed Appointment

A provider shall not receive payment for a missed appointment unless the appointment was arranged by the carrier or the employer. If the carrier or employer fails to cancel the appointment not less than 24 hours prior to the time of the appointment and the provider is unable to arrange for a substitute appointment for that time, the provider may bill the carrier for the missed appointment using procedure code 99199 with a maximum fee of BR.

N. Medical Report of Initial Visit and Progress Reports for Other Than Inpatient Hospital Care

1. Except for inpatient hospital care, a provider shall furnish the carrier with a narrative medical report for the initial visit, all information pertinent to the covered injury or illness if requested at reasonable intervals, and a progress report for every 60 days of continuous treatment for the same covered injury or illness.
2. If the provider continues to treat an injured or ill employee for the same covered injury or illness at intervals which exceed 60 days, then the provider shall provide a progress report following each treatment that is at intervals exceeding 60 days.
3. The narrative medical report of the initial visit and the progress report shall include all of the following information:
   a. Subjective complaints and objective findings, including interpretation of diagnostic tests.
   b. For the narrative medical report of the initial visit, the history of the injury, and for the progress report(s), significant history since the last submission of a progress report.
   c. The diagnosis.
   d. As of the date of the narrative medical report or progress report, the projected treatment plan, including the type, frequency, and estimated length of treatment.
   e. Physical limitations.
   f. Expected work restrictions and length of time if applicable.
4. Cost of the narrative medical reports required by I.N.1. shall be reimbursed at the following rates: Initial Report-- $40.00; Subsequent Reports--$11.00; and Final Report-- $28.00. Under no circumstances may a provider bill for more than one report per visit. Initial reports should be billed using procedure code WC101, subsequent reports

should be billed using procedure code WC102, final reports should be billed using procedure code WC103.

5. A medical provider may not charge any fee for completing a medical report form required by the AWCC.

O. Additional Reports

Nothing in this rule shall preclude a carrier or an employee from requesting reports from a provider in addition to those specified in the preceding rule.

P. Deposition/Witness Fee Limitation

1. Any provider who gives a deposition shall be allowed a witness fee.
2. Procedure Code 99075 must be used to bill for a deposition.
3. Reimbursement for a deposition is limited to $28.00 per quarter hour, including preparation time.
4. This limitation does not apply to an expert witness who has never provided direct professional services to a party or who has provided only direct professional services which were unrelated to the workers' compensation case.

Q. Joint Petition Cases

See Commission Rule 19.

R. Out-of-State Providers

All services and requests for change-of-physician to out-of-state providers must be made to providers who agree to abide by the AWCC Medical Fee Schedule. Providers shall sign an agreement stating they shall comply with AWCC Rule 30. Carriers/self-insured employers which are not contracted with a certified Managed Care Organization shall be responsible for obtaining this agreement.

S. Preauthorization

Preauthorization is required for all nonemergency hospitalizations, transfers between facilities, and outpatient services expected to exceed $1000.00 in billed charges for a single date of service by a provider. A denial decision for payment for any type of health care service and/or treatment resulting from a utilization review, as opposed to a determination of whether such service or treatment is related to a compensable injury, shall only be made by an Arkansas certified private review agent. The Arkansas Department of Health Utilization Review certification number is required upon request. See Arkansas Workers' Compensation Hospital Inpatient Fee Schedule Part III for procedures for requesting preauthorization. Upon emergency admission, notice must be given to the carrier within 24 hours or the next business day.

II. PROCESS FOR RESOLVING DIFFERENCES BETWEEN CARRIER AND PROVIDER REGARDING BILL

A. Carrier's Dispute of a Bill

1. When a carrier adjusts and/or disputes a bill or portion thereof, the carrier shall notify the provider within 30 days of the receipt of the bill of the specific reasons for adjusting and/or disputing the bill or portion thereof, and shall notify the provider of its right to provide additional information and to request reconsideration of the carrier's action.
2. If the provider sends a bill to a carrier and the carrier does not respond in 30 days, and if a provider sends a second bill and receives no response within 60 days from the date the provider supplied the first bill, the provider may then file a request for Administrative Review with the Administrator of the Medical Cost Containment Division, with a copy to the carrier.
3. The carrier shall notify the employer, employee and the provider that the rules prohibit a provider from billing an employee, employer, or carrier for any amount for health care services provided for the treatment of a covered work-related injury or illness when that amount is disputed by the carrier pursuant to its utilization review program, or when the amount exceeds the maximum allowable payment established by the Fee Schedule. The carrier shall request the employee to notify the carrier if the provider so bills the employee, or employer.
4. The carrier shall notify the Medical Cost Containment Division when a provider attempts to balance bill or attempts to bill when a dispute exists between a carrier and a provider regarding services.
    a. A desk audit shall be conducted by the Medical Cost Containment Division on all notices regarding balance billing.
    b. The provider and carrier shall be notified of the results of the desk audit.
    c. Providers found guilty of balance billing shall be counseled (1st offense) and may be referred to the appropriate authority (2nd offense).
    d. Providers found guilty of balance billing may ask for a review of the decision before referral by the Medical Cost Containment Division to the appropriate authority.

B. Provider's Request for Reconsideration of Bill

A provider may request reconsideration of its adjusted and/or disputed bill by a carrier within 30 days of receipt of a notice of an adjusted and/or disputed bill or portion thereof. The provider's request to the carrier for reconsideration of the adjusted and/or disputed bill shall include a statement

in detail of the reasons for disagreement with the carrier's adjustment and/or dispute of a bill or portion thereof.

C. Carrier's Response to Provider's Request for Reconsideration of Bill; Provider's Right to Appeal

1. Within 30 days of receipt of a provider's request for reconsideration, the carrier shall notify the provider of the actions taken and a detailed statement of the reasons. The carrier's notification shall include an explanation of the appeal process provided under this rule.
2. If a provider is in disagreement with the action taken by the carrier on its request for reconsideration, the provider may file a request for Administrative Review within 30 days from the date of receipt of a carrier's denial of the provider's request for reconsideration, and the provider shall supply a copy to the carrier.
3. If within 60 days of the provider's request for reconsideration, the provider does not receive payment for the adjusted and/or disputed bill or portion thereof, or a written detailed statement of the reasons for the actions taken by the carrier, then the provider may make application for Administrative Review.

D. Disputes

1. Unresolved disputes between a carrier and provider due to conflicting interpretation of Rule 30 and/or the Official Medical Fee Schedule may be appealed to, and resolved by, the Administrator of the Cost Containment Division. A request for Administrative Review may be submitted to:
   Administrator of the Cost Containment Division
   Arkansas Workers' Compensation Commission
   P.O. Box 950
   Little Rock, AR 72203-0950
2. Valid requests for Administrative Review do not require a particular form but must be legible and contain copies of the following:
   a. Copies of the original and resubmitted bills in dispute which include dates of service, procedure codes, charges for services rendered and any payment received, and an explanation of unusual services or circumstances.
   b. Copies of the specific reimbursement.
   c. Supporting documentation and correspondence, if any..
   d. Specific information regarding contact with the carriers.
   e. A verified or declared written medical report signed by the physician.
   f. A specific written request for Administrative Review.

3. The party requesting Administrative Review must send a copy of the request and all documentation accompanying the request to the opposing party.

III. HEARINGS

A. Administrative Review Procedure

1. When the request for Administrative Review is received by the Administrator and it is determined that the Commission has jurisdiction over the cause of action, all parties shall be notified by certified mail return receipt requested. All parties shall have thirty (30) days from the date of receipt of notification to submit further evidence, documentation, or clarifications to the Administrator. After thirty (30) days, a decision will be determined by the Administrator and an order will be issued to the parties. Prior to this determination, the Administrator may request all parties to attend a hearing on the matter. The hearing shall be recorded verbatim. Failure to appear at such hearing may result in dismissal of request for Administrative Review.
2. Any party feeling aggrieved by the order of the Administrator shall have ten (10) days from the date of notification to request a rehearing. A request for rehearing shall be in writing and shall state the grounds upon which the moving party relies. Upon a finding that the record is not complete or that error was made in the hearing process, the Administrator may order a rehearing. A rehearing shall follow the same procedure as Subsection A.1. above.
3. Any party feeling aggrieved by the rehearing order of the Administrator shall have ten (10) days from the date of notification to appeal the ruling to an Administrative Law Judge of the Workers' Compensation Commission. Notice of appeal shall be filed with the Clerk of the Arkansas Workers' Compensation Commission. The Notice of Appeal shall contain the following:
   a. A copy of the Administrative Review Order appealed from;
   b. Copies of all materials submitted to the Administrator in the Administrative Review proceedings;
   c. A statement identifying each portion of the Administrator's order claimed to be in error; and
   d. An explanation of how each portion of the Administrator's order conflicts with the Schedule of Medical Fees or this rule.
4. The appealing party shall mail a copy of all materials which are filed in the appeal to each opposing party. No response to the appeal of the Administrator's order is required. A decision must be entered by the Administrator before any appeal may be brought. A judge of the

Workers' Compensation Commission may affirm the decision of the Administrator, or reverse or modify said decision only if it is found to be contrary to the Medical Fee Schedule and rules existing at the time the said medical care or treatment was provided.

5. If any bill for services rendered under Ark. Code Ann. § 11-9-508 by a provider of health care is not paid within 30 days after it has been approved by the Commission and returned to the responsible party by certified mail return receipt requested, there shall be added to such unpaid bill an amount equal to eighteen per centum (18%) thereof, which shall be paid at the same time as, but in addition to, such medical bill unless such late payment is excused by the Commission.

B. Computation of Time Periods

In computing a period of time prescribed or allowed by this rule, the day of the act, event or default from which the designated period of time begins to run shall not be included. The last day on which a compliance therewith is required shall be included. If the last day within which an act shall be performed or an appeal filed is a Saturday, Sunday, or a legal holiday, the day shall be excluded, and the period shall run until the end of the next day which is not a Saturday, Sunday, or legal holiday. ["Legal holiday" means those days designated as a holiday by the President or Congress of the United States or so designated by the laws of this State.]

C. Extension of Time; Request; Waiver

A request for an extension of time for the filing of any document shall be filed with the Medical Cost Containment Administrator in advance of the day on which the document is due to be filed. This requirement may be waived for good cause shown.

IV. UTILIZATION REVIEW

A. Scope

Requirements contained in this part shall pertain to utilization review activity as defined by Ark. Code. Ann. § 20-9-901 et seq. with respect to all bills (except repriced bills) submitted for payment by a provider for health care or health related services furnished as a result of a covered injury or illness arising out of and in the course of employment.

1. A private review agent who approves or denies payment or who recommends approval or denial of payment for hospital or medical services or whose review results in approval or denial of payment for hospital or medical services on a case by case basis, may not conduct utilization review in this state unless the Arkansas Board of Health has granted the private review agent a certificate.

2. Merely **repricing (matching CPT codes to the fee schedule)** patient bills against the Arkansas Fee Schedule will not be required to certify with the Arkansas Board of Health as a private review agent.
3. Denying, recommending denial or negotiating inpatient or outpatient bill payment or BR's requires certification by the Arkansas Board of Health as a private review agent.

B. Carrier's Utilization Review Program

1. The carrier shall have a utilization review program.
2. Utilization review shall be conducted in a reasonable manner and in accordance with this rule.
3. Under the utilization review program, the carrier shall do all of the following:
   a. Perform ongoing utilization review of medical bills to identify overutilization of services and improper billing.
   b. Determine the accuracy of the procedure coding. If the carrier determines, based upon review of the bill and any related material which describes the procedure performed, that the procedure is incorrectly or incompletely coded, the carrier may recode the procedure, but shall notify the provider of the reasons for the recoding within 30 days of receipt of the bill.
   c. Reduce the bill to the maximum allowable payment for that procedure.
   d. Refer to the Commission providers whose billing practices indicate overutilization.
   e. A carrier may have another certified entity perform utilization review activities on its behalf.
4. The utilization review program, whether operated by the carrier or an entity on behalf of the carrier, shall be certified by the Arkansas State Board of Health. For information regarding certification, parties should contact The Arkansas Department of Health.
5. The carrier shall provide the Medical Cost Containment Division with the name, address, and license number (and a copy of the contract agreement between the carrier and other entity if applicable) of the entity responsible for conducting the carrier's utilization review program.
6. The carrier is responsible for notifying the Medical Cost Containment Division when changing reviewing entities.
7. For purposes of this rule, a carrier which has another entity perform utilization review activities on its behalf maintains full responsibility for compliance with this rule.

8. Under the carrier's utilization review program, the carrier shall make determinations concerning a covered injury or illness through one of the following approaches:
   a. Review by licensed, registered, or certified health care professionals.
   b. The application of criteria developed by licensed, registered, or certified health care professionals.
   c. A combination of approaches in subdivisions (a) and (b) of this Subsection according to the type of covered injury or illness.
9. Licensed, registered, or certified health care professionals shall be involved in determining the carrier's response to a request by a provider for reconsideration of its bill.
10. These licensed, registered, or certified health care professionals shall have suitable occupational injury or disease expertise, or both, to render an informed clinical judgment on the medical appropriateness of the services provided.

C. Commission Utilization Review and Monitoring Responsibilities

1. The Commission shall monitor the carriers:
   a. To ensure they have a utilization review plan that complies with Commission requirements and Ark. Code Ann. §§ 20-9-202, et seq. (1989).
   b. To monitor their claims handling and reimbursement practices.
2. The Commission shall perform utilization review of health care providers who have been identified to have trends or patterns of overutilization or inappropriate billing, as well as to investigate patterns of abuse.
3. The Commission is responsible for the review process and the implementation of penalties and/or sanctions for findings of overutilization and/or violations by carriers and/or providers.

D. Commission Investigative Process

1. The Commission shall perform two types of utilization review regarding carriers and/or providers:
   a. Individual Claimant Review. The review of an individual case with all applicable documentation.
   b. Random Sample Review. The review of a random sample of a health care provider's workers' compensation cases for a given time based on a valid referral from a carrier, claimant or governmental source or based on Commission reports which indicate provider patterns which deviate from the norm.

2. The Medical Cost Containment Division may recommend corrective actions, such as provider or carrier education, referrals to professional organizations, referrals to the Department of Insurance and other appropriate authorities, for providers or carriers whose practices are determined to be questionable.
3. Monitoring activities by the Commission can result in penalties imposed upon:
   a. A provider for findings of improper practice patterns, or
   b. A carrier for inappropriate claims handling practices.

V. RULE REVIEW

The Arkansas Workers' Compensation Commission encourages participation in the development of and changes to the Medical Cost Containment Program and fee schedules by all groups, associations, and the public. Any such group, association or other party desiring input into or changes made to this rule and associated schedules must make their recommendations, in writing to the Medical Cost Containment Administrator. After analysis, the Commission may incorporate such recommended changes into this rule after appropriate public comment pursuant to Ark. Code Ann. § 11-9-205. The Medical Fee Schedule shall be reviewed July 2001 and every two years thereafter.

VI. PROVIDER AND FACILITY FEES FOR COPIES OF MEDICAL RECORDS

A. Health care providers and facilities are entitled to recover a reasonable amount to cover the cost of copying documents which have been requested by the carrier, self-insured employer, employee, attorneys, and etc.
   1. Certain procedure code descriptors and Rule 30 guidelines require the submission of records and/or reports. The amount of reimbursement is designated in Rule 30 for these.
   2. Documentation which is submitted by the provider and/or facility, but was not specifically requested by the carrier, is not allowed a copy charge.

B. Health care providers and facilities must furnish an injured employee or his attorney and carriers/self-insureds or their attorneys copies of his records and reports upon request. The charge shall be the same as set out in Ark. Code Ann. § 16-46-106(a)(2).

C. Health care providers and facilities may charge the actual direct cost of copying x-rays, microfilm or other non-paper records.

D. The copying charge shall be paid by the party who requests the records.

E. An itemized invoice shall accompany the copy.

(Adopted September 15, 1992; Revised Effective September 1, 1994; Revised effective May 15, 2000 for services rendered on and subsequent to this date.)

MEDICAL FEE SCHEDULE

For Services Rendered Under The Arkansas Workers' Compensation Laws

The official Medical Fee Schedule of the Arkansas Workers' Compensation Commission shall be based upon the Health Care Financing Administrations's (HCFA) Medicare Resource Based Relative Value Scale (RBRVS), utilizing HCFA's national relative value units and Arkansas specific conversion factors adopted by the AWCC. Parties using this schedule should also be familiar with Commission Rule 30, the most current *CPT*, the Health Care Financing Administration Common Procedure Coding System (HCPCS), and the *ASA Relative Value Guide*.

I. EFFECTIVE DATE AND CODING REFERENCES

This fee schedule shall replace the current AWCC fee schedule on May 15, 2000 and the most current versions of *CPT* and the Medicare RBRVS shall automatically be applicable upon their effective dates.

II. GENERAL INFORMATION and INSTRUCTIONS for USE

A. FORMAT

This schedule consists of the following sections: **Medicine (including Evaluation and Management Services), Surgery, Radiology, Pathology, Anesthesiology, Injections, Durable Medical Equipment, Orthotics, Pharmacy, and Hospital**. Providers are to use the section(s) which contain the procedure(s) they perform, or the service(s) they render. Each section has specific instructions or Guidelines. (See Guidelines).

B. REIMBURSEMENT

Reimbursement to providers shall be the lesser of the following:

1. The provider's usual charge
2. The fee calculated according to the AWCC Official Fee Schedule
3. The MCO/PPO contracted price

C. FEE SCHEDULE CALCULATION

The AWCC Official Fee Schedule can be calculated for any specific CPT code by multiplying the national "transitioned nonfacility total relative value units" (RVUs) by the conversion factor applicable to that *CPT*.

D. **CONVERSION FACTORS**

The conversion factors applicable to this Fee Schedule are as follows:

Anesthesia $33.89
Surgery $70.00
Radiology $70.00
Medicine (includes Evaluation and Management Services) $44.28
Pathology $58.28
Pathology codes that do not have RVUs listed in the Medicare RBRVS should be reimbursed 200% of Arkansas Medicare for Clinical Diagnostic Laboratory Fee Schedule allowance, with 30% for the Professional Component and 70% for the Technical Component.

E. **FORMS**

The following forms (or their replacements) should be used for provider billing:
HCFA 1500
UB 92

Bills for reimbursement should be sent directly to the party responsible for reimbursement. In most instances, this is the Insurance Carrier or the Self-Insured Employer. Providers should be able to obtain this information from the employer.

III. GUIDELINES

Guidelines define items that are necessary to appropriately interpret and report the procedures and services contained in a particular section and provide explanations regarding terms that apply only to a particular section.

The Guidelines found in the most current *CPT* apply to the following: **Evaluation and Management, Medicine, Surgery, Radiology, and Pathology.**

In addition to the Guidelines found in the *CPT,* the following AWCC Guidelines also apply:

A. SURGERY

1. **Multiple Procedures:** Reimbursement shall be based on 100% of the physician's usual charge for the major procedure (not to exceed 100% of the Medical Fee Schedule allowable) plus 50% of the physician's usual charge for the lesser or secondary procedure (s) (not to exceed 50% of the Medical Fee Schedule allowable).

2. **Services Rendered by More Than One Physician:**

a. **Concurrent Care:** See Evaluation and Management (E/M) Services Guidelines.

b. **Surgical Assistant:** Only a physician who assists at surgery may be reimbursed as a surgical assistant. To identify surgical assistant services, Modifier 80 or 81 should be added to the surgical procedure code which is billed. A surgical assistant must submit a copy of the operative report to substantiate the services rendered. Reimbursement is limited to the lesser of the surgical assistant's usual charge or 20% of the maximum allowable Fee Schedule amount.

c. **Two Surgeons:** For reporting see the most current ***CPT.*** Each surgeon must submit an operative report documenting the specific surgical procedure(s) provided. Each surgeon must submit an individual bill for the services rendered. Reimbursement must not be made to either surgeon until the carrier has received each surgeon's individual operative report and bill. Reimbursement to each surgeon must be made at the provider's usual charge or the maximum allowable Fee Schedule amount, whichever is less.

B. ANESTHESIA

1. General Information and Instructions.

The current ***ASA Relative Value Guide***, by the American Society of Anesthesiologists will be used to determine reimbursement for codes that do not appear in the **RBRVS**. These values are to be used only when the anesthesia is personally administered by an Anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) who remains in constant attendance during the procedure, for the sole purpose of rendering such anesthesia service.

To order the ***Relative Value Guide,*** write to the American Society of Anesthesiologists; 520 N Northwest Highway; Park Ridge, IL 60068-2573 or call (847)825-5586.

When anesthesia is administered by a CRNA not under the medical direction of an anesthesiologist, reimbursement shall be 90% of the provider's usual charge or the ARA, which ever is less. No payment will be made to the surgeon supervising the CRNA.

When anesthesia is administered personally by an anesthesiologist or administered by a care team involving an anesthesiologist and CRNA, reimbursement shall not exceed 100% of the provider's usual charge or the ARA, whichever is less.

2. **Anesthesia Values**

Each anesthesia service contains two value components which make up the charge and determine reimbursement: a **Basic Value** and a **Time Value.**

a. **Basic Value** relates to the complexity of the service and includes the value of all usual anesthesia services except the time actually spent in anesthesia care and any modifiers. The **Basic Value** includes usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood products incidental to the anesthesia or surgery and interpretation of non-invasive monitoring (ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry). When multiple surgical procedures are performed during an operative session, the **Basic Value** for anesthesia is the **Basic Value** for the procedure with the highest unit value. The **Basic Values** in units for each anesthesia procedure code are listed in the current ***ASA Relative Value Guide.***

b. **Time Value**

Anesthesia time starts when the anesthesiologist or CRNA begins to prepare the patient for induction of anesthesia and ends when the personal attendance of the anesthesiologist or CRNA is no longer required and the patient can be safely placed under customary, postoperative supervision. Anesthesia time must be reported on the claim form as the total number of **minutes** of anesthesia. For example, one hour and eleven minutes equals 71 minutes of anesthesia. The **Time Value** is converted into units for reimbursement as follows:

Each 15 minutes or any fraction thereof equals one (1) time unit.

Example: 71 minutes of anesthesia time would have the following time units: 71/15 = 5 Time Units.

No additional time units are allowed for recovery room observation monitoring after the patient can be safely placed under customary postoperative supervision.

3. **Total Anesthesia Value**
   The **total anesthesia value (TAV)** for an anesthesia service is the sum of the Basic Value (units) plus the Time Value which has been converted into units. The TAV is calculated for the purpose of determining reimbursement.
4. **Billing**
   Anesthesia services must be reported by entering the appropriate anesthesia procedure code and descriptor into Element 24 D of the HCFA 1500 Form. The provider's usual total charge for the anesthesia service must be entered in Element 24 F on the HCFA 1500 Form. The total time in minutes must be entered in Element 24 G of the HCFA 1500 Form.
5. **Reimbursement**
   Reimbursement for anesthesia services must be made at the provider's usual charge or the **Anesthesia Reimbursement Allowance (ARA)**, whichever is less. The ARA is calculated by determining the total anesthesia value for the service rendered and then multiplying that value by an established conversion factor which has a dollar value.

   Total Anesthesia Value (Basic Value + Time Value + Physical Status Modifiers when applicable)
   X Conversion Factor = ARA

   The conversion factor for Arkansas Workers' Compensation is **$33.89**.
6. **Methodology for Calculating ARAs**
   a. Refer to the Anesthesia Codes in the ***Relative Value Guide*** to locate the applicable anesthesia procedure code and corresponding Basic Value.
   b. Determine Time Units.
   c. Any minutes which exceed the whole units are counted as whole units.
   d. Add Basic Value and Time Units to determine Total Anesthesia Value (TAV).
   e. Multiply TAV by the Conversion Factor, $33.89, to obtain the ARA.

7. **Special Anesthesia Services**

   a. Unusual Circumstances (Modifiers 22, and 23). Under certain circumstances, the anesthesia service(s) provided may vary significantly from those usually required for the listed procedures. The use of modifiers is appropriate for these instances. The following are modifiers which are commonly used in anesthesia services.

   b. 22 Unusual Services: When the service(s) provided is greater than usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number or by use of the separate five-digit modifier code 09922. A report is required.

   c. 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 the modifier 23 to the procedure code of the basic service or by use of the separate five digit modifier code 09923.

   d. For additional modifiers for physical status and qualifying circumstances see the ***Relative Value Guide***. The use of modifiers does not guarantee additional reimbursement.

8. **Monitored Anesthesia Care**

   When an anesthesiologist or CRNA is required to participate in, and be responsible for, monitoring the general care of the patient during surgery but does not administer anesthetic, such professional services must be billed and reimbursed as though an anesthetic were administered; that is, basic anesthesia plus time.

9. **Medical Direction Provided by Anesthesiologists**

   When an anesthesiologist is not personally administering the anesthesia but is providing medical direction for the services of a nurse anesthetist who is not employed by the anesthesiologist, the anesthesiologist may bill for the medical direction. Medical direction includes the pre and postoperative evaluation of the patient. The anesthesiologist must remain within the operating suite, including the pre-anesthesia and post-anesthesia recovery areas, except in extreme emergency situations. Reimbursement for medical direction by anesthesiologists must be at the provider's usual charge or 50 percent of the ARA, whichever is less.

10. **Anesthesia by Surgeon**

    a. **Local Anesthesia**

    When infiltration, digital block or topical anesthesia is administered by the operating surgeon or surgeon's assistant, reimbursement for the procedure and anesthesia are included in the global reimbursement for the procedure.

    b. **Regional or General Anesthesia**

    When regional or general anesthesia is provided by the operating surgeon or surgeon's assistant, the surgeon may be reimbursed for the anesthesia service in addition to the surgical procedure.

    1) To identify the anesthesia service, list the CPT surgical procedure code and add Modifier 47.
    2) Reimbursement shall be either the provider's usual charge or the ARA.

    The operating surgeon must **not** use the diagnostic or therapeutic nerve block codes to bill for administering regional anesthesia for a surgical procedure.

11. **Unlisted Service, Procedure or Unit Value:** When an unlisted service or procedure is provided or without specified unit values, the values used should be substantiated **"BR"** (By Report).

12. **Procedures Listed In The ASA Relative Value Guide Without Specified Unit Values:** For any procedure or service that is unlisted or without specified unit value, the physician or anesthetist shall establish a unit value consistent in relativity with other unit values shown in the current **ASA *Relative Value Guide***. Pertinent information concerning the nature, extent and need for the procedure or service, the time, the skill and equipment necessary, etc., is to be furnished. Sufficient information should be furnished to identify the problem and the service(s).

13. **Actual time** of beginning and duration of anesthesia time may require documentation, such as a copy of the anesthesia record in the hospital file.

14. **Special Supplies:** Supplies and materials provided by the physician over and above those usually included with the office visit or other services rendered may be listed separately. List drugs, tray supplies, and materials provided separately.
    Supplies and materials provided in a hospital or other facility must not be billed separately by the physician or CRNA. These charges must be billed by the hospital.

15. **Separate or Multiple Procedures:** It is appropriate to designate multiple procedures that are rendered on the same date by separate entries.

C. **INJECTIONS**

General Information and Guidelines

Reimbursement for injection(s) (such as J codes) includes allowance for CPT code 90782 in addition to wholesale price of each drug. In cases where multiple drugs are given as one injection, only one administration fee is owed.

Surgery procedure codes defined as injections include the administration portion of payment for the medications billed.

J Codes are found in the Health Care Financing Administration Common Procedure Coding System (HCPCS).

D. **DURABLE MEDICAL EQUIPMENT (DME) Guidelines**

Supplies and equipment addressed in this fee guideline will be reimbursed at a reasonable amount. Supplies and equipment not addressed in this fee guideline will be reimbursed at a reasonable amount and coded 99070. All billing must contain the brand name, model number, and/or catalog number. Codes to be used are found in the *HCPCS*.

1. **QUALITY**

The reimbursement for supplies/equipment in this fee guideline is based on a presumption that the injured worker is being provided the highest quality of supplies/equipment. All billing must contain the brand name, model number, and/or catalog number, and a copy of the invoice.

2. **RENTAL/PURCHASE**

Rental fees are applicable in instances of short-term utilization (30-60 days). If it is more cost effective to purchase an item rather than rent it, this must be stressed and brought to the attention of the insurance carrier. The first month's rent should apply to the purchase price. However, if the decision to purchase an item is delayed by the insurance carrier, subsequent rental fees cannot be applied to the purchase price. When billing for rental, identify with modifier "RT".

3. TENs UNITS

All bills submitted to the carrier for Tens and Cranial Electrical Stimulator (CES) units must be accompanied by a copy of the invoice.

a. Rentals

1) Include the following supplies:
   (a) lead wires;
   (b) three (3) rechargeable batteries;
   (c) battery charger;
   (d) electrodes; and
   (e) instruction manual and/or audio tape.

2) Supplies submitted for reimbursement must be itemized. In unusual circumstances where additional supplies are necessary, use modifier 22 and "**BR**".

3) Limited to 30 days trial period.

b. Purchase:

1) Prior to the completion of the 30-day trial period, the prescribing doctor must submit a report documenting the medical justification for the continued use of the unit. The report should identify the following:
   (a) Describe the condition and diagnosis that necessitates the use of a TENs unit.
   (b) Does the patient have any other implants which would affect the performance of the TENs unit or the implanted unit?
   (c) Describe how the TENs unit will be utilized in the treatment plan.
   (d) Who/how was the unit evaluated for effective pain control during the trial period?
   (e) Who/how was the patient instructed in the use of the unit?
   (f) And how often does the patient use the unit and under which conditions is it used?

2) The purchase price should include:
   (a) lead wires;
   (b) three (3) rechargeable batteries; and
   (c) a battery charger.

3) Only the first month's rental price will be credited to purchase price.

4) Provider will indicate TENs manufacturer, model name, and serial number as shown on invoice.
5) All TENs units and supplies are listed in the DME list.

4. CONTINUOUS PASSIVE MOTION (USE CODE D0540)
Use of this unit in excess of 30 days requires documentation of medical necessity by the doctor. Only one (1) set of soft goods will be allowed for purchase.

E. ORTHOTICS AND PROSTHETICS

Reimbursement for orthotics and prosthetics shall be based on reasonableness and necessity. Orthotics and prosthetics should be coded according to the HCFA Common Procedures Coding System and billed By Report (BR). Copies may be obtained from the American Orthotic and Prosthetic Association, 1650 King Street, Suite 500, Alexandria, VA 22314, (703) 836-7116.

F. PHARMACY SCHEDULE

The Pharmaceutical Fee Guideline for prescribed drugs (medicines by pharmacists and dispensing practitioners) under the Arkansas workers' compensation laws is the lesser of:

1. The provider's usual charge; or
2. The fees established by the formula for brand-name and generic pharmaceuticals as described in subsection (2) of this section.
3. Prescribed Medication Services
   a. "Medicine" or "drugs" shall be defined by Ark. Code Ann. § 17-92-101.
   b. Medicine or drugs may only be dispensed by a currently licensed pharmacist or a dispensing practitioner.
   c. For the purposes of this act medicines are defined as drugs prescribed by an authorized health care provider and include only generic drugs or single-source patented drugs for which there is no generic equivalent, unless the authorized health care provider writes or states that the brand name is medically necessary and includes on the prescription "dispense as written" or "DAW."
4. Reimbursement
   a. The pharmaceutical reimbursement formula for prescribed drugs (medicines by pharmacists and dispensing practitioners) is the lesser of:

Average Wholesale Price (AWP) + $5.13 dispensing fee; or the provider's usual charge.

b. Reimbursement to pharmacists must not exceed the amount calculated by the pharmaceutical reimbursement formula for prescribed drugs.

c. A bill or receipt for a prescription drug shall include all of the following:

1) When a brand name drug is dispensed, the brand name shall be included unless the prescriber indicates "do not label."
2) If the drug has no brand name, the generic name, and the manufacturer's name or the supplier's name, shall be included, unless the prescriber indicates "do not label."
3) The strength, unless the prescriber indicates "do not label."
4) The quantity dispensed.
5) The dosage.
6) The name, address, and federal tax ID# of the pharmacy.
7) The serial number of the prescription, if available.
8) The date dispensed.
9) The name of the prescriber.
10) The name of the patient.
11) The price for which the drug was sold to the purchaser.
12) The NDC Number (National Drug Code Number).

d. Determine AWP from the appropriate monthly publication. The monthly publication that shall be used for calculation shall be the same as the date of service. When an AWP is changed during the month, the provider shall still use the AWP from the monthly publication. The publications to be used are:

1) Primary reference. *PriceAlert* from First DataBank.
2) Secondary reference (for drugs **NOT** found in PriceAlert).
Red Book from Medical Economics.

5. "Patent" or "Proprietary Preparations"

a. "Patent" or "Proprietary preparations," frequently called "over-the-counter drugs," are sometimes prescribed for

a work-related injury or illness instead of a legend drug.

b. Generic substitution as discussed in A.3. above applies also to "over-the-counter" preparations.

c. Pharmacists must bill and be reimbursed their usual and customary charge for the "over-the-counter" drug(s).

d. The reimbursement formula does not apply to the "over-the-counter" drugs and no dispensing fee may be reimbursed.

6. Dispensing Practitioner

a. Dispensing practitioners shall be reimbursed the same as pharmacists for prescribed drugs (medicines), except they shall not receive a dispensing fee.

b. "Patent" or "proprietary preparations" frequently called "over-the-counter drugs," dispensed by a physician(s) from their office(s) to a patient during an office visit should be billed as follows:

1) Procedure Code 99070 must be used to bill for the "proprietary preparation" and the name of the preparation, dosage and package size must be listed as the descriptor.

2) An invoice indicating the cost of the "proprietary preparation" must be submitted to the carrier with the HCFA 1500 Form.

3) Reimbursement is limited to the provider's charge or up to 20 percent above the actual cost of the item.

THE FOLLOWING PUBLICATIONS SHOULD BE USED :

Health Care Financing Administrations's Medicare Resource Based Relative Value Scale
A printed version is available from the United States Government Printing Office, Superintendent of Documents; P.O. Box 371954; Pittsburgh, PA 15250-7954, or call (202) 512-1900 and the American Medical Association; 515 N State St.; Chicago, IL 60610.
An electronic version is available also from the Government Printing Office by using the following specific instructions.

1. Open Internet Explorer
2. Type: http://www.hcfa.gov/stats/pufiles.htm in the "Address" line
3. Scroll down until "National Physician Fee Schedule Relative Value File" section is displayed.
4. Click on the RVU00_A.EXE link.
5. Read the license agreement and click on the "ACCEPT" button.
6. Click on the link to "Download the CY 2000 in .EXE(self-extracting format)."
7. The "File Download" window will appear, make sure the "Save this program to disk" option is selected and click the "OK" button.
8. A "Save As" window will appear. Select where the file should be saved and press the "Save" button.
9. A window should appear showing the download progress.
10. When the download is complete, locate the downloaded file in the Windows Explorer and double click on the file name.
11. A "Self-Extractor" window will appear type in where the files need to be saved and press the "Unzip" button.
12. When finished extracting, close the window and open the file "PPRRVU00.XLS" with MS Excel.

1. Open Internet Explorer.
2. Type: http://www.hcfa.gov/stats/pufiles.htm in the "Address" line.
3. Scroll down until "Clinical Diagnostic Laboratory Fee Schedule" section is displayed.
4. Click on the 00CLPUF.EXE link.
5. Read the license agreement and click on the "Accept" button.
6. Click on the link to "Download the CY2000 in.EXE (self-extracting format)."
7. The "File Download" window will appear, make sure the "Save this program to disk" option is selected and click the "OK" button.
8. A "Save As" window will appear. Select where the file should be saved and press the "Save" button.
9. A window should appear showing the download progress.
10. When the download is complete, locate the downloaded file in the Windows Explorer and double click on the file name.
11. A "Self-Extractor" window will appear type in where the files need to be saved and press the "Unzip" button.
12. When finished extracting, close the window and open the file "CLAB2000.XLS" with MS Excel.

ASA Relative Value Guide, American Society of Anesthesiologists; 520 N Northwest Highway; Park Ridge, IL 6008-2573 or call (847)825-5586.

***Health Care Financing Administration Common Procedure Coding System (HCPCS)*, United** States Government Printing Office; Superintendent of Documents; P.O. Box 371954; Pittsburgh, PA 15250-7954.

***Health Care Financing Administration Common Procedure Coding System* for coding Orthotics and Prosthetics**, American Orthotic and Prosthetic Association; 1650 King Street, Suite 500; Alexandria, VA 22314, (703)836-7116.

***Current Procedural Terminology*, (CPT)**, American Medical Association; 515 North State Street; Chicago, IL 60610.

PriceAlert, First DataBank, (800)428-4495.

Red Book, Medical Economics, (800)232-7379.

BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

IN RE: ADOPTION OF AMENDED RULE 30

CERTIFICATE OF RULE APPROVAL & ADOPTION

Pursuant to the rule-making authority granted to it by Ark. Code Ann. §11-9-205 (1996 Repl.), the Arkansas Workers' Compensation Commission, by its undersigned Commissioners, does hereby approve and adopt the attached:

AMENDED RULE 30

This Rule shall be effective: Twenty days after its adoption date (below).

Done and adopted in Little Rock on April 25, 2000.

Eldon F. Coffman, Chairman

Pat West Humphrey, Commissioner

Michael K. Wilson, Commissioner

DEPARTMENT Arkansas Workers' Compensation Commission
DIVISION Administrative
PERSON COMPLETING THIS STATEMENT Richard Lucy, Information Officer
TELEPHONE NUMBER: 501-682-3930 FAX NUMBER: 501-682-2777

FINANCIAL IMPACT STATEMENT

To comply with Act 884 of 1995, please complete the following Financial Impact Statement and file with the questionnaire and proposed rules.

SHORT TITLE OF THIS RULE Rule 30, "Medical Cost Containment Program"

1. **Does this proposed, amended, or repealed rule or regulation have a financial impact?** Yes x No ___

2. **If you believe that the development of a financial impact statement is so speculative as to be cost prohibited, please explain.**
Proposed changes in fee schedule will not be "revenue neutral" among health care and equipment providers, insurance carriers, and self-insured employers; and it is speculative to attempt to determine which group or groups will gain or lose revenue under each category.

3. **If the purpose of this rule or regulation is to implement a federal rule or regulation, please give the incremental cost for implementing the regulation.**

1999-2000 Fiscal Year		2000-2001 Fiscal Year	
General Revenue		General Revenue	
Federal Funds		Federal Funds	
Cash Funds		Cash Funds	
Special Revenue		Special Revenue	
Other		Other	

4. **What is the total estimated cost by Fiscal Year to any party subject to the proposed, amended, or repealed rule or regulation?**

1999-2000 Fiscal Year	2000-2001 Fiscal Year
Unknown	Unknown

5. **What is the total estimated cost by Fiscal Year to the agency to implement this regulation?**

1999-2000 Fiscal Year	2000-2001 Fiscal Year
Modest reduction in cost of providing Fee schedule. Primary cost will be to Print and mail revised rule to AWCC's Fee schedule and rule book subscribers	Unknown, but costs may be lower as need for distribution declines after first year.

FILED
AR. REGISTER DIV.
00 APR 25 PM 4:23
SHARON PRIEST
SECRETARY OF STATE
STATE OF ARKANSAS
BY

July 23, 1995