

# Mark Up Rule

## AMENDED RULE 099.30 MEDICAL COST CONTAINMENT PROGRAM #099.30

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#### 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 \$1,000.00 in billed charges for a single date of service by a provider. (See Arkansas Workers' Compensation Commission Inpatient Hospital Fee Schedule Part III.)
- t. Establishes Medical Treatment Guidelines.
- u. Establish a Drug Formulary

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 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 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.

**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 for 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, information 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 carriers' 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 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 1.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 \$1,000.00 in billed charges for a single date of service by a provider. A denial decision for payment for any type of health care services 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 for the next business day.

#### **T. Treatment Guidelines**

Effective January 15, 2015, the scope and duration of the medical treatment under workers' compensation shall be provided in accordance with the current edition of Official Disability Guidelines (ODG), as published by the Work Loss Data Institute. Medical treatment provided by or at the direction of the treating physician in accordance with ODG is presumed to be reasonable and necessary and not subject to utilization review. The employer or insurance carrier shall not be responsible for charges for medical treatment that is not provided in accordance with the ODG unless (1) it was provided in a medical emergency, (2) it was preauthorized by the employer or insurance carrier, or (3) it was approved by the Workers' Compensation Commission upon a finding based on clear and convincing evidence provided by or at the direction of the treating physician. Medications with the Status of N in the ODG Drug Formulary require preauthorization.

## **U. Drug Formulary**

The Full Commission hereby adopts the ODG Workers' Compensation Drug Formulary. For workers' compensation claims with a date of injury on or after July 1, 2015, the closed formulary applies to all drugs that are prescribed and dispensed for outpatient use as of July 1, 2015. For legacy claims with a date of injury before July 1, 2015, the closed formulary applies to all drugs that are prescribed and dispensed for outpatient use as of July 1, 2016. Under the closed formulary, preauthorization is required for all drugs with Status N in the ODG.

## **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 disputed exists between a carrier and a provider regarding services.
  - a. A disk 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 (1<sup>st</sup> offense) and may be referred to the appropriate authority (2<sup>nd</sup> 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, 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 xrays, 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 Administration'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.

**[Due to the length of the Medical Fee Schedule, it is not being reproduced herein.**

**Anyone desiring a copy of the Medical Fee Schedule can obtain same by contacting the Arkansas Workers' Compensation Commission (800-622-4472).]**

**ARKANSAS WORKERS' COMPENSATION COMMISSION INPATIENT HOSPITAL FEE SCHEDULE [Due to the length of the Inpatient Hospital Fee Schedule, it is not being reproduced herein. Anyone desiring a copy of the Inpatient Hospital Fee Schedule can obtain same by contacting the Arkansas Workers' Compensation Commission (800-622-4472).]**