

UTAH LABOR COMMISSION
Industrial Accidents Division



2013

MEDICAL FEE
STANDARDS

Effective December 1, 2012

TABLE OF CONTENTS

2013 Medical Fee Standards

<u>TITLE</u>	<u>PAGE</u>
I. FORWARD	
A. GENERAL STATEMENT - MEDICAL CARE REIMBURSEMENT STANDARDS	1
B. RBRVS - DEFINITION OF USE	2
Assigned Conversion Factor Dollar Amount	2
C. MAXIMUM ALLOWABLE FEE	3
1. The RBRVS Fee Schedule is the Maximum Fee for a Procedure	4
2. Discounting of Medical Provider Bills	4
3. Rounding to the Nearest Dollar	4
4. Consultation & Referral	4
5. Emergency Room Consultation	4
6. Professional - Technical Billing	4
7. After Hour Coverage	4
8. Clarification of R612-2-18 for Reimbursement for Dental Procedures	4
II. GENERAL	
A. MEDICAL CARE STANDARDS	5
1. Excessive Charges	6
2. Excessive, Unnecessary or Questionable Services	6
3. Medical Necessity	7
4. Billing Disputes	7
B. HOSPITAL/AMBULATORY SURGICAL CENTERS	7
C. PHARMACY SCHEDULE	8
D. NON-PHYSICIAN SERVICES	8
E. SURGICAL PRE-AUTHORIZATION	8
F. CHANGING OF CODE NUMBERS ON BILLINGS	8
III. SPECIFIC STANDARDS	
A. MODIFIERS	9
B. HOME HEALTH CARE	10

TABLE OF CONTENTS (continued)
2013 Medical Fee Standards

<u>TITLE</u>	<u>PAGE</u>
III. SPECIFIC STANDARDS <i>(continued)</i>	
C. MULTIPLE OR BILATERAL INJURIES OR SURGICAL PROCEDURES PERFORMED AT THE SAME OPERATIVE SESSION	11
D. COST OF MATERIALS (COM)	12
E. SPECIAL REPORT	12
F. NON COVERED PROCEDURES	12
G. CODES WHICH HAVE BEEN ASSIGNED A “0” RVU VALUE	12
H. WORKERS’ COMPENSATION RULES - HEALTH CARE PROVIDERS	13
I. REIMBURSEMENT FOR SPECIFIC PROCEDURES	13
1. Restorative Services.....	13
2. Special Services	15
3. Mechanized/Computerized Evaluation w/Printout of Joint Muscle/Trunk Function.....	15
4. Multiple Treatment Areas	15
5. Transcutaneous Electrical Nerve Simulators (TENS)	15
6. Maintenance or Palliative Treatment.....	16
7. Maximum Allowable Procedures	16
8. Physicians - Office Visits and Modalities.....	16
9. Chiropractic Manipulative Treatment.....	16
10. Physical Therapy Provided by Physicians (MD’s).....	16
11. Electrophysiologic Testing	17
12. Somatosensory Evoked Potential Monitoring During Surgery	18
Indications and Limitations of Coverage and/or Medical Necessity	18
Professional-Self Treatment	19
 IV. SPECIFIC CODE STANDARDS	
A. MEDICINE	20
1. Impairment Rating	20
2. Impairment Rating by Treating Physician	21
3. Impairment Rating by Independent Physician.....	21
4. Special Medical Evaluation	21

TABLE OF CONTENTS (continued)
2013 Medical Fee Standards

<u>TITLE</u>	<u>PAGE</u>
IV. SPECIFIC CODE STANDARDS <i>(continued)</i>	
B. RESTORATIVE SERVICES	22
1. Variance in Utah adaptation of RBRVS	22
2. Codes Which Have Been Assigned a “O” RVU Value	22
3. Physical Therapy/Occupational Therapy	22
4. Manual Therapy Techniques.....	23
5. Osteopathic and Chiropractic Manipulative Treatments	24
6. Educational Codes	24
7. Functional Capacity Evaluations	25
8. Evaluation Codes	26
9. Debridement Codes.....	26
C. ANESTHESIA	26
1. Standards.....	27
2. Time Reporting	27
D. SURGERY	27
1. Needle Procedures	27
E. RADIOLOGY	28
1. Two Patterns of Billing currently Prevail in Radiology	28
2. Professional Services; Technical Component.....	28
3. Other Physicians	28
4. Institutional Charges	28
5. Supply Costs	28
6. Professional Component Reimbursement.....	28
7. Professional Component – Hospital or Other Facility.....	28
F. PATHOLOGY	29
1. Laboratory and Pathology.....	29
V. SURGICAL SUPPLY TRY	29
GLOSSARY OF COMMON HEALTH REIMBURSEMENT TERMS	29

I. FOREWARD

A. GENERAL STATEMENT - MEDICAL CARE REIMBURSEMENT STANDARDS

The Utah Labor Commission (Labor Commission) annually sets the medical fee standards and updates, as needed, administrative rules for medical providers as defined and authorized in §34-2-407, *Utah Code Annotated*. The Commission adopted its first Relative Value Fee Schedule (RVS) in 1956 and has updated and maintained a Medical Fee Schedule until this present time through the efforts of many individuals serving on the Commission's Medical Advisory Committee. Current members of the Medical Advisory Committee are:

Utah Labor Commission

Alan Colledge, MD, Medical Director, Chair of the Medical Fee Advisory Committee
Ronald Dressler, Director, Industrial Accidents Division

Orthopedic Physician Representative

Dean Walker, MD

Primary Care Physician Representative

Phil Jiricko, MD, MHA, MS

Occupational Physician

Edward Holmes, MD

Chiropractic Physician Representative

James D. Knight, DC

Physical Therapy Representative

Dell Felix, PT

Nurse Practitioner Representative

Deborah M. Judd, MSN, FNP-C

Injured Worker Legal Representative

Dawn Atkin, Esq.

Employer Legal Representative

Dori K. Petersen, Esq.

Workers' Compensation Representatives

Roger Stuart, MD, Medical Director, Workers Compensation Fund

Private Worker's Compensation Writers

Truman Child CEO, American Liberty Insurance

Self Insured

M. Jeff Rowley

Coding Expert Resource

Peg Howarth, Workers Compensation Fund

Mari Ann Randall, OptumInsight

Melissa Fannesbeck, OptumInsight

Karine McOmie, OptumInsight

The Labor Commission, with the approval of the Workers' Compensation Advisory Council, has adopted these 2013 Medical Fee Standards, based on the 2012 Centers for Medicare and Medicaid Services, First Quarter (RVU12AR) Emergency Update Edition of the 2012 Resource Based Relative Value Scale ("RBRVS"), and the 2012 American Medical Association Current Procedural Terminology (CPT). The adoption of this standard allows recognition of the latest technology in the exchanging of information electronically through one fee schedule for all types of billings by medical providers, i.e., Medicare, health insurance, or workers' compensation from computer systems with one procedure listing. As defined below, the Labor Commission has adopted its own unique conversion factors for each specialty.

B. RBRVS – DEFINITION OF USE

The 2012 Centers for Medicare and Medicaid Services, the First Quarter Emergency Update, of the 2012 Resource Based Relative Value Scale ("RBRVS") has been selected as the method for calculating reimbursement using the 2012 American Medical Association Current Procedural Terminology (CPT) coded procedures for those providing care for injured workers covered under the Utah Workers' Compensation Act. A copy of the current AMA CPT may be obtained by calling 1-800-621-8335. A copy of the 2012 First Quarter Emergency Update Edition of the Resource Based Relative Value Scale (RBRVS) can be obtained by calling OptumInsight (Ingenix) at 1-800-464-3649.

- * This RBRVS system uses the three variables listed below to derive a single number, referred to as the Relative Value Unit (RVU), which has been assigned to each CPT-4 code.
- * The total RVU is comprised of three distinct values:
 - Work Expense Value (WE)
 - Practice Expense Value (PE)
 - Malpractice Expense Value (MP)

To determine the total amount for reimbursement, the RVU assigned to each CPT code is to be multiplied by each specialty's unique 2013 Utah Labor Commission's conversion factor to obtain the total reimbursement value.

[Example: (2012 CPT's RVU) First Quarter Emergency Update Edition RBRVS x (2013 Utah Labor Commission's designated conversation factor as per specialty expressed in dollars) = the Total Reimbursement Value.]

- The Commission has chosen NOT to use CMS's designated Utah's Geographic Practice Cost Indexes, (GPCI) adjustment, but to use the non-adjusted national RBRVS to calculate reimbursement values. This will simplify calculating current reimbursement rates by providers and payors, and also, facilitate the Labor Commission's yearly updates and comparative studies.

ASSIGNED CONVERSION FACTOR DOLLAR AMOUNT

- **Effective December 1, 2012, the Utah Labor Commission's conversion factor to be used with the OptumInsight Essential RBRVS, 2012 First Quarter Emergency Update Edition, procedural unit value as per specialty will be:**

Medicine	\$46
Evaluation and Management with codes 99201-99204 and 99211-99214	\$46
Restorative Services	\$46
Anesthesiology*	\$41
Pathology and Laboratory **	\$52
Radiology	\$53
Surgery	\$37
Surgery in all 20000 codes, codes 49505-49525, and all 60000 codes	\$58

* **Anesthesia:** Medicare’s Base Units and methodology for time calculation (**1 unit for 15 minutes of anesthesia**) is adopted with the conversion factor listed above.

** **Pathology and Laboratory:** The 2012 RBRVS identifies values for specific codes that require Pathologist services. All other reimbursement rates for laboratory and pathology codes will be determined by the OptumInsight (Ingenix) gap-filled methodology. For further explanation of this method, please see the Introduction Section of the Ingenix RBRVS.

It is highly recommended that providers and payers purchase the 2012 First Quarter Emergency Update Edition of the Essential Resource Based Relative Value Scale (“RBRVS”). This is a comprehensive listing of all RVUs.

+ **Setting for Procedure:** The physician must identify the setting where the procedure was performed when billing.

Provided in an office or clinic setting: These procedures are reimbursed using the Non-Facility Total RVU, with the exception of injections of a type of which cannot be self-administered, and if they are directly related to the treatment of an injury or direct exposure or condition. Splints, redressing materials and casting supplies are payable separately under the Labor Commission’s supply provision rule – R612-2-16. In addition, unusual services and medications may be billed separately if Identified with a -25 modifier and supported by documentation.

Provided in a facility setting: These procedures for physician services are reimbursed using the Facility Total RVU for the calculation of payment as the facility will be billing for the direct and indirect costs related to the service.

+ **Non Assigned CPT Codes:** For those few codes not listed in the RBRVS or Ingenix /Publishing/Medicode, contact the Labor Commission to see if a reimbursement value has been assigned.

C. MAXIMUM ALLOWABLE FEE

1. The RBRVS Fee Schedule, is the maximum fee for a procedure used with the Utah Labor Commission's conversion factors for each specialty. The RBRVS, through an intense study of input, is based on the resources needed to accomplish a particular procedure, and thus, an unusual method in itself does not warrant an increased fee. A physician should not charge more than his/her usual fee. Items that are a portion of an overall procedure are not to be itemized or billed separately.
2. If an employer or carrier has a contract with a provider for discounted service given to an injured worker, the discount applies. If there is no contract, then the RBRVS fee schedule applies.
3. **Rounding to the Nearest Dollar:** Carriers may calculate fees ending in odd cents by rounding to the nearest dollar; round down for \$.49 or less and round up for \$.50. If this is done on some charges, it must be done with all charges. If the medical provider has rounded all individual fees, the total of these fees should be paid as submitted, by recognizing that in any given series of bills, this may represent a trivial under payment or overpayment that will average out with time.
4. **Consultation:** Initial evaluation and subsequent services are designated as listed in Levels of Service. Visits and consultations should be placed in the proper category for the level of service. A referral may ensue after completion of a consultation, but such an event does not preclude the fact that the initial evaluation was, indeed, a consultation. Only advice and/or an opinion should be rendered for consultation services. Care and treatment of the patient should not be undertaken without a clear and mutual understanding between the treating physician and the consulting physician.
Referral: A referral is the transfer of the total or specific care of a patient from one physician to another and does not constitute a consultation.
5. **Emergency Room Consultation:** When a physician is called to the emergency room to see and assume the care of a patient in his specialty, he can make a charge for a consultation prior to surgery using a -57 modifier. (New) In the case of a non-surgical admission, one cannot charge for a consultation in the emergency room and, also, for a work-up for the hospital admission.
6. **Professional – Technical Billing:** Each service rendered will be reimbursed one time. If the service has a professional and technical component, billed by separate entities, each will be reimbursed by their respective component. A second interpretation may be covered when pre-authorized with the payor.
7. **After Hour Coverage:** Utah's standards are consistent with the RBRVS using the standard Medicare guides. Codes 99050 through 99058 are used to identify emergency and after hour care.
8. **Clarification of R612-2-18 for Reimbursement for Dental Injuries:**
 - A. This rule establishes procedures to obtain dental care for work-related dental injuries and sets fees for such dental care.
 - B. Initial Treatment.
 1. If an employer maintains a medical staff or designates a company doctor, an injured worker seeking dental treatment for work-related injuries shall report to such medical staff or doctor and follow their instructions.
 2. If an employer does not maintain a medical staff or designate a company doctor, or if such staff or doctor are not available, an injured worker may consult a dentist to obtain immediate dental care for injuries caused by a work-related accident. The insurer shall pay the dentist providing this initial treatment at 70% of UCR for the services rendered.
 - C. Subsequent care by initial treatment providers.

1. If additional treatment is necessary, the dentist who provided initial treatment may submit to the insurer a request for authorization to continue treatment. The transmission date of the request must be verifiable. The request itself must include a description of the injury, the additional treatment required, and the costs of the additional treatment. If the dentist proceeds with treatment without authorization, the dentist must accept 70% of UCR as payment in full and may not charge any additional sum to the injured worker.
 2. The insurer shall respond to the request for authorization within ten working days of the request's transmission. This ten day period can be extended only with written approval of the Industrial Accidents Division. If the insurer does not respond to the dentist's request for authorization within ten working days, the insurer shall pay the cost of treatment as contained in the request for authorization.
 3. If the insurer approves the proposed treatment, the insurer shall send written authorization to the dentist and injured worker. This authorization shall include the anticipated payment amount.
 4. On receipt of the insurer's written authorization, and if the dentist accepts the payment provision therein, the dentist may proceed to provide the approved services. The dentist must accept the amount to be paid by the insurer as full payment for those services and may not bill the injured worker for any additional amount.
- D. Subsequent care by other providers.
1. If the dentist who provided initial treatment does not agree to the payment offered by the insurer, the insurer shall within 20 calendar days direct the injured worker to a dentist located within a reasonable travel distance who will accept the insurer's payment offer.
 2. If the insurer cannot locate another dentist to provide the necessary services, the insurer shall attempt to negotiate a satisfactory reimbursement with the dentist who provided initial treatment.
 3. If the insurer is successful in arranging treatment with another dentist, the insurer shall notify the injured worker.
 4. If, after having received notice that the insurer has arranged the services of another dentist, the injured worker shall only be responsible for payment at 70% of UCR. Under the circumstances of this subsection (4), the treating dentist may bill charges and the amount paid by the insurer.
- E. Payment or treatment disputes that cannot be resolved by the parties may be submitted to the Labor Commission's Adjudication Division for decision, pursuant to the Adjudication Division's established forms and procedures.

II. GENERAL STANDARDS

A. MEDICAL CARE STANDARDS

An injured employee is entitled, without personal expense, to medical care, treatment, and hospitalization reasonably necessary, up to the limits prescribed by the law. The physician should always bear in mind that the payor must make his/her decision based on the information provided by the physician. If the physician has not sufficiently documented the treatment given and the reasons for that treatment, the payor may consider treatment unreasonable or unnecessary. It is the prerogative of the attending physician to determine the type, duration and frequency of treatment, including hospitalization and nursing services. Such services must be provided in

accordance with recognized professional standards for the type of injuries incurred. Services in addition to those prescribed or ordered by the attending physician, must be paid for by the patient.

- * **Billing for a new patient:** A physician may bill the new patient E&M code when seeing an established patient if there is a new injury.
- * Discharge from the hospital, or transfer to a facility of a lesser nature, should be done at the earliest time appropriate to good medical practice. Extended-care facilities should be utilized when necessary. In certain cases, arrangements should be made with the carrier for home care. Payment for hospital care is limited to the bed rate for semi-private room. If the patient requests a more private hospital accommodation without medical documentation of need, the patient will be responsible for the difference personally. The physician should also use special hospital units, such as intensive care, only to the extent necessary. Special nursing care is rarely required, due to the intensive or critical care units in hospitals, but can be utilized if necessary.

Section 34A-2-111 of the Utah Workers' Compensation Act allows self insured employers and insurance carriers to develop "preferred provider programs" to provide medical care for injured workers. An injured worker who has been notified of such a preferred provider program is generally required to receive initial medical treatment from a preferred provider. Exceptions to this general requirement include: 1) emergency treatment when a preferred provider is unavailable; 2) an injured workers' good-faith belief that the medical problem is not work related; and 3) situations where travel to a preferred provider location is unduly burdensome.

Initial Medical Care. An injured worker who is subject to a preferred provider program, but who obtains initial medical treatment outside the preferred provider program, is personally liable for any fees that exceed the amount that would have been paid for such treatment within the preferred provider program.

Subsequent Medical Treatment. After an injured worker has received initial treatment within a preferred provider program, the worker may choose to obtain subsequent medical care outside the program: the employer/insurance carrier cannot require the worker to continue receiving treatment from a preferred provider. If the worker opts to obtain medical care outside the preferred provider program, the employer/insurance carrier is liable for the reasonable expense of such medical care, subject to the limits established by the Labor Commission's Medical Fee Standards.

1. **Excessive Charges**

A charge is excessive if any of the following conditions apply to the charge:

- a. The charge exceeds the amount for the type of service allowed in the medical fee schedule of this chapter, or
- b. If not specified in the RBRVS fee schedule, the charge exceeds that which prevails in the same geographic community for similar services or treatment, or
- c. The charge wholly or partially duplicates another charge for the same service, such that the charge has been paid or will be paid in response to another billing.

2. **Excessive, Unnecessary or Questionable Services**

No payment is to be made for service which is considered to be excessive, or questionable to the degree that any of the following standards apply:

- a. The service is not listed in this schedule or, the service does not comply with the standards and requirements concerning the reasonableness and necessity, quality, coordination, and frequency of services; or
- b. The service was performed by a provider prohibited from receiving reimbursement; or
- c. The service is not usual, customary, and reasonably required for the cure or relief of the effects of a compensable injury, or
- d. The service is not listed in the RBRVS schedule.

UCR (Usual and Customary) pricing methodology may be obtained by the Carrier from various vendors which allow the carrier to price supplies based on purchase, new, used, or rented, based on the Zip Code in which the service is rendered.

3. **Medical Necessity**

All services and supplies provided to injured workers must be medically necessary.

Medical necessity includes the following considerations:

- a. Provided as remedial treatment for an on-the-job illness or injury, or
- b. Appropriate to the patient's diagnosis, or
- c. Consistent with the location of service, or
- d. Consistent with the level of care provided, or
- e. Widely accepted by the practicing peer group, or
- f. The service is listed in this medical fee schedule.

“Drug testing: drug screenings for addictive classes of pain medications should be performed as recommended in the Utah Clinical Guidelines on Prescribing Opiates for Treatment of Pain, Utah Department of Health 2009. The collection and billing should be limited to one 80100 code per date of service, unless unusual situations present themselves and are documented.”

4. **Billing Disputes**

To resolve billing disputes, the Labor Commission utilizes this medical fee schedule and other standard industry protocols including, but not limited to, the Complete Global Service Data for Orthopedic Surgery, published by the American Academy of Orthopedic Surgeons.

Pursuant to R612-2-24, health care providers and payors are primarily responsible to resolve disputes over fees for services among themselves following the standards contained therein. If a dispute cannot be resolved, the Division of Industrial Accidents can review the dispute pursuant to the Medical Fee Standards and the RBRVS in order to make a determination. Any aggrieved party has the option to file for a hearing with the Division of Adjudication. Absent a contract for services, usual and customary rates (UCR) will apply in these instances. Claims outside of the Medical Fee Standards and the RBRVS will need to be formally resolved by the Division's Adjudication Division. Typically these claims are made by the party seeking payment. The process regarding fee disputes is outlined in R612-2-24: <http://www.rule.utah.gov/publicat/code/r612/r612-002.htm#T24>

B. HOSPITAL / AMBULATORY SURGICAL CENTERS

The Labor Commission does not have a Hospital or Ambulatory Surgical Center fee schedule. However, provider reimbursement for services performed at these facilities as defined in §34A-2-111, is subject to the Utah fee schedule per §34A-2-407(8)(b). Carriers and self-insured employers may reimburse hospitals per contracted rates or UCR. If a preferred provider (PPO) program is developed by an insurance carrier or self-insured employer, an employee may be required to use the preferred providers. Failure to do so may result in the employee being obligated for charges in excess of the preferred provider allowances.” Refer to Utah Code 34-A-111.

C. PHARMACY SCHEDULE

The Labor Commission does not have a pharmacy fee schedule. However, provider reimbursement for pharmacy services as defined in §34A-2-111 is subject to the Utah fee schedule per §34A-2-407(8)(b).

D. NON-PHYSICIAN SERVICES

The following medical providers may provide services only under the direction of, or by the prescription of, a licensed physician or nurse practitioner: registered physical therapists, registered occupational therapists, registered nurses; licensed practical nurses; licensed psychologists, speech pathologists and audiologists, and physicians assistants. All such services rendered by non-physician providers will either be billed separately by the physician or itemized and identified as a portion of the bill of the physician (except for physical therapist or occupational therapists services in their own field). (See Modifier +-83)

Certified, Registered Nurse Anesthetists may also bill separately, but must be identified by their credentials on the billing. (See Modifier +-83.)

Acupuncturists, Naturopathic providers may only provide care if the care has been preauthorized by the payor.

Massage therapy is not paid for as a stand alone code. It must be administered by those recognized professionals specified in the fee schedule and billed according to the restorative section rules.

E. SURGICAL PRE-AUTHORIZATION

As required by rule R612-2-4, “Hospital or Surgical Pre-authorization, any ambulatory surgery or inpatient hospitalization, other than a life or limb threatening admission allegedly related to an industrial injury or occupational disease, shall require pre-authorization by the employer/ insurance carrier.”

F. CHANGING OF CODE NUMBERS ON BILLINGS

Physicians’ code numbers on billings are to be supported by the appropriate documentation as to the level of service or code billed. Disagreements between carrier and physician as to code changes are addressed in the Labor Commission’s Rule R612-2-24, Review of Medical Payments. If the disagreement cannot be worked out between the carrier and physician, the Labor Commission will review the issue and make a final ruling as per 11-1-D of the above mentioned rule.

A processor of industrial fee claims may change the code number supplied by the physician under the following circumstances:

1. When there is a code that more clearly identifies the nature of the services than the code used by the physician.
2. When the identified service is a portion of a larger procedure and included in the fee for the larger procedure, such as “global services.”
3. When the number is incorrect for the services described.
4. When codes 99202-99205 are billed for injured workers who are seen for an initial evaluation, it is important for the provider to accurately describe the mechanism of injury, the type of pathology now present because of the injury, and how this pathology is related to the patient’s course of employment. Likewise the provider is to identify any similar pre-existing conditions that are discovered during the evaluation. At the end of the evaluation, the provider is to identify what it is that the patient can do. The provider is to clearly state the patient’s capability and hours they can work as it relates to their job.
5. When codes 99212-99215 are billed, the provider is to accurately describe the patient’s objective progress. For those workers involved with physical therapy, this is best done by reviewing the physical therapist’s RSA form. If no objective improvement is being made, i.e., in hours working, the patient self-report of pain, and functional, the worker is either at maximum medical improvement or there is something that needs to be identified and addressed. At the end of the follow up visit, the provider is to identify what it is that the patient can do. The provider is to clearly state the patient’s capability and hours they can work as it relates to their job. Whenever a code number of a physician’s bill is changed by a reviewer, the reason for that change must be identified to the physician with his payment as per Labor Commission Rule R612-2-23, Adjusting Relative Value Schedule (RVS) Codes.

The physician should be given the name and phone number of the claims processor, and the physician advised to call, if necessary, and discuss the matter if unsatisfied.

The procedure for resolving disputes over fees for medical services is addressed in the Labor Commission’s Rule R612-2-24, Review of Medical Payments.

III. SPECIFIC STANDARDS

A. MODIFIERS

In addition to modifiers defined in the current CPT schedule, the Utah Labor Commission has identified the following to also be used for workers’ compensation medical care:

-83 Paramedical Personnel: In limited circumstances, services may be performed by paramedical licensed personnel as listed below, under the supervision of a licensed physician. These should be billed for by the physician at the percentages listed below of the amount that would be paid had a physician performed those services. These individuals should be qualified, competent and licensed in the state of Utah to carry out the services performed.

They may include the following:

Physician Assistants 75%

Nurse Practitioners	75%
Medical Social Workers	75%
Nurse Anesthetists	75%
Physical Therapy Assistants	75%

-81 Paramedical Assistant Surgeon

Modifiers: Clarification on reimbursement for surgical assistants:

- a. Assistant Surgeon and assistant surgeon paramedical modifiers and their reimbursements.

-80 Assistant Surgeon: MD’s, DO’s and Podiatrists
20% of the primary surgeon’s value

-81 Assistant Surgeon: Minimum paramedical
15% of the primary surgeon’s value OR 75% of the MD assistant rate

-82 Assistant Surgeon: When a qualified resident surgeon is not available 20% of the primary surgeon’s value

*A listing of procedures that qualify for an assistant at surgery can be found in the Ingenix Essential RBRVS Appendix A, see column called “Assistant Surgeon,” or in Medicare’s Physician Fee Schedule and see column A for assistant surgeon indicators:

https://www.noridianmedicare.com/macj3b/fee/docs/2011/2011_mpfldb_indicators.pdf, see column A for assistant surgeon indicators.

Assistant surgeon indicators are translated as follows:

- 0 = Assistant payable with documentation
- 1 = No assistant payable
- 2 = Assistant payable
- 9 = concept does not apply

Paramedical individuals billing separately:

Other paramedical assistants, including surgical assistants are not billed separately for work on industrial injury workers.

TC Technical Component: Under certain circumstances, the technical component alone may be identified. [See definition of technical circumstances, the technical component is identified by adding this modifier (TC) to the usual procedure number.]

**B. HOME HEALTH CARE
For Home Health Codes 99500 through 99602**

All include mileage and travel time.

RN	\$100/2hr.
LPN	\$75/2hr.
Home Health Aide	\$25/hr. + \$6 additional 30 min.
Speech Therapists	\$80/visit
Physical Therapy	\$125/hr.

Occupational Therapy \$125/hr.

Home Infusion Providers

This is to be done with a direct contract with home infusion providers. If a contract isn't established then the carrier should defer to the Home Health rates specified in Days Guidelines and pay UCR or Cost + 15% for the drugs and supplies.

C. MULTIPLE OR BILATERAL INJURIES OR SURGICAL PROCEDURES PERFORMED AT THE SAME OPERATIVE SESSION– (Use Modifiers -50 and -51)

1. Primary Procedure: Should be billed at 100% of the profile fee.
2. Lesser Procedures: These are called secondary procedures performed through the same operative incision, or that are performed in the same general operative area, which add significant time or complication shall be billed at 50% of the relative value, unless they are an integral part of the primary procedure, in which case no additional fee is charged.
3. Should Not Bill: Procedures that are uneventful and performed through the same incision or in the same operative area and do not add significant risk or time to the primary procedure. Examples: Lysis or excision of scar tissue, a reasonable amount of debridement, removal of loose bodies, etc.
4. Should Not Be Billed for in Addition To: Care of wounds, including debridement in connection with open fractures or other deep structures requiring repair such as tendons, nerves, bone, blood vessels, etc, unless the laceration or wound necessitates a surgical procedures significantly greater than the operative incision that would have been necessary for repair of the underlying structures.
5. Secondary Surgical Procedures Performed at the Same Operative Session, but requiring a separate, remote operative site and preparation from any other, shall be billed at 75% of the profile.
6. Second and Additional Surgical Procedures in Each Incision, Area or Region will be billed at 50% of the unit value.
7. When medical care is the treatment of one injury and surgical care is the treatment of a separate injury, bill both at 100% of usual fees if they represent significant time and complication of treatment. Routine care of these minor non-surgical injuries carried out in conjunction with major injuries should only be billed in addition when they add significant complexity or time to the care that would be required by the major injuries.
8. Diagnostic arthroscopy should be billed at 50% when followed by open surgery.
9. There is no separate fee when it is followed by arthroscopic surgery.
10. Whenever the descriptor refers to “each” the rules for multiple surgery apply.
11. Spinal procedures are coded and reimbursed based on the current CPT. When performing bilateral injections, use the 50 modifier unless otherwise defined by the CPT. Maximum of six (6) spinal injections per visit. Preauthorization required.
12. Summary:
 - Primary Procedure – 100%
 - Secondary Procedures Same Incision, Region or Area – 50%
 - Secondary Procedures in Remote Areas – 75%
 - Additional Procedures – 50%
 - Bilateral – 75%
13. See Integumentary system for lacerations.

D. COST OF MATERIALS (COM)

Certain supplies and materials are to be provided by the physician that are usually included with the visit or other services performed. Fees covering ordinary dressings, materials or drugs used in diagnosis and treatment shall not be charged for separately, but shall be included in the amount for the office or hospital treatment. If the record of the case shows that it was necessary to use an extraordinary amount of dressing material or drugs, these will be paid for using – ALPHA – Numeric HCPCS Level II Codes.

E. SPECIAL REPORT – Use CPT Modifier -22 when coding for these services and it should include medical document support. A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure; and the time, effort and equipment necessary to provide the service. Additional items which may be included are:

The medical provider is asked to provide a narrative or treatment summary;

- * Fill out forms for the patient or payor, or answer questions that are not included in the usual required reporting for the Evaluation Management codes.
- * Complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems, and follow up care.

Recommendations: In this particular situation, a physician should provide supporting documentation and may bill the extra time necessary to complete information that is in addition to the usual required reporting code.

F. NON COVERED PROCEDURES

“Category III T Codes” are experimental codes and are currently not covered procedures for Utah’s injured workers.

G. CODES WHICH HAVE BEEN ASSIGNED A “0” RVU VALUE

Artificial discs, percutaneous diskectomies, endoscopic diskectomies, IDEPT, platelet rich plasma injections, thermo rhizotomies and other heat or chemical treatments for discs are still considered investigational. VAX D or other unique mechanical vertebral traction can be billed as traction under the restorative service section of the fee schedule using the traction codes and existing rules.

Massage therapy is not paid for as a stand alone code. It must be administered by those recognized professionals specified in the fee schedule and billed according to the restorative section rules.

Formal research is needed to demonstrate value to Utah’s injured workers before assigning any reimbursement value. The provider may consult with the payor seeking preauthorization of such treatment and the payor may agree to reimburse on an individual basis. Providers may also present to the Medical Fee Committee evidence a procedure’s efficacy for consideration to be added to the fee schedule. Other procedures which have been assigned a “0” RVU value include:

93760 & 93762	Thermograms
95832 (part of E&M)	Muscle Testing

95833 (part of E&M)	Muscle Testing
95834 (part of E&M)	Muscle Testing
96000	Computer based Motion Analysis
96001	With Plantar Pressure Measurements
96002	Dynamic Surface EMG
96003	Dynamic Fine Wire EMG
96004	Physician Review and Interpretation of Comprehensive Based Motion Analysis
97005	Athletic Training Evaluation
97006	Athletic Training Reevaluation
97810	Acupuncture
97811	Acupuncture
97813	Acupuncture
97814	Acupuncture
99090 (part of E&M)	Analysis of Data, now BR
98960	Patient Education Codes (Use 97535)
98961	Patient Education Codes (Use 97535)
98962	Patient Education Codes (Use 97535)
99071	Educational supplies

H. WORKERS' COMPENATION RULES – HEALTH CARE PROVIDERS

1. Definitions	R612-2-1
2. Authority	R612-2-2
3. Official Forms	R612-1-3
4. Supply Rule	R612-2-15
5. Utilization Review Rule	R612-2-26
6. Restorative Service Rule	R612-2-3
7. Medical Disputes	R612-2-24
8. Discounting (Lump Sums Settlement)	R612-1-4
9. Interest (on benefits)	R612-1-5
10. Hospital or Surgery Pre-Authorization	R612-2-4
11. Regulation of Medical practitioner Fees	R612-2-5
12. Fees in Cases Requiring Unusual Treatment	R612-2-6
13. Who May Attend Industrial Patients	R612-2-8
14. Insurance Carrier's Privilege to Examine	R612-2-7
15. Changes of Doctors and Hospitals	R612-2-9
16. Interest for Medical Services	R612-2-13
17. Hospital Fees Separate	R612-2-14
18. Charges for Ordinary Supplies, Materials or Drugs	R612-2-15
19. Charges for Special or Unusual Supplies, etc.	R612-2-16
20. Fees for Unscheduled Procedures	R612-2-17
21. Dental Injuries	R612-2-18
22. Ambulance Charges	R612-2-19
23. Travel Allowance and Per Diem	R612-2-20
24. Notice – Denial of Liability	R612-2-21

I. REIMBURSEMENT FOR SPECIFIC PROCEDURES

1. Restorative services are an integral part of the healing process for a variety of injured workers. Recognizing this, the Utah Medical Fee Standards includes codes for restorative services, i.e., those modalities, procedures, tests, and measurements in the Physical Medicine Section, codes 97010 through 97750, representing specific therapeutic procedures performed by medical doctors, chiropractic physicians, licensed physical and occupational therapists and other physicians. All medical providers billing under CPT codes 97001 through 97703 are limited to payment of a maximum of three (3) procedures/Units per visit six (6) if treating different sites for an on-the-job injury/injuries even if billing for additional procedures. The payer shall pay the three highest of the billed procedures for each treatment site for the visit.

Electrodes are included in the practice expense portion of the relative value and therefore should not be reimbursed separately.

The following criteria must be met in all cases where restorative services are rendered in order for a service to qualify for reimbursement:

- a. The patient's condition must have the potential for restoration of function.
- b. The treatment must be prescribed by the authorized attending or treating physician.
- c. The treatment must be specific for the improvement of the patient's condition.
- d. The restorative services must be provided under the reporting requirements of rule R612-2-3 of the Workers' Compensation Rules and Regulations of the Labor Commission:
 - * The chiropractor shall file Form 123, "Physicians Initial Report," with the Labor Commission and the carrier/self-insured employer within one week of the initial examination.
 - * S.O.A.P. Notes (subjective, objective, assessment and plan/procedure) or progress notes must be sent to the insurance carrier/self-insured employer by all providers at the time of billing or at the request of the Commission, insurance carrier or self-insured employer.
 - * All providers billing under the restorative services section shall file a Restorative Services Authorization Form 221 with the insurance carrier/self-insured employer and the division within 10 days of initial treatment. All such providers must submit progress notes or a progress summary when billing for services and on request by the insurance carrier.
- e. The physician or therapist must be in constant attendance during the providing of services.
- f. Physical therapy, consisting of modalities only, is generally inappropriate beyond the first visit post-injury, unless the treatment also includes hands-on-procedures. A program of home treatment should be considered when modalities are the only treatment needed.
- g. For acute conditions, the patient should be closely followed by the physician, with no less than one physician follow-up every three weeks.
- h. Daily therapy is rarely needed, with documentation of objective improvement per RSA rule utilizing the Form 221.
- i. In addition to the foregoing, there is an affirmative duty placed on the provider of restorative services to teach the patient the principles on which therapy is based, as well as those parts of the therapy which he, the patient, can self-administer. This should be done under supervision during restorative treatment in order to maintain the level of function achieved during the restorative therapy. When it is determined that no further restoration can be achieved from therapy, the design of a independent maintenance program and the instruction for carrying out that program for patient must be concurrently completed in order

that additional cost may not be incurred. Therapy performed by the patient, or other lay person, after proper instruction, is not reimbursable, even when supervised by a therapist or physician.

j. When patients do not show measurable progress, further treatment will not be reimbursable, per RSA 221.

2. **Special Services**

a. “Work hardening” and similar programs are to be billed using the listed physical therapy schedule. More specific and comprehensive programs are rehabilitative in nature and thus not covered separately, but may be undertaken upon agreement with the carrier pursuant to “b” [See below].

b. If the carrier is of the opinion that these special services are desired for their purpose they may authorize in advance with payment agreed upon, including duration, frequency and number of treatment visits.

3. **Mechanized/Computerized Evaluation with Printout of Joint/Muscle/Trunk Function Whether Isotonic, Isometric and/or Isokinetic and Functional Evaluations of Patient And Capabilities**

a. All assessments/evaluations should be done only when necessary and shall be consistent with the patient’s medical diagnosis and dysfunction. The assessment shall be for the benefit of therapy and not for purposes of research.

b. Such testing requires a specific prescription by the physician.

c. Standardized testing and/or testing with special standardized equipment should be done on patients where such information is needed to establish an adequate baseline on which to base treatment, establish functional skills relative to the job, or serve as a baseline to objectively monitor patient progress.

d. Such equipment should be reputable with appropriate and reasonable information available on reliability and validity. Where appropriate, the subject can serve as the control for normal and, where available, other normal performance guidelines should be used as reference.

e. Standardized tests utilized shall be appropriate to the type of disability, have forms for the subject’s age and have standard administration procedures.

f. A report is to accompany the bill.

4. **Multiple Treatment Areas**

For multiple treatment areas when treatment is pre-authorized to more than one area, a single office visit charge will remain, and not over two additional modalities can be billed for the first injury. For a second site, up to 3 additional modalities can be billed for.

5. **Transcutaneous Electrical Nerve Stimulators (TENS)**

* TENS must be prescribed by a physician or under the physician’s prescription. (See 64550)

* Prior diagnostic testing must be performed to determine the efficacy of TENS in control of the patient’s chronic pain.

- * TENS testing and training is limited to four (4) sessions and a 30-day trial period. To exceed this limitation, written documentation of a medical necessity is required.

6. **Maintenance or Palliative Treatment**

- a. Since the maintenance of health is of benefit to everyone and an individual responsibility, utilization of fitness centers and associated equipment or services solely for health maintenance is not covered under workers' compensation.
- b. Since workers' compensation services must be medically necessary in the treatment of on-the-job illness or injury, no reimbursement will be made for medical services rendered for the prevention or the recurrence of illness or injury.

7. **Maximum Allowable Procedures**

All medical providers billing under CPT code 97001 through 97703 are limited to payment of a maximum of three (3) procedures/units per visit; six (6) if treating different sites for an on-the-job injury/injuries even if billing for additional procedures. The payer shall pay the three (3) highest of the billed procedures for each treatment site for the visit.

The Utah Labor Commission recognizes the entire spine as one region, for billing purposes.

8. **Physicians – Office Visits and Modalities**

Under most circumstances, medical, osteopathic, chiropractic physicians performing restorative services will use the 99201 or 99202 code for new patients and 99211 or 99212 for established patients. Other office medical codes in the most current AMA CPT-4 may be used when warranted, and when they are substantiated by a report of the examination performed which specifies the findings of the examination and the subsequent treatment rendered. If an office visit is billed, 2 other modalities may be billed per visit. If an office visit is not billed, 3 modalities may be billed per visit.

All services performed should be itemized, even if not billed (NC).

9. **Chiropractic Manipulative Treatment**

- a. The AMA-CPT edition states that chiropractic manipulative treatment codes include the pre-manipulation patient assessment. Additional Evaluation and Management services may be reported separately using modifier 25, if the patient's condition requires a significantly separate identifiable E&M service, above and beyond the usual pre-service and post service work associated with the procedure. The E&M service may be caused or prompted by the same symptoms or condition for which they see chiropractic manipulative treatment service was provided.

10. **Physical Therapy Provided by Physicians (MD's)**

- a. **Initial Office Visit (New Patient):** A physician may charge and be reimbursed for an initial office visit to examine and evaluate the patient and perform physical therapy. For injured workers who are seen for an initial evaluation, it is important for the provider to accurately describe the mechanism of injury, the type of pathology now present because of

the injury, and how this pathology is related to the patient's course of employment. Likewise the provider is to identify any similar pre-existing conditions that are discovered during the evaluation. Clearly state the patient's capability and hours they can work as it relates to their job.

b. **Follow-up Office Visit (Established Patient):** A physician may charge and be reimbursed for a follow-up visit and physical therapy only if new symptoms present the need for reexamination and evaluation. Documentation of medical necessity must be submitted for reimbursement to be made and the new diagnosis must be reported to the carrier on the proper form.

The provider is to accurately describe the patient's objective progress. For those workers involved with physical therapy, this is best done by reviewing the physical therapist's RSA form. If no objective improvement is being made, i.e., in hours working, the patient self-report of pain, and functional, the worker is either at maximum medical improvement or there is something that needs to be identified and addressed. At the end of the follow up visit, the provider is to identify what it is that the patient can do. The provider is to clearly state the patient's capability and hours they can work as it relates to their job.

11. Electrophysiologic Testing

a. **Referrals for Testing:** Physicians referring patients for electrophysiologic testing should provide those testing with specific information about the patient. This information would include but not be limited to, the working diagnosis, prior testing results, and what issues the electrical testing is to clarify.

b. **Testing with Electromyography and Nerve Conduction Studies:** There are situations in which both electromyography and nerve conduction studies must be accomplished, such as when defining whether neuropathy is of demyelinating or axonal type. Seldom is it required that both studies be accomplished in straightforward condition of median and ulnar neuropathies or peroneal nerve compression neuropathies.

c. **Multiple Extremity Testing:** It is rarely necessary for more than two extremities to be examined, and it is never necessary for four extremities to be examined.

d. **Radiculopathies:** There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of a spinal root process, (radiculopathy).

e. **Number of Tests to be Completed:** To list each specific nerve which might be studied and determine limits of the study techniques permitted is not practical. There must be a latitude provided to the examining tester which permits judicious and appropriate extension in the examination as required by the types of abnormalities be identified. Clearly, if normal values are being recorded, there is in most cases, less rather than greater justification for extending the scope of the examination.

f. **Reimbursement:** The reimbursement for electrophysiological testing under the current RBRVS is adequate, and includes both a professional and technical fee. If the tester uses a facility's equipment and/or technician for the testing, the bill submitted will be for the professional component only with a modifier -26.

g. **Upper Extremity:** Distal entrapment syndromes, encompassing the median and ulnar nerves, are generally readily suspicioned and clinically diagnosed conditions, known by most physicians. In the case of presumed carpal tunnel syndrome, the ulnar nerve in the same extremity should also be tested to evaluate for the possibility that multiple neuropathies are present in the same extremity. If both median and ulnar values are abnormal, the patient's

other extremity should then be examined to assess for the possibility of there being widespread polyneuropathy. Charges for the mid-palmer parameters, inching techniques, should not be greater than charges for routine single nerve stimulation.

h. **Lower Extremity:** A similar situation would be appropriate should the patient be under evaluation for a condition that involved one lower extremity neuropathies.

i. **Who Should Perform Tests on Utah's Injured Workers:** Nerve conduction studies and Electromyographic examinations on injured workers in Utah should be accomplished by qualified individuals. Billing for non physicians would be 75% of the amount a physician would be paid had a physician performed those services. Billing Rational: Although the physical therapist can do the electrophysiologic studies, unlike a physician, their practice act as defined in 58-24b-102 does not allow them to diagnose disease.

12. Somatosensory Evoked Potential Monitoring During Surgery

The following Medicare standards have been adopted to assist surgeons for those conditions that currently warrant Somatosensory Evoked Potential Monitoring during surgery. At this time there is no additional professional fee payment to be made to the surgeon, in that "real time monitoring" provides the surgeon with prevention of complications. Somatosensory Evoked Potential Monitoring is an ongoing science and the committee will reevaluate these standards as the value and conditions for monitoring become clearer with further medical studies.

Inter-operative Neurophysiological Testing may be used to identify/prevent complications during surgery on the nervous system, its blood supply, or adjacent tissue.

Monitoring can identify new neurologic impairment, identify, or separate nervous system structures (e.g., around or in a tumor), and can demonstrate which tracts or nerves are still functional. Intra-operative neurophysiological testing may provide relative reassurance to the surgeon that no identifiable complication has been detected up to a certain point, allowing the surgeon to proceed further and provide a more thorough or careful surgical intervention than would have been provided in the absence of monitoring.

Some high-risk patients may be candidates for a surgical procedure only if monitoring is available.

Indications and Limitations of Coverage and/or Medical Necessity

A. Based on information in the scientific literature, Intra-operative testing is indicated with the following types of surgery:

- surgery of the aortic arch, its branch vessels, or thoracic aorta, including internal carotid artery surgery, when there is risk of cerebral ischemia;
- resection of epileptogenic brain tissue or tumor;
- protection of cranial nerves:
 - * tumors that are optic, trigeminal, facial, auditory nerves
 - * cavernous sinus tumors
 - * oval or round window graft endolymphatic shunt for Ménière's disease
 - * vestibular section for vertigo

- * correction of scoliosis or deformity of spinal cord involving traction on the cord
 - * protection of spinal cord where work is performed in close proximity to cord as in the removal of old hardware or where there have been numerous interventions
 - * decompressive procedures on the spinal cord or cauda equine carried out for myelopathy or claudication
 - * where function of spinal cord or spinal nerves is at risk
 - * spinal cord tumors
 - * neuromas of peripheral nerves or brachial plexus when there's risk to major sensory or motor nerves
 - * surgery for intracranial AV malformations
 - * surgery for intractable movement disorders
 - * arteriography, during which there is a test occlusion of the carotid artery
 - * circulatory arrest with hypothermia
 - * distal aortic procedures, where there is risk of ischemia to spinal cord; and
 - * leg lengthening procedures, where there is traction on sciatic nerve or other nerve trunks
 - * basil ganglia movement disorders
 - * surgery as a result of traumatic injury to spinal cord/brain
- B. Medicare requires that this test be requested by the operating surgeon. This service can not be separately billed to (or paid by) Medicare if performed by:
- * the operating surgeon;
 - * the technical/surgical assistant;
 - * the anesthesiologist rendering the anesthesia; or
 - * a hospital employee.
- C. *The physician must be performing intra-operative testing in real time. While the physician may monitor more than one patient at a time he/she must be solely dedicated to performing this service. The physician may be in the operating room or at a remote site with monitoring performed utilizing digital transmission or closed circuit television. There must be provisions for continuous or immediate contact with the surgeon to report changes.

Professional Self Treatment:

Any professional that treats themselves and then bills insurance for that treatment would be practicing unprofessional conduct and should be reported to the Utah Division of Occupational and Professional Licensing.

IV. SPECIFIC CODE STANDARDS

Some variances in the Utah adaptation of the RBRVS, have been made to allow for more clarity of the services rendered relating to billing.

Unless otherwise identified in the following, the most current AMA CPT-4 coding guidelines apply for Medicine, Evaluation & Management, Restorative Services, Radiology, Pathology & Laboratory, Anesthesia and Surgery.

A. MEDICINE

1. Impairment Rating

- a. The treating physician is the person most knowledgeable regarding the condition, progress and final status of the injured employee and, for this reason, shall be in the best position to render an impairment rating, and is encouraged to do so.
- b. The rating should be based solely on the objective maximum achieved condition of the patient. This service of calculating an impairment is not considered a portion of any of the services previously rendered and is not included in the routine post-operative care. There are special code numbers for payment for this service. The attending physician is encouraged to complete the case unless he feels that there is some specific reason that the doctor-patient relationship may be impaired by making such a determination.
- c. If for any reason the attending physician prefers to not make this evaluation, the insurance carrier should be notified in order that a decision can be made as to a proper referral for the evaluation. The physician may make a recommendation to the carrier of a proper referral.
- d. The following codes are used to report evaluation and management services provided to patients when the physician is providing an impairment rating to the insurance carrier and/or employer. Impairment ratings include evaluation of the patient, review of records, and diagnostic studies where necessary.
- e. It is never appropriate for the reporting physician to require prepayment for impairment rating services. If the physician prefers not to make the evaluation without prepayment that is his/her prerogative but the Carrier should refer the claimant to another physician who does not have this requirement as prepayment for a rating is not allowed.
- f. The Medical Report at Stability is a comprehensive report prepared after the injured worker is medically stable. As this is an administrative document, the final disposition of the examiner should include the following information:
 - * **Diagnosis:** The examiner needs to clearly state the diagnosis and have it clearly substantiated from the medical record. The examiner should also define, as best as possible, their impressions as the relationship of the diagnosis and the industrial event. It is recognized that in many cases specific pathologic diagnoses are not clearly evident. The examiner has the responsibility to provide a diagnosis as valid as the clinical findings allow.
 - * **Stability:** The examiner must declare the patient medically stable. The examiner must state that it is his/her medical opinion that all that can be done medically for the patient has been done, and that the patient is not expected to improve with further medical care and/or time. It is important to note that “medically stability” does not always mean that ongoing care is not needed.
 - * **Calculation of Impairment:** Using valid, standardized rating criteria, the examiner should calculate the residual impairment, based on clinical findings established in the medical record.
 - * **Apportionment:** The examiner must identify and list any factors, physical and non-physical, which add to the impairment, but are not directly resultant from the injury.
 - * **Capabilities Assessment:** Following the guidelines established by the U.S. Department of Labor, a limited functional capacity assessment should augment the medical record. Not only does this clearly establish physical abilities, but also facilitates the patient/employer relationship for return to work. (See

Physical Demands Characteristics of Work Chart in the Guide to Impairment Rating Fourth Edition.)

- * **Future Medical Treatment:** The examiner should identify future medical treatment that may be required to maintain the stability of the patient’s medical condition.

2. **Impairment Rating by Treating Physician**

The following codes are used to report the impairment rating by the treating physician. For an impairment rating by an independent physician see code 99456.

Codes 99455 and 99456 are to be used by physicians on the final visit when stability is declared. These codes are to be used alone and include concurrent evaluation and management services.

Code		Unit Value
99455	Work related or medical disability examination by treating physician that includes: completion of a medical history commensurate with the patient’s condition – performance of an examination commensurate with the patient’s condition – formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment – development of future medical treatment plan – and completion of necessary documentation/certificates and report. With 2.0 RVU assigned/30 min.	2.0

3. **Impairment Rating by Independent Physician**

Code		Utah Value
99456	Work related or medical disability examination by other than the treating physician that includes: completion of a medical history commensurate with the patient’s condition – performance of an examination commensurate with the patient’s condition – formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment – development of future medical treatment plan – and completion of necessary documentation/certificates and report. Assigned 2.65 units/30 min.	2.65

4. **Special Medical Evaluations (Independent Medical Examinations)**

Special Medical Evaluation is specialized evaluation of an ill or injury patient. These exams are initiated or requested by the insurance carrier or their authorized agent. An independent medical exam includes detailed review of medical records for the patient, which may include treatment prior to the date of injury. This review of records will include, but is not limited to chart notes, dictations, radiology reports and laboratory studies. Independent medical exams

also include a complete and thorough physical exam of the patient. A detailed report includes findings and conclusions from the record review and the physical evaluation of the patient must be submitted to the carrier.

Services rendered that are beyond the scope of consultations, referred as Special Medical Evaluations, must be agreed upon ahead of time and are outside the scope of the RBRVS.

The following code is to be used to report special medical evaluations:

Code	
99700	Special Medical Evaluations that include review of records and diagnostic studies and evaluation of the patient and report. Reimbursement for Special Medical Evaluations will be given individual determination.

B. RESTORATIVE SERVICES

1. Some variances in the Utah adaptation of the RBRVS have been made to allow for more clarity of the services rendered relating to billing for restorative services, which includes medical, osteopathic and chiropractic physicians, and occupational and physical therapist services. All Restorative Services must conform to the Labor Commission’s Restorative Rule R612-2-3. “Filings.” RSA Form 221 must be submitted to the carrier or self-insured employer for authorization. Some changes have been made in either the unit value or the Utah created procedure codes of some of the associated services.

2. **Codes Which Have Been Assigned A “O” RVU Value**

- * 97024 Diathermy
- * 97026 Infrared Therapy
- * 97028 Ultraviolet Therapy
Cold Laser Therapy
- * 97005 Athletic Training Evaluations
- * 97006 Athletic Training Reevaluation
- * 98960 Patient Education Codes (Use 97535)
- * 98961 Patient Education Codes (Use 97535)
- * 98962 Patient Education Codes (Use 97535)

3. **Physical Therapy/Occupational Therapy**

- a. Physical therapists will use codes 97001 through 97770, except in special circumstances. In addition to this office basic charge, they may bill for not more than 2 additional modalities/procedures from this section per day when necessary and performed. Please identify all procedures performed in the medical record, even if not billed.
- b. Physical therapists may make additional billing, when justified, under special circumstances. Such additional billing requires prior authorization from the appropriate carrier. Such additional billing can be accomplished by using the Physical Medicine codes 97001 through 97750. An example of such a special circumstance would be if the therapist were treating a neck and an arm, or a spine and a leg, at the same visit.

Code	
97001 & 97003	Per CPT descriptor and used on initial evaluation or change due to complications, additional surgeries and/or procedures, change in medical provider or a change in stability of the PT's condition, may be used on the same date of treatment.
97002 & 97004	Should not be used as an office charge only, but must reflect that a reevaluation was necessary and performed. Generally this should only be used every 6 visits, unless there is objective documentation that an evaluation and modification of treatment was significantly necessary and may coincide with new RSA From 221 update. May be used on same date of treatment.

- c. Two or more areas of the spine will not be considered a special circumstance, as the spine shall be considered one unit. The Utah Labor Commission recognizes the entire spine as one region. (This also applies to manipulation provided by physicians only.)
- d. All services provided should be itemized even if not billed.
- e. Independently practicing registered physical or occupational therapists:
 - * To be considered independently practicing, a therapist must operate a private office or rehabilitation clinic devoted exclusively to providing rehabilitative services to patients.
 - * The office or clinic must have its own professional license from the applicable local government.
- f. Registered therapists may bill for services related to range of motion (ROM) exercises and gait training. Reimbursement may be made for ROM exercises for a specific disease or injury only when training for those services are performed by a licensed therapist (see Procedure Code 97110). Reimbursement may be made for gait evaluation and training for claimants impaired by neurological or skeletal abnormalities (see Procedure Code 97116). However, records must reflect the degree of loss resulting from the specific disease or injury, as well as the degree of restoration attributable to the therapy program.
- g. An independently practicing therapist may be requested by a physician or other party to provide a written assessment to assist in the determination of the degree of restorative potential and the development of a treatment plan. This independent assessment by a therapist is reimbursable as a separate service only when treatment is not assumed by the evaluating therapist or his or her associates in a clinic. Necessary consultation between the physician and therapist to develop or modify an individual plan of treatment administered by the same therapist is a necessary service and is included as part of the allowance for procedures and therapies provided to the patient. For this service, use the appropriate most current AMA CPT-4 consultation code.
 - * A physician therapist is not to charge for a consultation and/or a report unless this is specifically requested.

4. **Manual Therapy Techniques**

Code	
97140	For Coding purposes the Utah Labor Commission recognizes the entire spine (head to pelvis) as one region and multiple spine codes are not to be used more than one time per treatment session.

5. **Osteopathic and Chiropractic Manipulative Treatments**

Code 98925	Osteopathic manipulative treatment (OMT) one or more body regions. For coding purposes the Utah Labor Commission recognizes the entire spine (head to pelvis) as one region and multiple spine codes are <u>not</u> to be used more than one time per treatment session.
---------------	--

Code 98940	Chiropractic manipulative treatment (CMT): spinal, more or more regions. For coding purposes the Utah Labor Commission recognizes the entire spine (head to pelvis) as one region and multiple spine codes are not to be used more than one time per treatment sessions.
---------------	--

The Utah Labor Commission does not recognize CPT codes 98941 and 98942 for coding purposes.

6. **Educational Codes/Work Conditioning and Work Hardening Codes**

The most current AMA CPT-4 codes are applicable with the following definitions: [See the CPT-4 time increments.]

Code	
97530	To be used per the descriptors in the 2012 AMA CPT-4, and billed within capitation limits.
97535	<u>Individual Education and Training</u> – Patient education to improve functional performance at work, work modification education and self care/home management training. This includes training in activities of daily living (ADL), lifestyle changes, and making specific recommendations and restrictions, if needed, to accommodate the patient’s return to work. Direct one-on-one contact by the provider. Billed outside the capitations with a limit of 4 units per injury claims.
97537	<u>Community/Work Reintegration Training</u> – (e.g., shopping, transportation, money management, avocational activities and/or work environment-modification analysis, work task analysis), direct one-on-one contact by provider.
97545	<u>Work Conditioning/Work Hardening</u> – A licensed practitioner, supervised, work-related, intensive goal-oriented treatment program specifically designed to restore an individual’s systemic, neuro-muscular-skeletal (strength, endurance, work conditioning should only be continued as long as objective improvement by the patient is documented. Pre-authorized: (Provider to specify amount of time anticipated, initial two hours). (Each additional hour use code 97546.)

97546	<u>Work Conditioning/Work Hardening Preauthorization</u> (Each additional hour.)
97150	<u>Group Education</u> : Training and activities of daily living, life style changes, actions to improve functional performance and work modification where appropriate in groups of 2 or more. (Pre-authorization is required per 30 minutes billed outside of capitation. Limit of 4 units per injury.)

7. **Functional Capacity Evaluations**

- a. **Limited Functional Capacity Evaluations (97750)** – Definition: “This determines a person’s dynamic maximal repetitive lifting, walking as patient reported standing and sitting tolerance.

Applications This test is used primarily to determine a patient’s functional ability profile level to be determined by a physician following the description of the Utah Medical

Association’s publication of “Workplace Functional Ability: Medical Guidelines.” This test can be used to determine if an individual is progressing or has reached a plateau as related to function. The test may also be used to work restrictions and to assist employers in determining accommodation.

(Provider to specify amount of time anticipated.)
Maximal Time: 45 minutes (15 minute segments)
Preauthorization required

- b. **Full Functional Capacity Evaluations (97750)** – Definition: This test described information concerning an individual’s maximum and repetitive lifting, walking, standing, sitting, range of motion, predicted maximal oxygen uptake, as well as ability to stoop, bend, crawl or perform work in an overhead or bent position. In addition, this test includes reliability and validity measures concerning the individual’s performance (i.e., grips, tests, repeated strength tests or distraction tests). Optimal measures may include isometric testing, pushing, pulling, hand dexterity, grip strength, etc.

Applications - This test is used to determine a patient’s general physical capability. It may be used when no job description is provided or the individual does not have a job to return to. This test is helpful for vocational rehabilitation counselors to determine capabilities for retraining into a different vocation. In addition, this test can be used to make disability and/or Social Security determinations. This can be used to make future recommendations.

Code	
97750	Full Functional Capacity Evaluation: (Provider to specify amount of time anticipated.) Maximum time: Up to 2.5 hours (15 minute segments) Preauthorization required

c. **Work Capacity Evaluation (97750)** – Description: This test determines a patient’s capabilities based on the physical aspects of a specific job description. The capabilities measured may vary greatly depending on the physical requirement of the job that the patient is to be compared against.

Code	
97750	Work Capacity Evaluation: (Provider to specify amount of time anticipated.) Maximum time: Up to 2 hours (15 minute segments) Pre-authorization required

Application The most common application for a work capacity evaluation is to determine an individual’s capability compared to his/her job and for preparation for return-to-work. A test can also be used to help an employer make reasonable accommodations if a patient has a documented disability.

d. **Job Analysis (97750)** – Description: Job Analysis is performed at a work site to determine physical aspects of a particular job. The job analysis may or may not include pictures of the essential aspects of the job.

Application Job Analysis is generally used to create work capacity evaluation to determine an individual’s ability to perform specific aspects of a particular job. This can be helpful in determining an individual’s ability to return to work. A job analysis can also help an employer to determine physical job descriptions, which include partial non-essential aspects of a particular job. A Job Analysis can be used if an employer decides to perform pre-work placement tests. A Job Analysis can also be used in making appropriate ergonomic adjustments to improve the safety of a particular workstation.

Code	
97750	Job Analysis: (Performed at work site, each 15 minutes.) Anticipated Time: Variable depending on the distance traveled and job analyzed. Pre-authorization required

8. **Evaluation Codes**

Codes 97001, 97002, 97003 and 97004 are only to be used by physical therapists or occupational therapists respectively when progress notes substantiate that the defined level of care was rendered.

Codes 99211 and 99212 are to be used by physicians (including chiropractors) *only when progress notes substantiate that the defined level of care was rendered.*

9. **Debridement** – as outlined in CPT Schedule

C. **ANESTHESIA**

1. **Standards**

- a. Medicare's Base Units and methodology for time calculation (1 unit for 15 min. of anesthesia) is adopted with the conversion factor of \$40.00.
- b. The basic value provided in the 2012 First Quarter RBRVS, for anesthesia when multiple surgical procedures are performed during a single anesthetic administration is the basic value for the procedure with the highest unit value. The appropriate basic value units, modifying units and time units may be applied to each anesthetic administration.
- c. Services which may necessitate skills and time of the physician beyond that usually required (e.g., unusual forms of monitoring, severe multiple injuries or other factors requiring extended pre and/or post operative care) should be substantiated "By Special Report" (NC).
- d. When it is necessary to have a second attending anesthesiologist assist with the preparation and conduct of the anesthesia, these circumstances should be substantiated "By Special Report." Such services shall have a Basic Value of 5.0 units plus Time Units.
- e. The minimum basic unit value for any procedure requiring endotracheal intubation for avoidance of the surgical field or to place the patient in a prone position shall be 4.0. Where the listed basic unit value is 4 or more, no additional units are warranted for endotracheal intubation. Use Modifier-22.
- f. Qualifying Circumstance codes 99100 through 99140 are not covered.

Refer to current CPT for physical status modifiers.

2. **Time Reporting**

Time Units will be added to the basic value for all cases at the rate of one unit for each 15 minutes or fraction thereof.

D. SURGERY

1. **Needle Procedures**

- a. Diagnostic needle procedures (lumbar puncture, thoracentesis, jugular or femoral vein taps, subdural taps, etc.) when performed as part of the necessary workup for a serious medical illness or injury should be billed in addition to the medical care on the same day.
- b. Therapeutic procedures (injecting into cavities, nerve blocks, joint and tendon problems, etc.) (20550-20610; 64400-64450) may be billed in addition to the medical care on the same day for a new patient.
- c. Puncture of a cavity or joint for aspiration followed by injection of a therapeuticum is one procedure and should be billed as such.
- d. In follow up cases for additional therapeutic aspiration and/or injection when the needle procedure is the primary service, an office visit charge in conjunction with that is only indicated if there is necessary a significant reevaluation of the patient. In this case a minimal service may be listed in addition to the injection.
- e. The above mentioned "needle" procedures do not include injections for X-ray procedures. Injection procedures in conjunction with radiological services include necessary local anesthesia, placement of needle or catheter and injection of contrast media.
- f. Immunization procedures are covered only if they relate directly to an industrial injury or exposure. They are not covered for routine services or prevention.

g. Puncture for injection, drainage, or aspiration (62270-62287) and Nerve Blocks (64400-64640) are listed in the surgical section of the Relative Value Study. There is only one reimbursement value per procedure regardless of the time required or the specialty of the physician rendering the service. These services are coded and reimbursed as surgery. Anesthesia units are to be used only when a supplemental anesthetic is required to carry out the procedure.

h. Trigger Point Injections: Regardless of the number of injections or trigger points treated, trigger point injections are reported per muscle. Report if one or two muscles are treated. Report on 20553 if three or more muscles are treated during the treatment session. Code 20553 is the maximum allowed for any one-treatment session regardless of the number of muscles treated. Do not report both code 20552 and 20553 for the same treatment session. Documentation must indicate which muscles were treated. Research has clarified that in this code number the word injections is plural and that is meant to include one or more injections. A reading of this descriptor will show that trigger point injections represent a much lesser procedure in general than the other procedures that justify a significant higher reimbursement than a trigger point injection. Thus injections is considered as plural and to refer to one or more injections in any extended anatomical site.

E. RADIOLOGY

1. Two patterns of billing currently prevail in Radiology. A total charge for the radiology service to include both professional fees and technical costs is made by radiologists working in offices, clinics and, under some circumstances, in hospital X-ray departments.
2. In the majority of voluntary hospital radiology departments, the radiologist submits a separate statement to the patient for his professional services – using Modifier -26. The hospital charges for the technical component (TC). A total (T) fee includes both the professional fee of the radiologist and the cost for non-physician personnel, facilities, supplies and overhead needed to accomplish the procedure. The separation of billing between the radiologist and hospital in no way implies a division of responsibility but only a needed medical service for the patient. The radiologist must retain full responsibility for his own activity and full responsibility for the supervision of the technologist, the selection and maintenance of equipment, the control of radiation hazards and the general administration of the radiology department.
3. If other physicians participate in a significant fashion in a procedure, then one must anticipate a fee for their services separate from the one asked by the radiologist.
4. The charges made by the institution cover the services of technologists and other helpers, the film, contrast media, chemicals and other materials, the use of the space and facilities of the X-ray department plus any other costs.
5. Radioisotopes, Gadolinium and comparable materials may be charged for (COM) at the provider's cost plus 15%. See 99070.
6. The professional component represents the reimbursement allowance of the professional radiological services of the physician and is identified by the use of Modifier -26. This includes examination of the patient when indicated, performance or supervision of the procedure, interpretation and written report of the examination and consultation with the referring physician.
7. The professional component is traditionally used by physicians under contract with a hospital or other facility who billed independently of the hospital or other facility. This component is payable only to the physician who renders the official interpretation or reading of the X-rays

and written report. When the X-rays are reviewed by others, that service is included as a part of the basic service rendered to the patient. It is inappropriate for others to use Modifier -26 when x-rays are reviewed as part of an evaluation of a patient for an independent medical evaluation, consultation or other office visit.

F. PATHOLOGY

1. The physician is allowed to bill from the RBRVS Fee Schedule. A handling fee is allowed only if an outside laboratory is billing for the test. Also, a physician **may not** have a financial interest in the laboratory.

V. SURGICAL SUPPLY TRAY

The Medical Fee Standards no longer provide for separate payment for a sterile supply tray when the service is provided in the physician's office since the value of these types of supplies are included in the value of the RVU non facility practice expense component.

GLOSSARY OF COMMON HEALTH REIMBURSEMENT TERMS

A

Allowable Amount – The dollar amount eligible for reimbursement to the physician or health care professional on the claim based on the lower of either the provider's charge or the "reasonable and customary amount," as explained in your health plan information. This dollar amount may not be the amount ultimately paid to the member or provider as it may be reduced by any coinsurance or deductible that is owed by the member.

B

Balance Billing – Balance billing is a type of health care billing that occurs when a provider bills member for the difference between an out-of-network provider's charges and the amount paid by a member's benefit plan. This situation happens when a provider is neither contracted nor a participant in a member's provider network.

Billed Charge – The amount billed by your physician or other health care provider for services you have received. If you use a provider in your plan's network, the billed charge should be the same as the allowed amount, or contracted rate, negotiated by your insurer. But, if you use providers outside your network, you will generally have to pay the full difference between your insurer's allowed amount and the amount that your provider charges.

C

Copayment or "Copay" – A form of medical cost sharing in a health insurance plan that requires you to pay a fixed dollar amount each time you visit a doctor. This fee is preset; it will be specified in your health insurance policy and may also be listed on your insurance card.

Covered Services – The medical services, procedures, prescription drugs and other health care services that your insurer pays for under your plan. Keep in mind that not all care is covered. For instance, some plans will not pay for medications that are available over-the-counter. And, even if a service is covered, you may still need to pay a copayment or co-insurance, request preauthorization, or get a referral from your primary care physician before your insurer will pay. Your policy should contain a detailed list of what is and is not covered.

CPT® Codes – A set of codes and descriptions of services and procedures performed by physicians and other health care providers. Each service and procedure is identified by its own five-digit code. Physicians and other health care providers use CPT codes in making claims for payment. CPT codes are maintained by the American Medical Association.

CPT® Modifier – A code that is used to provide additional information on a procedure or service. For example, there are modifiers that indicate that a procedure is being repeated or that multiple surgeries were performed at the same time. They can also indicate that the service is more or less complex than normal. The modifier can affect how much the health plan will pay the provider

D

Department of Health and Human Services – The federal cabinet-level agency that administers federal health, welfare, and human services programs and activities. HHS has lead agency responsibility for significant aspects of the Patient Protection and Affordable Care Act and is home to the Centers for Medicare and Medicaid Services and its Center for Medicare and Medicaid Innovation, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the National Institutes of Health, the HHS Inspector General, the HHS Office for Civil Rights, the HHS Office of Minority Health, the Substance Abuse and Mental Health Services Administration, the Indian Health Service, and other Federal agencies that oversee the Patient Protection and Affordable Care Act.

E

Explanation of Benefits (EOB) – Your insurer will provide you with an EOB after you have submitted a medical claim to your insurance or after a provider has submitted a claim to your insurer on your behalf. The EOB will include a detailed explanation of how your insurer determined the amount of reimbursement it made to your provider or to you for a particular medical service. The EOB will also include information on how to appeal or challenge your insurer's reimbursement decision. Note that you may not receive an EOB for care that you have received from a provider or facility that is in your insurer's network.

Exclusive Provider Organization (EPO) – A managed care organization that exhibits characteristics of both health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Like an HMO, an EPO plan requires that members visit in-network providers only; care from out-of-network providers is not covered. Like a PPO, an EPO plan often allows members to see specialists without first obtaining a referral from a primary care doctor; these specialists visits are covered as long as the providers are in the network.

H

Healthcare Professional – A physician, nurse, physician assistant, or other individual who is licensed or certified as required in their state and is performing services within the scope of that license or certification.

I

In-network – Pertains to treatment from doctors, clinics, health centers, hospitals, medical practices and other providers with whom your plan has an agreement to care for its members. You will almost always pay less out of your own pocket when you receive treatment from in-network providers.

Institutional Review Board (IRB) – A group of people appointed by an institution (such as a hospital or university) to review and monitor research projects involving human subjects, with the purpose of protecting the rights and welfare of the people who are participating as subjects in the research. An IRB seeks to ensure that subjects are not placed at undue risk, and that they give uncoerced, informed consent to their participation. To this end, an IRB has the authority to approve, disapprove, and require modifications to research projects

involving human subjects. Once a project is approved, the IRB must monitor the progress of the ongoing research, prospectively approve modifications and suspend the project if necessary to protect subjects.

N

Non Covered Charges – Costs for medical treatment that your insurer does not pay. You may wish to call your insurer or consult your health insurance policy to determine whether certain services are included in your plan before you receive those services from your doctor. If you receive services not included in your health insurance policy, your doctor will bill you (not your insurer) for those services and you will be responsible for paying that bill.

Non Covered Services – Medical services that are not included in your plan. If you receive non-covered services, your provider will bill you, not your health insurer, and you will be responsible for the full cost. You will need to consult with your health insurer, but generally payments you make for these services do not count toward your deductible. Make sure you know what services are covered before you visit your doctor.

O

Out-of-Network – Pertains to treatment from doctors, clinics, health centers, hospitals, medical practices and other providers that do not have an agreement with your health insurer to provide care to its members. You typically will pay more out of your own pocket when you receive treatment from out-of-network providers.

Out-of-Network Benefits – Benefit plan coverage for services provided by doctors and other health care professionals who are not under a contract with your health plan.

Out-of-Pocket Costs – That portion of the cost of health services that the plan member must pay, including the difference between the amount charged by an out-of-network provider and what a health plan may pay for such services.

Out-of-Pocket Maximum – The limit on the total amount a health insurance company requires a member to pay in deductible and coinsurance in a year. After reach an out-of-pocket maximum, a member no longer pays coinsurance because the plan will begin to pay 100% of medical expenses. This only applies to covered services. Members are still responsible for services that are not covered by the plan even if they have reached the out-of-pocket maximum for covered expenses. Members also continue to pay their monthly premiums to maintain their health insurance policies.

P

Participating Provider – A physician or other health care professional, hospital or health care facility that contracts with your health insurer to provide services to its members at a discount.

Percentile – A statistical measure used to describe how a particular quantity (such as the cost of a specific healthcare procedure) varies across a range of sources (such as all the doctors in your area). For example, 50% of all fees billed by providers are at or below the level indicated by the 50th percentile. 80% of all fees billed by providers are at or below the level indicated by the 80th percentile. Percentiles are important because they are used by many insurers in determining how much of a billed charge they will reimburse.

Physician – An individual who has received a “Doctor or Medicine” (MD) or Doctor of Osteopathic Medicine (DO) degree and is licensed to practice medicine in their state.

Point of Service (POS) Plan – A health plan that allows you to choose at the time medical services are needed whether you will go to a provider within your plans, network or seek care outside the network.

Preferred Provider Organization (PPO) – A health plan that is designed to encourage you to receive your health care through a network of selected health care providers (such as hospitals and physicians). If your plan is a PPO, your medical expenses will be lower if you use a provider or facility that is part of your plan’s network. You are entitled to receive reimbursement for care from providers and facilities that are outside the network, but you will be required to pay larger costs for such “out-of-network” care.

Preauthorization – A decision by your health insurer or plan that particular health care services, treatment plans, prescription drugs or durable medical equipment prescribed by your doctor are covered and medically necessary. Your plan may require preauthorization for certain services, such as hospitalization, before you receive them. Preauthorization requirements are generally waived if you need emergency care.

Premium – The amount an employer pays to health insurance company for health coverage. The health insurance company generally recalculates the premium each policy year. This amount is usually paid in monthly installments. When a consumer receives health insurance through an employer, the employer generally pays a portion of the cost of the premium and the consumer pays the rest, often through regular payroll deductions.

Provider – A physician or other health care professional, hospital or health care facility that is accredited, licensed or certified to practice in their state, and is providing services within the scope of that accreditation, license or certification.

Provider Network – Doctors and other health care professionals who agree to provide medical care to members of a health plan, under the terms of a contract.

Q

Qualified Medical Expenses – Qualified medical expenses are defined under Section 213 of the Internal Revenue Code. (See the Internal Revenue Service’s Publication 502 about medical and dental expenses.) Qualified medical expenses and other expenses permitted to be reimbursed from health savings accounts (HSAs) include, but are not limited to the following:

- Doctors’ visits
- Ambulance and hospital services
- Prescription drugs and certain over-the-counter prescription medications
- Durable medical equipment
- Dental care
- Acupuncture
- Chiropractic services
- COBRA health care continuation coverage
- Qualified long-term care services and limited long-term care premiums
- Vision care
- Health insurance premiums for individual receiving unemployment compensation
- At age 65 and over, Medicare Part A and B, Medicare HMO, and a member’s share of employer-sponsored health insurance premiums (but no Medicare Supplement premiums)

A medical expense is not a qualified expense if a member receives reimbursement for it under insurance coverage. If the member’s expense is paid for or reimbursed by an HSA account, that expense cannot be included for purposes of determining itemized tax deductions.

R

Reimbursement – The amount that your insurer has agreed to pay for a specific service. For instance, your insurer’s reimbursement rate for a primary care visit may be \$80. If your provider charges \$100 you would be responsible for the remaining \$20.

S

Self Insured – If you work for a large employer or group of employers, your plan may be self insured. This means that your employer pays medical claims and administers the benefits in-house, rather than hiring an outside health insurance company or plan administrator to manage your coverage.

U

Usual and Customary Rate (UCR) – A term often used to describe how insurers may calculate reimbursements for out-of-network care. If your plan covers some out-of-network care, your insurer may base the payment on a price that it determines to be “unusual, customary and reasonable” in your area. It’s a good idea to find out this rate first. Ask your provider how much he or she will charge for the service you need and then call your insurer to find out what they consider to be the UCR for that service so you can understand how much of the cost they will pay to an out-of-network provider. That way, you can make an informed decision and you won’t be surprised by a large bill.