Office of the Registrar of Regulations,
Legislative Council,
State of Delaware

DEPARTMENT OF LABOR

DIVISION OF INDUSTRIAL AFFAIRS

Statutory Authority: 19 Delaware Code, Sections 105 and 2322B(19 **Del.C.** §§105 & 2322B)
19 **DE Admin. Code** 1341

ERRATA

1341 Workers' Compensation Regulations

*** Please Note:** The Department of Labor regulation, 19 **DE Admin. Code** 1341 Workers' Compensation Regulations, was published as proposed in the *Delaware Register of Regulations*, 27 **DE Reg.** 317 (11/01/23) and as final in the *Delaware Register of Regulations*, 27 **DE Reg.** 614 (02/01/24**)**. The following subsections were inadvertently published incorrectly.

New proposed and final subsection 4.10.6 was published as:

~~4.9.6~~ 4.10.6Inpatient Care

~~4.9.6.1~~ 4.10.6.1~~Definition~~ Definition.

~~4.9.6.1.1~~ 4.6.10.1.1For purposes of this fee schedule, “inpatient” means being admitted to a hospital setting for ~~twenty-four (24)~~ 24 hours or more. An inpatient admission does not require official admission to the hospital.

New proposed and final subsection 4.10.6 should have read:

~~4.9.6~~ 4.10.6Inpatient Care

~~4.9.6.1~~ 4.10.6.1~~Definition~~ Definition.

~~4.9.6.1.1~~ 4.10.6.1.1For purposes of this fee schedule, “inpatient” means being admitted to a hospital setting for ~~twenty-four (24)~~ 24 hours or more. An inpatient admission does not require official admission to the hospital.

New proposed and final subsection 4.10.7.1 was published as:

4.9.7.1 4.10.7.1~~Definition~~ Definition.

~~4.9.7.1.1~~ Observation services are those services furnished by a hospital on the hospital’s premises, and include use of a bed and periodic monitoring by a hospital’s staff. The service must be reasonable and necessary to evaluate a patient’s condition or to determine need for inpatient admission. To qualify for observation status, the patient needs observation due to an unforeseen circumstance or has a medical condition with a significant degree of instability.

New proposed and final subsection 4.10.7.1 should have read:

~~4.9.7.1~~ 4.10.7.1~~Definition~~ Definition.

~~4.9.7.1.1~~ Observation services are those services furnished by a hospital on the hospital’s premises, and include use of a bed and periodic monitoring by a hospital’s staff. The service must be reasonable and necessary to evaluate a patient’s condition or to determine need for inpatient admission. To qualify for observation status, the patient needs observation due to an unforeseen circumstance or has a medical condition with a significant degree of instability.

New proposed and final subsection 4.13.3 was published as:

~~4.12.3~~ 4.12.3 The payment system will be adjusted yearly pursuant to 19 **Del.C.** §2322B(5) for a procedure, treatment or service in effect in January of that year.

New proposed and final subsection 4.13.3 should have read:

~~4.12.3~~ 4.13.3 The payment system will be adjusted yearly pursuant to 19 **Del.C.** §2322B(5) for a procedure, treatment or service in effect in January of that year.

New proposed and final subsection 4.17 was published as:

~~4.16~~ 4.17Fees for Non-Clinical Services

4.16.1 4.17.1Pursuant to 19 **Del.C.** §2322B(13), fees for certain non-clinical services are set as follows, and will be periodically revised upon recommendation of the Workers' Compensation Oversight Panel to reflect changes in the cost of providing such services:

New proposed and final subsection 4.17 should have read:

4.16 4.17Fees for Non-Clinical Services

4.16.1 4.17.1Pursuant to 19 **Del.C.** §2322B(13), fees for certain non-clinical services are set as follows, and will be periodically revised upon recommendation of the Workers' Compensation Oversight Panel to reflect changes in the cost of providing such services:

New proposed and final subsection 4.19.2.2 was published as:

4.18.2.2 4.19.2.2The Delaware Workers' Compensation Health Care Practice Guidelines remain in effect and care is presumed compensable when followed. It is the intent of these new Rules and Regulations that care that was allowed under the previous billing system is still compensable, and under no circumstances is the new billing system defining what care is acceptable, but rather a maximum allowable reimbursement.

New proposed and final subsection 4.19.2.2 should have read:

4.18.2.2 4.19.2.2The Delaware Workers' Compensation Health Care Practice Guidelines remain in effect and care is presumed compensable when followed. It is the intent of these new Rules and Regulations regulations that care that was allowed under the previous billing system is still compensable, and under no circumstances is the new billing system defining what care is acceptable, but rather a maximum allowable reimbursement.

New proposed and final subsection 4.21.4.2.4.2 was published as:

o 4.21.4.2.4.2 When an anesthesiologist provides medical direction to the CRNA or AA providing the anesthesia service, then the reimbursement will be divided between the two of them at fifty percent (50%) 50%.

New proposed and final subsection 4.21.4.2.4.2 should have read:

o 4.21.4.2.4.2 When an anesthesiologist provides medical direction to the CRNA or AA providing the anesthesia service, then the reimbursement will be divided between the two 2 of them at fifty percent (50%) 50%.

New proposed and final subsections 4.22.1 and 4.22.1.1 was published as:

4.21.1 **General Guidelines** General Guidelines

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

New proposed and final subsections 4.22.1 and 4.22.1.1 should have read:

4.21.1 4.22.1**General Guidelines** General Guidelines

4.21.1.1 4.22.1.1**Global Reimbursement** Global Reimbursement.The reimbursement allowances for surgical procedures are based on a global reimbursement concept that covers performing the basic service and the normal range of care required after surgery.

New proposed and final subsection 4.22.1.1.2 was published as:

o 4.22.1.1.2Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia anesthesia.

New proposed and final subsection 4.22.1.1.2 should have read:

o 4.22.1.1.2 Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia anesthesia;

New proposed and final subsection 4.22.1.1.5 was published as:

o 4.22.1.1.5Evaluating the patient in the post anesthesia recovery area

New proposed and final subsection 4.22.1.1.5 should have read:

o 4.22.1.1.5Evaluating the patient in the post anesthesia recovery ~~area~~ area;

New proposed and final subsection 4.22.1.19, **50 Bilateral Procedure** was published as:

50 Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate five-digit code. **Note:** This modifier should not be appended to designated "add-on" codes (see Appendix D of *CPT*).

State Note: There will be no reductions to the procedures billed with the modifier 50.

State Note: Procedures performed bilaterally are reported as two line items and modifier 50 is not appended. These codes are identified with CPT specific language at the code or subsection level. Modifiers RT and LT may be appended as appropriate.

New proposed and final subsection 4.22.1.19, **50 Bilateral Procedure** should have read:

50 Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate five-digit code. **Note:** This modifier should not be appended to designated “add-on” codes (see Appendix D of CPT).

State Note: There will be no reductions to the procedures billed with the modifier 50.

State Note: Procedures performed bilaterally are reported as two line items and modifier 50 is not appended. These codes are identified with CPT specific language at the code or subsection level. Modifiers RT and LT may be appended as appropriate.

New proposed and final subsection 4.23.2.5.3 was published as:

o 4.23.2.5.3Sterile ~~supplies~~ ~~supplies;~~

New proposed and final subsection 4.23.2.5.3 should have read:

o 4.23.2.5.3Sterile ~~supplies~~ supplies;

New proposed and final subsections 4.26.3.2 and 4.26.3.3 were published as:

4.25.3.2 Diagnostic arthroscopy is not billed when followed by arthroscopic surgery.

4.25.3.3 If there are only minor findings that do not confirm a significant preoperative diagnosis, the procedure should be billed as a diagnostic arthroscopy.

New proposed and final subsections 4.26.3.2 and 4.26.3.3 should have read:

~~4.25.3.2~~ 4.26.3.2 Diagnostic arthroscopy is not billed when followed by arthroscopic surgery.

~~4.25.3.3~~ 4.26.3.3 If there are only minor findings that do not confirm a significant preoperative diagnosis, the procedure should be billed as a diagnostic arthroscopy.

New proposed and final subsection 4.26.6.12 was published as:

o 4.26.6.12Closure of ~~wound~~ wound;

New proposed and final subsection 4.26.6.12 should have read:

o 4.26.6.12Closure of ~~wound~~ wound.

New proposed and final subsections 4.28.1.1.2 through 4.28.1.1.5 were published as:

~~4.27.1.1.2~~ 4.27.1.1.2Whenever the health care payment system does not set a specific fee for a procedure, treatment or service in the schedule, the amount of reimbursement shall be a percentage reduction from 85% of the actual charge.

~~4.27.1.1.3~~ 4.27.1.1.3The payment system will be adjusted yearly pursuant to 19 **Del.C.** §2322B(5).

~~4.27.1.1.4~~ 4.27.1.1.4Physicians should include CPT codes for specific performance of diagnostic tests/ studies for which specific CPT codes are available. Items used by all physicians in reporting their services are presented in the introduction. Definitions and explanations unique to pathology and laboratory are included below.

~~4.27.1.1.5~~ 4.27.1.1.5The maximum number of times that drug screening, testing, or the like, may occur is ~~four (4)~~ 4 samples per year absent written pre-authorization by the employer or its insurance carrier. If the point of care testing is not consistent with that which the prescriber expected based on the drug or medicine prescribed, then, and only then, will confirmatory testing be permitted and subject to payment. A maximum charge of ~~one hundred dollars ($100.00)~~ $100 for point of care testing, or the provider's actual charge, whichever is less, shall be permitted, regardless of the number of drugs being screened for and/or the number of dip sticks, testing instruments, materials, or the like, used.

New proposed and final subsections 4.28.1.1.2 through 4.28.1.1.5 should have read:

~~4.27.1.1.2~~ 4.28.1.1.2Whenever the health care payment system does not set a specific fee for a procedure, treatment or service in the schedule, the amount of reimbursement shall be a percentage reduction from 85% of the actual charge.

~~4.27.1.1.3~~ 4.28.1.1.3The payment system will be adjusted yearly pursuant to 19 **Del.C.** §2322B(5).

~~4.27.1.1.4~~ 4.28.1.1.4Physicians should include CPT codes for specific performance of diagnostic tests/ studies for which specific CPT codes are available. Items used by all physicians in reporting their services are presented in the introduction. Definitions and explanations unique to pathology and laboratory are included below.

~~4.27.1.1.5~~ 4.28.1.1.5The maximum number of times that drug screening, testing, or the like, may occur is ~~four (4)~~ 4 samples per year absent written pre-authorization by the employer or its insurance carrier. If the point of care testing is not consistent with that which the prescriber expected based on the drug or medicine prescribed, then, and only then, will confirmatory testing be permitted and subject to payment. A maximum charge of ~~one hundred dollars ($100.00)~~ $100 for point of care testing, or the provider's actual charge, whichever is less, shall be permitted, regardless of the number of drugs being screened for and/or the number of dip sticks, testing instruments, materials, or the like, used.

New proposed and final subsection 4.29.1.2 was published as:

~~4.28.1.2~~ 4.29.1.2**Initial Evaluation and Re-evaluation by Physical Therapists or Occupational Therapists** Initial Evaluation and Re-evaluation by Physical Therapists or Occupational Therapists

New proposed and final subsection 4.29.1.2 should have read:

~~4.28.1.2~~ 4.29.1.2~~**Initial Evaluation and Re-evaluation by Physical Therapists or Occupational Therapists**~~ Initial Evaluation and Re-evaluation by Physical Therapists or Occupational Therapists

New proposed and final subsection 4.29.1.3 was published as:

~~4.28.1.3~~ 4.29.1.3~~**Exam Visits to Occupational Therapists or Physical Therapists**~~ Exam Visits to Occupational Therapists or Physical Therapists. Services performed by a physical therapist and/or occupational therapist shall be performed in conjunction with the authorized treating physician detailing the type, frequency, and duration of therapy to be provided. Only physical therapists and/ or occupational therapists procedures and services are billable.

New proposed and final subsection 4.29.1.2 should have read:

~~4.28.1.3~~ 4.29.1.3~~**Exam Visits to Occupational Therapists or Physical Therapists**~~ Exam Visits to Occupational Therapists or Physical Therapists. Services performed by a physical therapist and/or occupational therapist shall be performed in conjunction with the authorized treating physician detailing the type, frequency, and duration of therapy to be provided. Only physical ~~therapists~~ therapists' and/or occupational ~~therapists~~ therapists' procedures and services are billable.

New proposed and final subsection 4.30 was published as:

~~4.29~~ 4.30**Durable Medical Equipment and Supplies**

New proposed and final subsection 4.30 should have read as:

~~4.29~~ 4.30~~**Durable Medical Equipment and Supplies**~~ Durable Medical Equipment and Supplies

New proposed and final subsection 5.4.4 was published as:

5.4.4 In the instance of a compensable claim in which open surgery is recommended by the health care provider and stated by ~~him/her~~ the provider to be within the applicable Practice Guideline, the following procedure may be followed by the operating surgeon to facilitate resolution of payment for such treatment: The operating surgeon must specify the particular surgery to be performed and must certify in writing that:

5.4.4.1.1 ~~(a) the~~ The surgery is causally related to the work ~~accident,~~ accident; and

5.4.4.1.2 ~~(b) the~~ The surgery is within the Practice Guideline, with specific reference to the Practice Guideline provision relied upon.

~~5.4.4.1~~ 5.4.4.2The information set forth above must be set forth by the operating surgeon in a separate written report, not through a copy of office notes and/or records. The employer/carrier must within 30 days from receipt of the above either accept/pre-authorize or deny such treatment. If the treatment is denied as non-compliant with the Practice Guidelines, it must be referred to Utilization Review within 15 days of date of denial in accordance with §2322F(h)(j). If the treatment is denied as not causally related to the compensable work accident, the claimant may file a Petition with the Industrial Accident Board to determine whether the treatment is compensable. If the employer/ carrier neither accepts/pre-authorizes nor denies the treatment within the 30-day period referenced above, then the treatment will be deemed compensable if performed.

New proposed and final subsection 5.4.4 should have read as:

5.4.4 In the instance of a compensable claim in which open surgery is recommended by the health care provider and stated by ~~him/her~~ the provider to be within the applicable Practice Guideline, the following procedure may be followed by the operating surgeon to facilitate resolution of payment for such treatment:

5.4.4.1 The operating surgeon must specify the particular surgery to be performed and must certify in writing that:

5.4.4.1.1 ~~(a) the~~ The surgery is causally related to the work ~~accident,~~ accident; and

5.4.4.1.2 ~~(b) the~~ The surgery is within the Practice Guideline, with specific reference to the Practice Guideline provision relied upon.

~~5.4.4.1~~ 5.4.4.2The information set forth above must be set forth by the operating surgeon in a separate written report, not through a copy of office notes and/or records. The employer/carrier must within 30 days from receipt of the above either accept/pre-authorize or deny such treatment. If the treatment is denied as non-compliant with the Practice Guidelines, it must be referred to Utilization Review within 15 days of date of denial in accordance with §2322F(h)(j). If the treatment is denied as not causally related to the compensable work accident, the claimant may file a Petition with the Industrial Accident Board to determine whether the treatment is compensable. If the employer/ carrier neither accepts/pre-authorizes nor denies the treatment within the 30-day period referenced above, then the treatment will be deemed compensable if performed.

27 DE Reg. 713 (04/01/24) (Errata)