DEPARTMENT OF LABOR

DIVISION OF INDUSTRIAL AFFAIRS

Office of Workers' Compensation

Statutory Authority: 19 Delaware Code, Section 2322 F(j) (19 **Del.C.** §§2322F(j))
19 **DE Admin. Code** 1341

PROPOSED

PUBLIC NOTICE

1341 Workers' Compensation Regulations

The Secretary of Labor, in accordance with 19 **Del.C.** §2322B, has proposed revisions to the rules and regulations relating to the Delaware Workers' Compensation Health Care Payment System (HCPS). These proposals 1) revise fees for hot/cold packs (CPT 97010); and 2) make Medispan the sole AWP source for pharmacy fees.

A public meeting will be held before the Health Care Advisory Panel ("Panel") at 4:00 p.m. on December 2, 2013, in the Department of Labor Fox Valley Annex, 4425 N. Market Street, Wilmington, Delaware, 19802, where members of the public can offer comments. Anyone wishing to receive a copy of the proposed rules may obtain a copy from Donna Forrest, Medical Component Manager, Office of Workers' Compensation, Division of Industrial Affairs, Department of Labor, 4425 N. Market Street, Wilmington, Delaware, 19802. Persons wishing to submit written comments may forward them to the Panel at the above address. The final date to receive written comments will be 20 days after the public meeting.

The Panel will consider making a recommendation to the Secretary at the regularly scheduled meeting following the public meeting.

1341 Workers' Compensation Regulations

1.0 Purpose and Scope

1.1 Section 2322B, Chapter 23, Title 19, **Delaware Code** authorizes and directs the Department within 180 days from the first meeting of the Health Care Advisory Panel to adopt a Health Care Payment System by regulation after promulgation by the Health Care Advisory Panel.

1.2 Section 2322B, Chapter 23, Title 19, **Delaware Code**, authorizes and directs the Health Care Advisory Panel to adopt and recommend, a coordinated set of instructions and guidelines to accompany the health care payment system, to the Department for adoption by regulation.

1.3 Section 2322B(3), Chapter 23, Title 19, **Delaware Code** establishes the formula based upon historical data required to determine the Fee Schedule Amounts for professional services.

1.4 Section 2322B(5), Chapter 23, Title 19, **Delaware Code** establishes the amount of reimbursement for a procedure, treatment or service to be eighty-five (85%) of the actual charge, if a specific fee is not set forth in the Fee Schedule Amounts.

1.5 Section 2322B(7), Chapter 23, Title 19, **Delaware Code** establishes separate service categories.

1.6 Section 2322B(8), Chapter 23, Title 19, **Delaware Code** establishes the Hospital fees developed for the Health Care Payment System.

1.7 Section 2322B(9), Chapter 23, Title 19, **Delaware Code** establishes the Ambulatory Surgical Treatment Center fees developed for the Health Care Payment System.

1.8 The fees to be established in Sections 2322B(11)(12) and (13) shall be promulgated and recommended by the Health Care Advisory Panel to the Department before the effective date of the regulation.

1.9 Section 2322D, Chapter 23, Title 19, **Delaware Code** authorizes and directs the Department to adopt by regulation complete rules and regulations relating to Health Care Provider Certification within one (1) year after the first meeting of the Health Care Advisory Panel.

1.10 Section 2322E, Chapter 23, Title 19, **Delaware Code**, authorizes and directs the Health Care Advisory Panel to approve, propose and recommend to the Department the adoption by regulation of consistent forms for the health care providers ("HCAP Forms").

11 DE Reg. 920 (01/01/08)
17 DE Reg. 322 (09/01/13)

2.0 Definitions

As used in this regulation:

"**Certification**" means the certification pursuant to 19 **Del.C.** §2322D, required for a Health Care Provider to provide treatment to an employee, pursuant to Delaware's Workers' Compensation Statute.

"**Certification of Health Care Providers in an Inpatient Hospital Setting**." With regard to health care provider certification as required by 19 **Del.C.** §2322D, such certification applies to physicians, chiropractors, and physical therapists providing treatment to an injured worker during his or her period of inpatient hospitalization; all other personnel employed by a hospital providing treatment to an injured worker during his or her period of inpatient hospitalization are excluded from certification.

"**Department**" means the Department of Labor.

"**Fee Schedule Amounts**" mean the fees as set forth by the Health Care Payment System.

"**HCAP Forms**" means the standard forms for the provision of health care services set forth in Section 2322E, Chapter 23, Title 19, **Delaware Code**.

"**Health Care Advisory Panel**" or "**HCAP**" means the seventeen (17) members appointed by the Governor by and with the consent of the Senate to carry out the provisions of Chapter 23, Title 19, **Delaware Code**.

"**Health Care Payment System**" means the comprehensive fee schedule promulgated by the Health Care Advisory Panel to establish medical payments for both professional and facility fees generated on workers' compensation claims.

"**Health Care Provider Application for Certification**" means the Department's approved application form which Health Care Providers must submit to the Department so that pre-authorization of each health care procedure, office visit or health care service to be provided to the employee is not required.

"**Utilization Review**" means the utilization review program and associated procedures to guide utilization of health care treatments in workers' compensation as set forth in Section 2322F(j), Chapter 23, Title 19, **Delaware Code.**

13 DE Reg. 1558 (06/01/10)

3.0 Health Care Provider Certification

3.1 Section 2322D(a), Chapter 23, Title 19, **Delaware Code** establishes the minimum certification requirement to be certified as a Health Care Provider:

3.1.1 With regard to the Certification of any hospital facility providing inpatient and/or outpatient services, the person completing and signing the Health Care Provider Application for Certification on behalf of the hospital shall have the authority to do so and must attest to and be responsible for the completion of all of the requirements set forth on the Health Care Provider Application for Certification.

3.1.2 Services provided by an emergency department of a hospital pursuant to §2322B(8)(c) of Chapter 23, Title 19, **Delaware Code** shall not be subject to the requirement of Certification.

3.1.3 The provisions of this section shall apply to all treatment of employees provided after the effective date of these rules and regulations regardless of the date of injury.

3.1.4 In accordance with the provisions of 19 **Del.C.** §2322(D), certification is required for a health care provider to provide treatment to an employee, pursuant to Delaware's Workers' Compensation Statute, without the requirement that the health care provider first pre-authorize each health care procedure, office visit or health care service to be provided to the employee with the employer if self-insured, or the employer's insurance carrier. Pursuant to 19 **Del.C.** §2322B and F, for purposes of the Certification requirements of §2322D, "health care provider in an inpatient hospital setting" specifically includes physicians, chiropractors and physical therapists providing treatment to an injured worker during his/her period of inpatient hospitalization; all other personnel employed by a hospital providing treatment to an injured worker during his/her period of inpatient hospitalization are excluded from the Certification requirements of this Subsection. With regard to any hospital facility providing inpatient and/or outpatient services, to be Certified in accordance with the provisions of §2322D so that pre-authorization from the employer or insurance carrier for the employer is not required for each health care procedure, office visit or health care service provided to an injured employee, the person completing and signing the Health Care Provider Application for Certification on behalf of the hospital shall have the authority to do so and must attest to and be responsible for the completion of all of the requirements set forth on such Application. Services provided by an emergency department of a hospital pursuant to §2322B(8)(c) shall not be subject to the requirement of Certification. The provisions of §2322(D) shall apply to all treatments to employees provided after the effective date of the rule/regulation provided by this subsection and regardless of the date of injury. A health care provider shall be certified only upon meeting the following minimum certification requirements:

3.1.4.1 Have a current license to practice, as applicable;

3.1.4.2 Meet other general certification requirements for the specific provider type;

3.1.4.3 Possess a current and valid Drug Enforcement Agency ("DEA") registration, unless not required by the provider's discipline and scope of practice;

3.1.4.4 Have no previous involuntary termination from participation in Medicare, Medicaid or the Delaware workers' compensation system. Any such involuntary termination shall be considered to be inconsistent with certification;

3.1.4.5 Have no felony convictions in any jurisdiction, under a federal-controlled substance act or for an act involving dishonesty, fraud or misrepresentation. A felony conviction in any jurisdiction under a federal-controlled substance act or for an act involving dishonesty, fraud or misrepresentation shall be considered to be inconsistent with certification;

3.1.4.6 Provide proof of adequate, current professional malpractice and liability insurance.

3.1.5 In addition to the above, the health care provider to be certified must agree to the terms and conditions set forth on the Health Care Provider Application for Certification, as follows:

3.1.5.1 Comply with Delaware workers' compensation laws and rules;

3.1.5.2 Maintain acceptable malpractice coverage;

3.1.5.3 Complete state-approved continuing education courses in workers' compensation every two (2) years from the last date the health care provider renewed his or her Delaware professional license. Out of state health care providers, who are not licensed in Delaware, must complete State-approved continuing education courses in workers' compensation every two (2) years from the date of the out of state provider's initial certification. A listing of continuing education courses in workers' compensation care approved by the State of Delaware, Department of Labor, Office of Workers' Compensation, will be posted on the Office of Workers' Compensation website. To maintain certification, the health care provider must provide written notification to the Office of Workers' Compensation of compliance with the continuing education course requirement noted above, setting forth the name of the course(s) completed and the date of completion, in accordance with the above;

3.1.5.4 Practice in a best-practices environment, complying with practice guidelines and Utilization Review Accreditation Council ("URAC") utilization review determinations;

3.1.5.5 Agree to bill only for services and items performed or provided, and medically necessary, cost-effective and related to the claim or allowed condition;

3.1.5.6 Agree to inform an employee of his or her liability for payment of non-covered services prior to delivery;

3.1.5.7 Accept reimbursement for and not unbundle charges into separate procedure codes when a single procedure code is more appropriate;

3.1.5.8 Agree not to balance bill any employee or employer. Employees shall not be required to contribute a co-payment or meet any deductibles;

3.1.5.9 Agree to have knowledge of all statements authorized under the certified health care provider's signature and to be responsible for the content of all bills submitted pursuant to the provisions of 19 **Del.C.** §§2322B, C, E, F;

3.1.5.10 Agree to provide written notification to the Department of Labor, Office of Workers' Compensation, State of Delaware, of any relevant changes to the requirements set forth in the Certification Form within thirty (30) days of the health care provider's knowledge or receipt of notice of any and all such change(s).

3.1.6 Notwithstanding the provisions of §2322D of Chapter 23, Title 19, **Delaware Code**, any health care provider may provide services during one office visit, or other single instance of treatment, without first having obtained prior authorization from the employer if self insured, or the employer's insurance carrier, and receive reimbursement for reasonable and necessary services directly related to the employee's injury or condition at the health care provider's usual and customary fee, or the maximum allowable fee pursuant to fee schedule adopted pursuant to Section 2322B of Chapter 23, Title 19, **Delaware Code** whichever is less.

3.1.7 The allowance of reimbursement for the employee's first contact with any health care provider for treatment of the injury as described in 3.1.4 is further limited to instances when the health care provider believes in good faith, that the injury or occupational disease was suffered in the course of the employee's employment.

3.1.8 The provisions of this subsection, §2322(D), shall apply to all treatments to injured employees provided after the effective date of this subsection, and regardless of the date of injury.

3.2 Completed Certification should be mailed to:

Ms. Donna Forrest

State of Delaware Department of Labor
Office of Workers' Compensation
Wilmington, DE 19809-9954

3.3 Instructions and provisions for completing the Certification Form online will be published on the Office of Workers' Compensation website when available.

14 DE Reg. 1375 (06/01/11)
17 DE Reg. 322 (09/01/13)

4.0 Workers' Compensation Health Care Payment Rates for Physicians and Hospitals (the "Fee Schedule"). Instructions and Guidelines

Introduction and Purpose

The intent of the health care payment system developed pursuant to Delaware's Workers' Compensation Act ("Act") is not to establish a "pushdown" system, but is instead to establish a system that eliminates outlier charges and streamlines payments by creating a presumption of acceptability of charges implemented through a transparent process, involving relevant interested parties, that prospectively responds to the cost of maintaining a health care practice, eliminating cost shifting among health care service categories, and avoiding institutionalization of upward rate creep.

The maximum allowable payment for health care treatment and procedures covered under the Workers' Compensation Act shall be the lesser of the health care provider's actual charges or the fee set by the payment system. The payment system will set fees at ninety percent (90%) of the 75th percentile of actual charges within the geozip where the service or treatment is rendered, utilizing information contained in employers' and insurance carriers' national databases. For purposes of the Act, "geozip" means an area defined by reference to United States ZIP Codes; Delaware shall consist of one "197 geozip" (comprised of all areas within the State where the address has a ZIP Code beginning with the three digits 197 or 198), and one "199 geozip" (comprised of all areas within the State where the address has a ZIP Code beginning with the three digits 199). If a geozip does not have the necessary number of charges and fees to calculate a valid percentile for a specific procedure, treatment or service, the Health Care Advisory Panel created pursuant to 19 **Del.C.** §2322(A), in its discretion may combine data from Delaware's two geozips for a specific procedure, treatment, or service. In the event that the Health Care Advisory Panel determines that there is insufficient data to calculate a valid percentile for a procedure, treatment or service, or that data from a commercial vendor is not sufficiently reliable to implement a payment system for professional services for a specific procedure, treatment or service, then the Health Care Advisory Panel may recommend an alternative method for a payment system for professional charges.

Three (3) years after the effective date of the Act, January 17, 2007, the Health Care Advisory panel shall review the geozip reporting system and make a recommendation concerning whether the State should operate its workers' compensation health care payment system on a geozip basis or on a single statewide basis.

If an employer or an insurance carrier contracts with a provider for the purpose of providing services under the Act, the rate negotiated in any such contract shall prevail.

This document is intended to assist with fee schedule application, and to ensure correct billing and reimbursement on workers' compensation medical claims. This document is NOT intended, and should not be construed, as a utilization review guide or practice manual.

The general payment system will be adjusted yearly based on percentage changes to the Consumer Price Index-Urban, U.S. City Average, All Items, as published by the United States Bureau of Labor Statistics. The Hospital and Ambulatory Surgery Treatment Center (ASTC) payment system will be adjusted yearly based on percentage changes to the Consumer Price Index-Urban, U.S. City Average, Medical Care, as published by the United States Bureau of Labor Statistics.

The physician portion of the fee schedule includes fee amounts for specific medical services and procedures as identified using CPT numeric identifying codes and modifiers for reporting medical services and procedures as established by the 2008 Current Procedural Terminology (CPT), copyright American Medical Association (AMA). Any use or interpretation of CPT descriptions not specifically described herein shall be based on CPT 2008.

4.1 Format of the Fee Schedule

This fee schedule represents the maximum amount of reimbursement providers may receive for medical or surgical services for the treatment of work-related injuries and illnesses covered under the workers' compensation laws of the State of Delaware.

4.1.1 The maximum allowable reimbursement for CPT codes is generally separable into eight distinct sections based on the category or type of service rendered. Each category of service has separate instructions for

the application of ground rules and modifier adjustments. The categories of service subject to this fee schedule are:

For each procedure, the fee schedule table includes the following details (if applicable):

4.1.1.1 New (*?*), changed descriptor (?), add-on (+), modifier 51 exempt (*), or conscious sedation (K) icons

4.1.1.2 Five-digit CPT code number

4.1.1.3 CPT description

4.1.1.4 Maximum allowable reimbursement

4.1.1.5 Maximum reimbursement for professional component modifier 26

4.1.1.6 Maximum reimbursement for technical component modifier TC

4.1.1.7 Follow-up day limits in FUD column

4.1.2 The total maximum allowable reimbursement includes the professional component for a procedure and the technical component. Under no circumstances shall the maximum allowable reimbursement be more than the value of the technical component and the professional component combined for a procedure.

4.1.3 For anesthesia fee amounts, anesthesia services provided to employees pursuant to this chapter shall be paid, pursuant to 19 **Del.C.** §2322B(7).

4.1.4 General Medical Services Categories CPT Codes

Evaluation & Management	99201–99499
Anesthesia	00100–01999, 99100–99140
Surgery	10021–69990
Radiology	70010–79999
Pathology & Laboratory	80048–89356
General Medicine	90281–96999, 97802–97804, 98960–99091, 99143-99199, 99500-99607
Physical Medicine	97001–97799, 97810–98943
HCPCS	A0000-V9999

4.1.4.1 Within each section, you will find definitions and medical terms that explain services provided. Also, in certain sections there is an index of procedures by CPT code identifiers. Use each specific section in addition to general ground rules for clarification of terms and services.

4.1.4.2 The fee schedule is designed to be an accurate and authoritative source of information about medical coding and reimbursement. Every reasonable effort has been made to verify its accuracy and all information is believed reliable at the time of publication. Absolute accuracy and completeness, however, is neither intended nor guaranteed. The rules and guidelines described herein cannot specifically refer to every payment contingency; 19 **Del.C.** §2322B(5) will govern treatment provided under unusual circumstances.

4.1.5 Reference Materials

The health care payment system and fee schedule is in accordance with the following documents, including codes, guidelines and modifiers:

- *Current Procedural Terminology*, copyright, American Medical Association, 515 N. State St., Chicago, IL 60610, Chicago, 2006;
- *HCPCS Level II*, U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 7500 Security Blvd., Baltimore, MD 21244, Baltimore, 2006;
- *National Correct Coding Policy Manual in Comprehensive Code Sequence for Part B Medicare Carriers, Version 12.0,* U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, 7500 Security Blvd., Baltimore, MD 21244, Baltimore, 2006;

- Diagnosis-Related Group (DRG) classification system, Centers for Medicare and Medicaid Services (CMS), *Federal Register*, Vol. 70, No. 155, August 2005.
- The follow up days for post-operative care that have been adopted by the Delaware Office of Workers' Compensation for their Fee Schedule and Guidelines have been established by reference to CMS (Centers for Medicare and Medicaid Services).

4.2 HCPCS (Healthcare Common Procedure Coding System) (Level II)

The health care payment system requires that services be reported with the Healthcare Common Procedural Coding System Level 2 ("HCPCS Level 2"), CPT (Current Procedural Terminology), or CDT (Current Dental Terminology) codes that most comprehensively describe the services performed. Proprietary bundling edits more restrictive than the National Correct Coding Policy Manual in Comprehensive Code Sequence for Part B Medicare Carriers, Version 12.0, U.S. Department of Health and Human Services, Centers for Medicare and Medicare Services, 7500 Security Boulevard, Baltimore, Maryland, 21244, 2009, no later dates or editions, shall be prohibited. Bundling edits is the process of reporting codes so that they most comprehensively describe the services performed.

4.3 Professional Services/CPT Code Set

4.3.1 Unless otherwise specified herein, the payment system for professional services shall conform to the Current Procedural Terminology ("CPT"), American Medical Association, 515 North State Street, Chicago, Illinois, 60610.

4.3.2 The fee schedule defers to guides and descriptions in the CPT Code Set in establishing the correct classification for health care services.

4.3.3 For codes that are deleted and bundled, the remaining/new code will be adjusted to reflect the value of the previously unbundled/deleted codes, so the charge is revenue neutral. For entire procedures that are bundled into a new code, the new code will include the value of the previously segregated codes. The Department of Labor will publish to its web site additional special instructions associated with the revenue neutral fee conversion, where applicable. Once revenue neutral fees are established, they will adjust with the annual CPI-U adjustment referenced in 19 **Del.C.** §2322(3).

4.4 Physician/Health Care Provider Services

4.4.1 The maximum allowable payment for health care treatment and procedures shall be the lesser of the health care provider's actual charges or ninety percent (90%) of the 75th percentile of actual charges within the geozip where the service or treatment is rendered, utilizing information contained in employers' and insurance carriers' national databases. If an employer or insurance carrier contracts with a provider for the purpose of providing services under the Act, the rate negotiated in such contract shall prevail.

4.4.2 Whenever 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 eighty-five percent (85%) of actual charge ("POC 85").

4.4.3 The payment system will be adjusted yearly pursuant to 19 **Del.C.** §2322B(14).

4.5 Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. If more than one modifier is needed, place modifier 99 after the procedure code to indicate that two or more modifiers will follow. Some modifier descriptions in this fee schedule have been changed from the CPT language.

4.6 Ambulatory Surgical Treatment

4.6.1 Ambulatory Surgery Centers shall be reimbursed pursuant to 19 **Del.C.** §2322B(9).

4.7 Dental Services

4.7.1 Whenever the health care payment system does not set a specific fee for a dental treatment, procedure or service in the schedule, the amount of reimbursement shall be eighty-five percent (85%) of actual charge ("POC 85") for such service as of October 31, 2006, subject to verification, review and/or audit by the Department of Insurance. Reasonable costs of such review or audit shall be reimbursed to the Department of Insurance by the dental practitioner whose billing is audited.

4.7.2 The payment system will be adjusted pursuant to 19 **Del.C.** §2322B(14) for a dental treatment procedure or service in effect in January of that year.

4.8 Emergency Department of a Hospital

4.8.1 Emergency services in a hospital shall be reimbursed pursuant to 19 **Del.C.** §2322B(8)(b).

4.9 Hospital

4.9.1 Hospital fees shall be reimbursed pursuant to 19 **Del.C.** §2322B(8).

4.10 Allied Health Care Professional

An allied health care professional, such as a certified registered nurse anesthetist ("CRNA"), physician assistant ("PA") or nurse practitioner ("NP"), shall be reimbursed at the same rate as other health care professionals when the allied health care professional is performing, coding and billing for the same services as other health care professionals if a physician health care provider is physically present when the service or treatment is rendered, and shall be reimbursed at eight percent (80%) of the primary health care provider's rate if a physician health care provider is not physically present when the service or treatment is rendered.

4.11 Independently Operated Diagnostic Testing Facility

4.11.1 Charges of an independently operated diagnostic testing facility shall be subject to the professional services and HCPCS Level II health care payment system where applicable. An independent diagnostic testing facility is an entity independent of a hospital or physician's office, whether a fixed location, a mobile entity, or an individual non-physician practitioner, in which diagnostic tests are performed by licensed or certified non-physician personnel under appropriate physician supervision.

4.11.2 In the event that the professional services and HCPCS Level II health care payment system is inapplicable, the fee for reimbursement of independent diagnostic testing facility services shall be eight-five percent (85%) of actual charge ("POC 85").

4.11.3 The payment system will be adjusted yearly pursuant to 19 **Del.C.** §2322B(14) for a procedure, treatment or service in effect in January of that year.

4.12 Pathology

4.12.1 The maximum allowable payment for pathology services and procedures shall be the lesser of the health care provider's actual charges or eighty-five percent (85%) of ninety percent (90%) of the 75th percentile of actual charges within the geozip where the pathology service or procedure is rendered, utilizing information contained in employers' and insurance carriers' national databases. If an employer or insurance carrier contracts with a provider for the purpose of providing services under the Act, the rate negotiated in such contract shall prevail.

4.12.2 Whenever the health care payment system does not set forth a specific fee for a pathology service or procedure in the schedule, the amount of reimbursement shall be eighty-five percent (85%) of actual charge ("POC 85").

4.12.3 The payment system will be adjusted yearly pursuant to 19 **Del.C.** §2322B(14) for a procedure, treatment or service in effect in January of that year.

4.13 Pharmacy

4.13.1 Prescribed drugs are capped at the lesser of the provider's usual charge; a negotiated contract amount; or the Average Wholesale Price (AWP) for the National Drug Code (NDC) for the prescription drug or medicine on the day it was dispensed minus twelve percent (12%) plus a dispensing fee of four dollars ($4.00) for brand name drugs or medicines, or minus twenty percent (20%) plus a dispensing fee of five dollars ($5.00) for generic drugs or medicines. If the actual charge is less than this amount, then it is the maximum allowed. Physicians dispensing drugs from their office do not receive the dispensing fee referenced above.

4.13.2 Definitions:

4.13.2.1 "**Average Wholesale Price**" or "**AWP**" means the average wholesale price of a prescription drug as provided in the most current release of the ~~Red Book by Thomson Media or~~ Medi-Span Master Drug Database by Wolters Kluwar Health on the day a prescription drug is dispensed or other nationally recognized drug pricing index adopted by the Health Care Advisory Panel (HCAP).

4.13.2.2 "**Brand name drug**" means a drug for which an application is approved under the Federal Food, Drug, and Cosmetic Act Section 505(c).

4.13.2.3 "**Generic drug**" means a drug for which an application is approved under the Federal Food, Drug, and Cosmetic Act Section 505(j).

4.13.3 Notwithstanding any other provision, if a prescription drug or medicine has been repackaged, the Average Wholesale Price used to determine the maximum reimbursement in controverted and uncontroverted cases shall be the Average Wholesale Price for the underlying drug product, as identified by its national drug code, from the original labeler.

4.13.4 Compounding includes the preparation, mixing, assembling, packaging, or labeling of a drug or device as the result of a practitioner-patient-pharmacist relationship in the course of professional practice. Compound drugs shall be billed by listing each drug included in the compound and separately calculating the charge for each drug, using national drug codes (NDC). When compounding, a single compounding fee of ten dollars ($10.00) per prescription shall be added to the calculated total.

4.13.5 As of the effective date of this Regulation, Oxycontin as well as oxycodone extended release; and Actiq, as well as transmucosal fentanyl, are not on the Preferred or Non-Preferred Medication List and may only be used with prior written approval of the employer or its insurance carrier. However, an employee on a stable dose of Oxycontin prior to the effective date of this Regulation may continue the use of this medication after the effective date of this Regulation.

4.13.6 The Fee Schedule created by this Regulation shall not apply to prescription drugs or medicines provided as part of treatment subject to the inpatient Fee Schedule set forth in 19 **Del.C.** §2322B(8).

4.13.7 Pursuant to this Regulation, the "Preferred Agents" and "Non-Preferred Agents" categories, as set forth on the Department of Labor (DOL) web site is hereby adopted. The Health Care Advisory Panel (HCAP) shall review on an annual basis, beginning July 1, 2014, those portions of the Preferred Drug List (PDL) referenced above.

4.13.8 When a brand name drug is prescribed to treat an injury for which a carrier or self-insured employer is liable, the pharmacist or medical provider dispensing the drug or medication shall substitute a preferred/ generic drug pursuant to this Regulation as set forth above. A physician may prescribe and a pharmacist must dispense a non-preferred/brand name drug or medication only upon the physician's or other authorized individual's completion of the "Justification For Use Of Non-Preferred Medication" form, approved by the Health Care Advisory Panel and set forth on the Department of Labor (DOL) web site. A provider may prescribe a medication from the Non-Preferred Agent list if the patient has trialled the use of two preferred agents and the trials have failed due to lack of efficacy or unacceptable side effects. Preferred agent trials should be documented in the medical record.

4.14 Total Component/Professional Component, Technical Component

4.14.1 A total fee includes both the professional component and the technical component needed to accomplish the procedure. Explanations of the professional component and the technical component are listed below. The values listed in the Amount column represent the total reimbursement. Under no circumstance shall the combined amounts of the professional and technical components exceed the amount of the total component.

4.14.2 Professional Component: The professional component represents the reimbursement allowance of the professional 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. Values in the PC Amount column are intended for the services of the professional for the professional component only and do not include any other charges. To identify a charge for a professional component only, use the five-digit code followed by modifier 26.

4.14.3 Technical Component: The technical component includes charges made by the institution or clinic to cover the services of the facilities. To identify a charge for a technical component only, use of the five-digit code followed by HCPCS Level II modifier TC.

4.15 Billing and Payment for Health Care Services

4.15.1 Pursuant to 19 **Del.C.** §2322F**,** charges for medical evaluation, treatment and therapy, including all drugs, supplies, tests and associated chargeable items and events, shall be submitted to the employer or insurance carrier along with a bill or invoice for such charges, accompanied by records or notes, concerning the treatment or services submitted for payment, documenting the employee's condition and the appropriateness of the evaluation, treatment or therapy, with reference to the health care practice guidelines adopted pursuant to 19 **Del.C.** §2322C, or documenting the preauthorization of such evaluation, treatment or therapy. The initial copy of the supporting notes or records shall be produced without separate or additional charge to the employer, insurance carrier or employee.

4.15.2 Those healthcare providers who obtained certification pursuant to 19 **Del.C.** §2322D are not required to first preauthorize each health care procedure, office visit or health care service to be provided to an injured employee with the employer or insurance carrier.

4.15.3 Charges for hospital services and items supplied by a hospital, including all drugs, supplies, tests and associated chargeable items and events, shall be submitted to the employer or insurance carrier along with a bill or invoice which shall be documented in a nationally recognized uniform billing code format and as reference above, in sufficient detail to document the services or items provided, and any preauthorization of the services and items shall also be documented. The initial copy of the supporting medical notes or records shall be produced without separate or additional charge to the employer, insurance carrier or employee.

4.15.4 Payment for hospital services, including payment for invoices rendered for emergency department services, shall be made within thirty (30) days of the submission of a "clean claim" accompanied by notes documenting the employee's condition and the appropriateness of the evaluation, treatment or therapy.

4.15.5 Preauthorized evaluations, treatments or therapy shall be paid at the agreed fee within thirty (30) days of the date of submission of the invoice, unless the compliance with the preauthorization is contested, in good faith, pursuant to the utilization review system set forth in 19 **Del.C.** §2322F(j) [see the rules and regulation regarding Utilization Review].

4.15.6 Treatments, evaluations and therapy provided by a certified health care provider shall be paid within thirty (30) days of receipt of the health care provider's bill or invoice together with records or notes as provided above and pursuant to 19 **Del.C.** §2322F, unless compliance with the health care payment system or practice guidelines adopted pursuant to 19 **Del.C.** §§2322B or 2322C is contested, in good faith, pursuant to the utilization review system as referenced above.

4.15.7 Denial of payment of health care services provided pursuant to the Act, whether in whole or in part, shall be accompanied with written explanation for reason for denial.

4.15.8 In the event that a portion of a health care invoice is contested, the uncontested portion shall be paid without prejudice to the right to contest the remainder. The time limits set forth above and in §2322F shall apply to payment of all uncontested portions of health care payments.

4.15.9 An employer or insurance carrier shall be required to pay a health care invoice within thirty (30) days of receipt of the invoice as long as the claim contains substantially all the required data elements necessary to adjudicate the invoice, unless the invoice is contested in good faith. If the contested invoice pertains to an acknowledged compensable claim and the denial is based upon compliance with the health care payment system and/or health care practice guidelines, it shall be referred to utilization review. Unpaid invoices shall incur interest at a rate of one percent (1%) per month payable to the provider. A provider shall not hold an employee liable for costs related to non-disputed services for a compensable injury and shall not bill or attempt to recover from the employee the difference between the provider's charge and the amount paid by the employer or insurance carrier on a compensable injury.

4.15.10 If, following a hearing, the Industrial Accident Board determines that an employer, an insurance carrier, or health care provider failed in its responsibilities under 19 **Del.C.** §§2322B, 2322C, 2322D, 2322E or 2322F, it shall assess a fine of not less than $1,000.00 nor more than $5,000.00 for violations of said sections, such fines shall be payable to the Workers' Compensation Fund.

4.15.11 Payment Rates for Physicians and Hospitals (Fee Schedule)

http://regulations.state.de.us/AdminCode/title19/1000/1300/1340/feeschedule.pdf Fee Schedule

4.16 Fees for Non-Clinical Services

4.16.1 Pursuant 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 Health Care Advisory Panel to reflect changes in the cost of providing such services:

4.16.1.1 Retrieving, copying and transmitting existing medical reports and records, to include copying of medical notes and/or records supporting a bill or invoice for charges for treatment or services:

- $25.00 for search and retrieval
- $1.25 per page for first 20 pages
- $.90 per page for pages 21 through 60
- $.30 per page for pages 61 and thereafter

4.16.1.2 Testimony by a physician for non-video deposition shall not exceed $2,000.00; for video deposition: $500.00 additional;

4.16.1.3 Live testimony by a physician at any hearing or proceeding shall not exceed $3,500.00;

4.16.1.4 Completion and transmission of any Statutorily required report, form or document by a physician/ health care provider: $30.00.

4.17 Effective Date

4.17.1 The health care payment system shall apply to all services provided after the effective date of the health care payment system regulations and regardless of date of injury.

4.17.2 The Department of Labor of the State of Delaware reserves the authority to determine applicability of all rules of the fee schedule. Any physician, other medical professional, or other entity having questions regarding applicability to their individual reimbursement as it applies to the fee schedule, should direct any such question to the Department of Labor or to such other authority as directed by the Department of Labor.

4.18 General Rules

4.18.1 Definitions

"**Adjust"** means that a payer or a payer's agent reduces or otherwise alters a health care provider's request for payment.

“**Appropriate care**” means health care that is suitable for a particular patient, condition, occasion, or place.

“**Bill**” means a claim submitted by a provider to a payer for payment of health care services provided in connection with a covered injury or illness.

“**Bill adjustment**” means a reduction of a fee on a provider's bill, or other alteration of a provider's bill.

“**Carrier**” means any stock company, mutual company, or reciprocal or inter-insurance exchange authorized to write or carry on the business of Workers' Compensation Insurance in this State, or self-insured group, or third-party payer, or self-insured employer, or uninsured employer.

“**CMS-1500**” means the CMS-1500 form and instructions that are used by non institutional providers and suppliers to bill for outpatient services. Use of the most current CMS-1500 form is required.

“**Case**” means a covered injury or illness occurring on a specific date and identified by the worker's name and date of injury or illness.

“**Consultation**” means a service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or other appropriate source. If a consultant, subsequent to the first encounter, assumes responsibility for management of the patient's condition, that physician becomes a treating physician. The first encounter is a consultation and shall be billed and reimbursed as such. A consultant shall provide a written report of his/her findings. A second opinion is considered a consultation.

“**Critical care**” means care rendered in a variety of medical emergencies that requires the constant attention of the practitioner, such as cardiac arrest, shock, bleeding, respiratory failure, postoperative complications, and is usually provided in a critical care unit or an emergency department.

“**Day**” means a continuous 24-hour period.

“**Diagnostic procedure**” means a service that helps determine the nature and causes of a disease or injury.

“**Durable medical equipment (DME)**” means specialized equipment designed to stand repeated use, appropriate for home use, and used solely for medical purposes.

“**Expendable medical supply**” means a disposable article that is needed in quantity on a daily or monthly basis.

“**Follow-up care**” means the care which is related to the recovery from a specific procedure and which is considered part of the procedure's maximum reimbursement allowance, but does not include complications.

“**Follow-up days**” are the days of care following a surgical procedure which are included in the procedure's maximum reimbursement allowance amount, but which do not include complications. The follow-up day period begins on the day of the surgical procedure(s).

“**Independent procedure**” means a procedure that may be carried out by itself, completely separate and apart from the total service that usually accompanies it.

“**Inpatient services**” means services rendered to a person who is admitted as an inpatient to a hospital.

“**Medical record**” means a record in which the medical service provider records the subjective findings, objective findings, diagnosis, treatment rendered, treatment plan, and return to work status and/or goals and impairment rating as applicable.

“**Medical supply**” means either a piece of durable medical equipment or an expendable medical supply.

“**Observation services**” means services rendered to a person who is designated or admitted as observation status.

“**Operative report**” means the practitioner's written description of the surgery and includes all of the following:

- A preoperative diagnosis;
- A postoperative diagnosis;
- A step-by-step description of the surgery;
- A description of any problems that occurred in surgery; and
- The condition of the patient upon leaving the operating room.

“**Optometrist**” means an individual licensed to practice optometry.

“**Orthotic equipment**” means an orthopedic apparatus designed to support, align, prevent, or correct deformities, or improve the function of a movable body part.

“**Orthotist**” means a person skilled in the construction and application of orthotic equipment.

“**Outpatient service**” means services provided to patients at a time when they are not hospitalized as inpatients.

"**Payer**" means the employer or self-insured employed group, carrier, or third-party administrator (TPA) who pays the provider billings.

"**Pharmacy**" means the place where the science, art, and practice of preparing, preserving, compounding, dispensing, and giving appropriate instruction in the use of drugs is practiced.

"**Physician Specialty**". The rules and reimbursement allowances in the Delaware Workers' Compensation Medical Fee Schedule do not address physician specialization within a specialty. Payment is not based on the fact that a physician has elected to treat patients with a particular/specific problem. Reimbursement to qualified physicians is the same amount regardless of specialty.

"**Procedure code**" means a five-digit numerical sequence or a sequence containing an alpha character and preceded or followed by four digits, which identifies the service performed and billed.

"**Prosthesis**" means an artificial substitute for a missing body part.

"**Prosthetist**" means a person skilled in the construction and application of prostheses.

"**Provider**" means a facility, health care organization, or a practitioner who provides medical care or services.

"**Secondary procedure**" means a surgical procedure performed during the same operative session as the primary surgery but considered an independent procedure that may not be performed as part of the primary surgery.

4.18.2 Injections

4.18.2.1 Reimbursement for injections includes charges for the administration of the drug and the cost of the supplies to administer the drug. Medications are charged separately.

4.18.2.2 The description must include the name of the medication, strength, and dose injected.

4.18.2.3 When multiple drugs are administered from the same syringe, reimbursement will be for a single injection.

4.18.2.4 Reimbursement for anesthetic agents such as Xylocaine and Carbocaine, when used for infiltration, is included in the reimbursement for the procedure performed and will not be separately reimbursed.

4.18.2.5 Anesthetic agents for local infiltration must not be billed separately; this is included in the reimbursement for the procedure.

4.18.2.6 Reimbursement for intra-articular and intra-bursal injections (steroids and anesthetic agents) may be separately billed. The description must include the name of the medication, strength, and volume given.

4.18.3 General Ground Rules

4.18.3.1 Multiple Procedures. It is appropriate to designate multiple procedures that are rendered on the same date by separate entries. For Example, if a level three established patient office visit (99213) and an ECG (93000) are performed during the visit, it is appropriate to designate both the established patient office visit and the ECG. In this instance both 99213 and 93000 would be reported.

4.18.3.2 Materials Supplied by Physician. Supplies and equipment used in conjunction with medication administration should be billed with the appropriate HCPCS codes and shall be reimbursed according to the Fee Schedule.

4.18.3.3 Separate Procedures

4.18.3.3.1 Some of the procedures or services listed in the CPT codebook that are commonly carried out as an integral component of a total service or procedure have been identified by the inclusion of the term "separate procedure." The codes designated as "separate procedure" should not be reported in addition to the code for the total procedure or service of which it is consider an integral component.

4.18.3.3.2 However, when a procedure or service that is designated as a "separate procedure" is carried out independently or considered to be unrelated or distinct from other procedure/services provided at that time, it may be reported by itself, or in addition to other procedures/services by appending modifier 59 to the specific "separate procedure" code to indicate that the procedure is not considered to be a component of another procedure, but is a distinct, independent procedure. This may represent a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries).

4.18.3.4 Concurrent/Coordinating Care. Providing similar service (e.g., hospital visits by more than one physician) to the same injured employee on the same day for treatment of the same illness is

concurrent care. When concurrent care is provided, no special reporting is required. Duplicate services, however, (e.g., visit by a physician of the same subspecialty for the same illness which is not a second opinion) will not be reimbursed. The authorized treating physician should coordinate care by all specialists.

4.18.3.5 Alternating Physicians. When physicians of similar skills alternate in the care of a patient (e.g., partners, groups, or same facility covering for another physician on weekends or vacation periods), each physician shall bill individually for the services each personally rendered and in accordance with the Medical Fee Schedule.

4.18.3.6 Ground Rules for Physician Assistants (PA) and Nurse Practitioners (NP)

4.18.3.6.1 Physician Supervision

Definition of Supervision

The term "supervise," for billing purposes, encompasses the following supervision requirement:

Direct personal supervision in the office setting does not mean that the physician must be present in the same room with a PA or NP. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the PA or NP is performing the services. In this instance, reimbursement should be made at the normal physician payment level as if the physician had provided the service. If the PA or NP provides care to the injured worker and the supervising physician is not immediately available, the reimbursements will be at 80% of the fee schedule rate.

4.18.3.6.2 Billing for PA or NP Service. The physician must render the bill for care, with the ensuing payment for the PA or NP service made directly to the physician employer.

4.18.3.6.3 Management of a New or Established Patient with a New Workers' Compensation Problem

If the physician supervises the physician assistant's or nurse practitioner's evaluation, payment should be made at the physician's normal Workers' Compensation level for PA or NP services rendered in an outpatient setting.

Where on-site direct physician supervision is not available and the physician assistant or nurse practitioner providing patient care is only able to communicate with a physician supervisor by telephone or other effective means of communication, payment for this service should be made at 80% of the Physician Payment Schedule.

Physician assistants and nurse practitioners acting in the capacity of an assistant at surgery will receive 20% percent of the total allowance for the surgical procedures. Payment will be made to the physician assistant's or nurse practitioner's employer (the physician).

4.18.3.6.4 Follow-up Care of an Existing Patient with a Compensable Problem. If the physician supervises the physician assistant's or nurse practitioner's evaluation, payment should be made at the physician's normal reimbursement level for the PA or NP services rendered in the outpatient setting.

4.18.3.6.5 Modifiers for Physician Assistant and Nurse Practitioner Services. When a physician assistant (PA) or nurse practitioner (NP) bills for services other than assistant at surgery, modifiers "PA" or "NP" are used. Modifier 83, AS, is used to identify assistant at surgery services provided by a physician assistant or nurse practitioner.

4.18.3.7 Add-On Procedures

Appendix D from the American Medical Association's 2009 CPT Codes
Summary of CPT Add-on Codes

01953	01968	01969	11001	11008	11101	11201	11732	11922	13102
13122	13133	13153	15003	15005	15101	15111	15116	15121	15131
15136	15151	15152	15156	15157	15171	15176	15201	15221	15241
15261	15301	15321	15331	15336	15341	15361	15366	15401	15421
15431	15787	15847	16036	17003	17312	17314	17315	19001	19126
19291	19295	19297	20930	20931	20936	20937	20938	20985	22103
22116	22208	22216	22226	22328	22522	22525	22527	22534	22585
22614	22632	22840	22841	22842	22843	22844	22845	22846	22847
22848	22851	26125	26861	26863	27358	27692	31620	31632	31633

31637	32501	33141	33225	33257	33258	33259	33508	33517	33518
33519	33521	33522	33523	33530	33572	33768	33884	33924	33961
34806	34808	34813	34826	35306	35390	35400	35500	35572	35600
35681	35682	35683	35685	35686	35697	35700	36218	36248	36476
36479	37185	37186	37206	37208	37250	37251	38102	38746	38747
43273	43635	44015	44121	44128	44139	44203	44213	44701	44955
47001	47550	48400	49326	49435	49568	49905	51797	56606	57267
58110	58611	59525	60512	61316	61517	61609	61610	61611	61612
61641	61642	61795	61797	61799	61800	61864	61868	62148	62160
63035	63043	63044	63048	63057	63066	63076	63078	63082	63086
63088	63091	63103	63295	63308	63621	64472	64476	64480	64484
64623	64627	64727	64778	64783	64787	64832	64837	64859	64872
64874	64876	64901	64902	65757	66990	67225	67320	67331	67332
67334	67335	67340	69990	74301	75774	75946	75964	75968	75993
75996	76125	76802	76810	76812	76814	76937	77001	77051	77052
78020	78478	78480	78496	78730	83901	87187	87904	88155	88185
88311	88312	88313	88314	90466	90468	90472	90474	92547	92608
92627	92973	92974	92978	92979	92981	92984	92996	92998	93320
93321	93325	93352	93571	93572	93609	93613	93621	93622	93623
93662	94645	95873	95874	95920	95962	95967	95973	95975	95979
96361	96366	96367	96368	96370	96371	96375	96376	96411	96415
96417	96423	96570	96571	97546	97811	97814	99100	99116	99135
99140	99145	99150	99292	99354	99355	99356	99357	99358	99359
99467	99602	99607	0054T	0055T	0063T	0076T	0079T	0081T	0092T
0095T	0098T	0151T	0159T	0163T	0164T	0165T	0172T	0173T	0174T
0189T	0190T	0196T							

4.18.3.8 Exempt from Modifier 51 Codes

4.18.3.8.1 The (*) symbol is used to identify CPT codes that are exempt from the use of modifier 51, but have NOT been designated as CPT add-on procedures/services. As the description implies, modifier 51 exempt procedures are not subject to multiple procedure rules and as such modifier 51 does not apply. Fee schedule amounts for modifier 51 exempt codes are not subject to reduction and should be reimbursed at the lesser of 100 percent of the listed value or the billed amount.

4.18.3.8.2 Modifier 51 exempt services and procedures can be found in Appendix E of CPT 2009 and include the following CPT codes:

Appendix E from the American Medical Association's 2009 CPT Codes
Summary of CPT Codes Exempt from Modifier 51

Note: Procedures on this list are often performed with another procedure or may be performed alone.

17004	20697	20974	20975	31500	36620	44500	61107	93503	93539
93540	93544	93545	93555	93556	93600	93602	93603	93610	93612
93615	93616	93618	93631	94610	95900	95903	95904	95992	99143
99144									

4.18.3.9 Modifiers

Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code: a two-digit number placed after the usual procedure code. If more than one modifier is needed, place modifier

99 after the procedure code to indicate that two or more modifiers will follow. Some modifier descriptions in this fee schedule have been changed from the CPT language.

21 Prolonged Evaluation and Management Services: When the face-to-face or floor/unit service(s) provided is prolonged or otherwise greater than that usually required for the highest level of evaluation and management service within a given category, it may be identified by adding modifier 21 to the evaluation and management code number. A report may also be appropriate.

22 Unusual Procedural Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate. Add an additional 20% to the value of the code when billed with this modifier.

23 Unusual Anesthesia: Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

24 Unrelated Evaluation and Management Services by the Same Physician During a Postoperative Period: The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service: It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service provided above or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for I instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M service on the same date. This circumstance may be reported adding modifier 25 to the appropriate level E/M code. Note: This modifier is not used to report and E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

26 Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

TC Technical Component: Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

27 Multiple Outpatient Hospital E/M Encounters on the Same Date: (This CPT modifier is for use by Ambulatory Surgery Center (ASC) and Hospital Outpatient Settings Only.) For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (e.g., hospital emergency department, clinic). Note: This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient evaluation and management services provided by the same physician on the same date and performed in multiple outpatient setting(s) (e.g., hospital emergency department, clinic), see Evaluation and Management, Emergency Department, or Preventive Medicine Services codes.

32 Mandated Services: Services related to mandated consultation and/or related services (e.g., PRO, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

47 Anesthesia by Surgeon: Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) Note: Modifier 47 would not be used as a modifier for the anesthesia procedures 00100-01999.

50 Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five-digit code.

51 Multiple Procedures: When multiple procedures, other than Evaluation and Management Services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes or modifier 51 exempt codes (See CPT Appendix D.)

52 Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 Discontinued Procedure: Under certain circumstances the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

54 Surgical Care Only: When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

55 Postoperative Management Only: When one physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

56 Preoperative Management Only: When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

57 Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period: The physician may need to indicate that the performance of a procedure or service during the postoperative period was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. Note: This modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier 78.

59 Distinct Procedural Service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

62 Two Surgeons: When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s)) are performed during the same surgical session, separate code(s) may be reported with modifier 62 added. Note: If a co-surgeon acts as an assistant in the performance of an additional procedure(s) during the same surgical session, that service(s) may be reported using separate procedure code(s) with modifier 80 or modifier 81 added, as appropriate.

66 Surgical Team: Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the "surgical team" concept. Such circumstances may be identified by each participating physician with the addition of modifier 66 to the basic procedure number used for reporting services.

76 Repeat Procedure by the Same Physician: The physician may need to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

77 Repeat Procedure by Another Physician: The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.

78 Return to the Operating Room for a Related Procedure During the Postoperative Period

The physician may need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures on the same day, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period: The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

80 Assistant Surgeon: Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

81 Minimum Assistant Surgeon: Minimum surgical assistant services are identified by adding modifier 81 to the usual procedure number.

82 Assistant Surgeon (when qualified resident surgeon not available): The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code number(s).

83 Physician Assistant or Nurse Practitioner as Assistant Surgeon: When a physician assistant or nurse practitioner performs services for assistants at surgery, identify the services by adding modifier 83 to the usual procedure code. Services of a physician assistant or nurse practitioner are reimbursed at 20 percent of the listed value of the surgical code and payable to the employing physician. This modifier is valid for surgery only.

90 Reference (Outside) Laboratory: When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.

91 Repeat Clinical Diagnostic Laboratory Test: In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number with the addition of modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results due to testing problems with specimens or equipment, or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

92 Alternative Laboratory Platform Testing: When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701-86703). The test does not require permanent dedicated space, hence by

its design may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.

99 Multiple Modifiers: Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

PA Services Performed by a Physician Assistant: When services of a physician assistant are performed, identify the services by adding modifier PA to the usual procedure code.

NP Services Performed by a Nurse Practitioner: When services of a nurse practitioner are performed, identify the services by adding modifier NP to the usual procedure code.

4.19 Evaluation and Management

4.19.1 Payment Ground Rules for E/M Category

4.19.1.1 General Guidelines

The E/M section is divided into broad categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes. This classification is important because the nature of a physician's work varies by type of service, place of service, and the injured employee's status.

Physicians should include CPT codes for specific performance of diagnostic tests/studies for which specific CPT codes are available. These CPT codes should be reported separately, in addition to the appropriate E/M code.

4.19.1.2 Definitions

Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians in differing specialties.

4.19.1.2.1 New and Established Patient

Solely for the purposes of distinguishing between a new and established patients, professional services are those face-to-face services rendered by a physician and reported by a specific CPT code(s). A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, with in the past three years.

An established patient is one who has received professional services from a physician or another physician of the same specialty who belongs to the same group practice, with the past three years.

4.19.1.2.2 On-Call or Substitute Physician

In the instance where a physician is on call for or is covering for the authorized treating physician, the injured employee's encounter will be classified as it would have been by the physician who is not available.

4.19.1.2.3 Emergency Situation

No distinction is made between new and established patients in the emergency room. Emergency room services should be reported for any patient (new or established) who presents for treatment in the emergency department.

4.19.1.2.4 Concurrent Care

Concurrent care is the provision of similar service (e.g., hospital visits) to the same patient by more than one physician on the same day. When concurrent care is provided, no special reporting is required.

4.19.1.2.5 Counseling

Counseling is a discussion with an injured employee and/or family concerning one or more of the following areas:

- Diagnostic results, impressions, and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of management (treatment) options
- Instructions for management (treatment) and/or follow-up
- Importance of compliance with chosen management (treatment) options
- Risk factor reduction
- Injured employee and family education.

4.19.1.2.6 Consultations

As defined in the CPT book, consultation is a type of service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or appropriate source. Consultations are reimbursable only to physicians with the appropriate specialty for the services provided. A consulting physician shall only initiate diagnostic and/or therapeutic services with approval from the authorized treating physician. Following a consultation, if the consulting physician assumes responsibility for management of all or any part of the injured employee's condition(s), the injured employee becomes an "established patient" (rather than follow-up consultation) under the care of the consulting physician.

4.19.1.2.7 Time

The amount of time spent with a patient is a factor to be taken into consideration when selecting the appropriate E&M code. CPT guidelines are to be followed.

4.19.2 Payment Modifiers for E/M Category

A modifier indicates that a service or procedure performed has been altered by some specific circumstance but has not changed its definition or code. The modifying circumstance shall be identified by the appropriate modifier following the procedure code. The two-digit modifier should be placed after the usual procedure number. If more than one modifier is used, place the "Multiple Modifiers" code 99 immediately after the procedure code. This indicates that one or more additional modifier codes will follow. Only certain modifiers in each of the categories (Evaluation and Management, Anesthesia, Surgery, Pathology/Laboratory, Radiology, General Medicine, and Physical Medicine) will be recognized for reimbursement purposes. It is understood that modifiers not only clarify the services performed, but that the fee may be adjusted accordingly based on the increase or decrease in service.

The modifiers listed below may differ from those published by the American Medical Association. Medical providers submitting workers' compensation billing shall use only the modifiers set out in the fee schedule. The following modifiers will be recognized for reimbursement by the fee schedule for Evaluation and Management (E/M) codes:

24 Unrelated Evaluation and Management Service by the Same Physician during a Postoperative Period: The physician may need to indicate that an E/M service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service: It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M service. Note: This modifier is not used to report and E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

52 Reduced Services: Under certain circumstances, a service or procedure is partially reduced or eliminated at the physician's election. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or canceled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use). When reporting a reduced service, it is expected that the billed amount will be reduced by the provider. The amount of the reduction is at the discretion of the provider, but should reflect a level of reimbursement commensurate with the actual work done.

53 Discontinued Procedure: Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.

For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/ service that is partially reduced or canceled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

57 Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

59 Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services, that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier available and use of modifier 59 best explains the circumstances should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

4.20 Anesthesia

4.20.1 Introduction

4.20.1.1 Anesthesia services provided to employees pursuant to 19 **Del.C.** §2322B(7) shall be paid at a unit charge of one hundred dollars ($100.00) per unit in geozip 197-198 and seventy-six dollars ($76.00) per unit in geozip 199, with an annual CPI-U adjustment as referenced in 19 **Del.C.** §2322B(14).

4.20.1.1.1 The formula to calculate anesthesia services is "Anesthesia fee = Total units X Conversion factor".

4.20.1.1.2 Total units = base units + time units + physical status modifier + qualifying circumstances

4.20.1.1.3 A time unit is a fifteen (15) minute increment.

4.20.1.1.3.1 Partial Units are rounded - 1) five (5) minutes or less round down to the previous unit; or 2) more than five (5) minutes round up to the next unit.

4.20.1.1.4 "Conversion Factors" are one hundred dollars ($100) per unit for geozip 197-198 and seventy-six dollars ($76) per unit for geozip 199. The annual CPI-U adjustment to these "Conversion Factors" referenced in 4.20.1.1 will be published on the Department of Labor web site.

4.20.1.2 The health care payment system as to Anesthesia will be adjusted yearly pursuant to 19 **Del.C.** §2322B for anesthesia treatment, procedures and/or services in effect in January of that year.

4.20.2 Special Circumstances

4.20.2.1 Physical Status Modifiers

Physical status modifiers are represented by the initial letter P followed by a single digit from one (1) to six (6) defined below:

Status Description Base Units

- P1 A normal healthy patient 0
- P2 A patient with mild systemic disease 0
- P3 A patient with severe systemic disease 1
- P4 A patient with severe systemic disease that is a constant threat to life 2
- P5 A moribund patient who is not expected to survive without the operation 3
- P6 A patient declared brain-dead whose organs are being removed for donor purposes 0

The above six levels are consistent with the American Society of Anesthesiologists' (ASA) ranking of patient physical status. Physical status is included in the CPT book to distinguish between various levels of complexity of the anesthesia service provided.

4.20.2.2 Qualifying Circumstances

4.20.2.2.1 More than one qualifying circumstance may be selected.

Many anesthesia services are provided under particularly difficult circumstances, depending on factors such as extraordinary condition of patient, notable operative conditions, and/or unusual risk factors. This section includes a list of important qualifying circumstances that significantly affect the character of the anesthesia service provided. These procedures would not be reported alone but would be reported as additional procedure numbers qualifying an anesthesia procedure or service.

99100 Anesthesia for patient of extreme age, younger than one year and older than seventy (List separately in addition to code for primary anesthesia procedure) 1

99116 Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure) 5

99135 Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure) 5

99140 Anesthesia complicated by emergency conditions (specify conditions) (List separately in addition to code for primary anesthesia procedure) (An emergency is defined as existing when delay in treatment of a patient would lead to a significant increase in the threat to life or body part.) 2

4.20.2.2.2 Payers must utilize their medical consultants when there is a question regarding modifiers and/or special circumstances for anesthesia charges.

4.20.3 Monitored Anesthesia Care

Monitored anesthesia care occurs when the attending physician requests that an anesthesiologist be present during a procedure. This may be to insure compliance with accepted procedures of the facility. Monitored anesthesia care includes pre-anesthesia exam and evaluation of the patient. The anesthesiologist must participate or provide medical direction for the plan of care. The anesthesiologist, resident, or nurse anesthetist must be in continuous physical presence and provide diagnosis and treatment of emergencies. This will also include noninvasive monitoring of cardiocirculatory and respiratory systems with administration of oxygen and/or intravenous administration of medications. Reimbursement will be the same as if general anesthesia had been administered.

4.20.4 Reimbursement for Anesthesia Services

4.20.4.1 Criteria for Reimbursement

Anesthesia services may be billed for any one of the three following circumstances:

4.20.4.1.1 An anesthesiologist provides total and individual anesthesia service.

4.20.4.1.2 An anesthesiologist directs a CRNA or AA.

4.20.4.1.3 Anesthesia provided by a CRNA or AA working independent of an anesthesiologist's supervision is covered under the following conditions:

- The service falls within the CRNA's or AA's scope of practice and scope of license as defined by law.
- The service is supervised by a licensed health care provider who has prescriptive authority in accordance with the clinical privileges individually granted by the hospital or other health care organization.

4.20.4.2 Reimbursement

4.20.4.2.1 Reimbursement includes the usual pre- and postoperative visits, the care by the anesthesiologist during surgery, the administration of fluids and/or blood, and the usual monitoring services. Unusual forms of monitoring, such as central venous, intra-arterial, and Swan-Ganz monitoring, may be reimbursed separately.

4.20.4.2.2 When an unlisted service or procedure is provided, the value should be substantiated with a report. Unlisted services are identified in this Fee Schedule as by report.

4.20.4.2.3 When it is necessary to have a second anesthesiologist, the necessity should be substantiated.

4.20.4.2.4 Payment for covered anesthesia services is as follows:

- When the anesthesiologist provides an anesthesia service directly, payment will be made in accordance with the billing reimbursement rules of this Fee Schedule.
- 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%).
- When the CRNA or AA provides the anesthesia service directly, then payment will be the lesser of the actual charge or the amount listed in the Fee Schedule for that procedure.

4.20.4.2.5 Anesthesiologists, CRNAs, and AAs must bill their services with the appropriate modifiers to indicate which one provided the service. Bills NOT properly coded may cause a delay or error in reimbursement by the payer. Application of the appropriate modifier to the bill for service is the responsibility of the provider, regardless of the place of service. Modifiers are as follows:

AA Anesthesiologist services performed personally by an anesthesiologist

AD Medical supervision by a physician: more than four concurrent anesthesia procedures

QK Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals (CRNA or AA) by an anesthesiologist

QX CRNA or AA service: with medical direction by an anesthesiologist

QY Medical direction of one certified registered nurse anesthetist (CRNA or AA) by an anesthesiologist

QZ CRNA service: without medical direction by an anesthesiologist

4.20.5 Anesthesia Modifiers

All anesthesia services are reported by using the anesthesia five-digit procedure codes. The fee for most procedures may be modified under certain circumstances as listed below. When applicable, the modifying circumstances should be identified by the addition of the appropriate modifier (including the hyphen) after the usual anesthesia code. Certain modifiers require a special report for clarification of services provided.

Modifiers commonly used in anesthesia are as follows:

22 Unusual Procedural Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate.

23 Unusual Anesthesia: Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

32 Mandated Services: Services related to mandated consultation and/or related services (eg, third-party payer, governmental, legislative, or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

53 Discontinued Procedure: Under certain circumstances the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.

59 Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier available and use of modifier 59 best explains the circumstances should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service with a non-E/M service with a non-E/M service performed on the same date, see modifier 25.

AA Anesthesia Services Performed Personally by the Anesthesiologist: Report modifier AA when the anesthesia services are personally performed by an anesthesiologist.

AD Medical Supervision by a Physician: More Than Four Concurrent Anesthesia Procedures: Report modifier AD when the anesthesiologist supervises more than four concurrent anesthesia procedures.

QK Medical Direction of Two, Three, or Four Concurrent Anesthesia Procedures Involving Qualified Individuals: Report modifier QK when the anesthesiologist supervises two, three, or four concurrent anesthesia procedures.

QX CRNA or AA Service with Medical Direction by a Physician: Regional or general anesthesia provided by the CRNA or AA with medical direction by a physician may be reported by adding modifier QX.

QY Medical Supervision by Physician of One CRNA or AA: Report modifier QY when the anesthesiologist supervises one CRNA or AA.

QZ CRNA or AA Service without Medical Direction by a Physician: Regional or general anesthesia provided by the CRNA or AA without medical direction by a physician may be reported by adding modifier QZ.

4.20.6 Moderate (Conscious) Sedation

4.20.6.1 CPT Codes that Include Moderate (Conscious) Sedation - Moderate (conscious) sedation is a drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

4.20.6.2 Moderate sedation does not include minimal sedation (anxiolysis), deep sedation or monitored anesthesia care (00100-01999).

4.20.6.3 When providing moderate sedation, the following services are included and NOT reported separately:

4.20.6.3.1 Assessment of the patient (not included in intraservice time);

4.20.6.3.2 Establishment IV access and fluids to maintain patency, when performed;

4.20.6.3.3 Administration of agent(s);

4.20.6.3.4 Maintenance of sedation;

4.20.6.3.5 Monitoring of oxygen saturation, heart rate and blood pressure; and

4.20.6.3.6 Recovery (not included in intraservice time).

4.20.6.4 Intraservice time starts with the administration of the sedation agent(s), require continuous face-to-face attendance, and ends at the conclusion of personal contact by the physician providing the sedation.

4.20.6.5 Do not report 99143-99150 in conjunction with 94760-94762.

4.20.6.6 Do not report 99143-99145 in conjunction with codes listed in Appendix G. Do not report 99148-99150 in conjunction with codes listed in Appendix G when performed in the non-facility setting.

Appendix G from the American Medical Association's 2009 CPT Codes
Summary of CPT Codes That Include Moderate (Conscious) Sedation

Note: Because these codes include moderate sedation, it is not appropriate for the same physician to report both the service and the sedation codes 99143-99145.

If a physician other than the treating physician provides moderate sedation in a facility for one of the procedures on this list, the other physician should report codes 99148-99150. If this arrangement occurs in the provider's office, these codes would not be reported.

CPT codes 00100-01999 can be used to report associated anesthesia services regardless of whether the procedure is on this list.

19298	20982	22526	22527	31615	31620	31622	31623	31624	31625
31628	31629	31635	31645	31646	31656	31725	32201	32550	32551
33010	33011	33206	33207	33208	33210	33211	33212	33213	33214
33216	33217	33218	33220	33222	33223	33233	33234	33235	33240
33241	33244	33249	35470	35471	35472	35473	35474	35475	35476
36555	36557	36558	36560	36561	36563	36565	36566	36568	36570
36571	36576	36578	36581	36582	36583	36585	36590	36870	37184
37185	37186	37187	37188	37203	37210	37215	37216	43200	43201
43202	43204	43205	43215	43216	43217	43219	43220	43226	43227
43228	43231	43232	43234	43235	43236	43237	43238	43239	43240
43241	43242	43243	43244	43245	43246	43247	43248	43249	43250
43251	43255	43256	43257	43258	43259	43260	43261	43262	43263
43264	43265	43267	43268	43269	43271	43272	43273	43453	43456
43458	44360	44361	44363	44364	44365	44366	44369	44370	44372
44373	44376	44377	44378	44379	44380	44382	44383	44385	44386
44388	44389	44390	44391	44392	44393	44394	44397	44500	44901
45303	45305	45307	45308	45309	45315	45317	45320	45321	45327
45332	45333	45334	45335	45337	45338	45339	45340	45341	45342
45345	45355	45378	45379	45380	45381	45382	45383	45384	45385
45386	45387	45391	45392	47011	48511	49021	49041	49061	49440
49441	49442	49446	50021	50382	50384	50385	50386	50387	50592
50593	58823	66720	69300	77600	77605	77610	77615	92953	92960
92961	92973	92974	92975	92978	92979	92980	92981	92982	92984
92986	92987	92995	92996	93312	93313	93314	93315	93316	93317

93318	93501	93505	93508	93510	93511	93514	93524	93526	93527
93528	93529	93530	93539	93540	93541	93542	93543	93544	93545
93555	93556	93561	93562	93571	93572	93609	93613	93615	93616
93618	93619	93620	93621	93622	93624	93640	93641	93642	93650
93651	93652								

4.20.6.7 When a second physician other than the healthcare professional performing the diagnostic or therapeutic services provides moderate sedation in the facility setting (e.g., hospital, outpatient hospital/ambulatory surgery center, skilled nursing facility) for the procedures listed in G, the second physician reports 99148-99150. However, for the circumstance in which these services are performed by the second physician in the non-facility setting (e.g., physician office, freestanding imaging center), codes 99148-99150 are not reported.

4.20.6.8 Some CPT codes include moderate (conscious) sedation as an inherent component of the procedure. These are identified in the CPT book with a K symbol. Because these services include moderate (conscious) sedation, special rules apply when reporting the moderate (conscious) sedation CPT codes 99143–99150. Moderate (conscious) sedation services provided by the same physician performing the diagnostic or therapeutic service that the sedation supports and requiring the presence of a second independent trained observer for monitoring purposes (CPT codes 99143–99145) may not be reported in conjunction with CPT codes identified with a K symbol and listed in Appendix G.

4.20.6.9 In rare instances a second physician other than the physician performing the diagnostic or therapeutic service may be required to provide the moderate (conscious) sedation service (CPT codes 99148–99150). When these sedation services are performed in a facility setting (e.g., hospital, outpatient hospital/ambulatory surgery center, skilled nursing facility), the second physician may report the moderate (conscious) sedation service with CPT code(s) 99148–99150 in conjunction with CPT codes identified with a K symbol and listed in Appendix G. However, when the second physician performs the moderate (conscious) sedation services in a non facility setting (e.g., physician office, freestanding imaging center) CPT code(s) 99148–99150 should not be reported separately and are not in **Delaware Workers' Compensation Medical Fee Schedule.** CPT code(s) 99148–99150 should not be reported separately and are not reimbursable when performed in conjunction with CPT codes identified with a K symbol and listed in Appendix G. See Appendix G in *CPT 2008* for a list of CPT codes that includes moderate (conscious) sedation.

4.21 Surgery

4.21.1 General Guidelines

4.21.1.1 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.

4.21.1.1.1 Global reimbursement includes:

- The operation per se
- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
- Immediate postoperative care, including dictating operative notes, talking with the family and other physicians
- Writing orders
- Evaluating the patient in the post anesthesia recovery area
- Normal, uncomplicated follow-up care for the time periods indicated in the follow- up days (FUD) column to the right of each procedure code. The number in that column establishes the days during which no additional reimbursement is allowed for the usual care provided following surgery, absent complications or unusual circumstances.
- The maximum reimbursement allowances cover all normal postoperative care, including the removal of sutures by the surgeon or associate. Follow-up days are specified by procedure.

4.21.1.1.2 Follow-up days listed are for 0, 10, or 90 days and are listed in the Fee Schedule as 000, 010, or 090.

4.21.1.2 Follow-up Care for Diagnostic Procedures

Follow-up care for diagnostic procedures (e.g., endoscopy, arthroscopy, injection procedures for radiography) includes only the care related to recovery from the diagnostic procedure itself. Care of the condition for which the diagnostic procedure was performed or of other concomitant conditions is not included and may be listed separately.

4.21.1.3 **Follow-up Care for Therapeutic Surgical Procedures**

Follow-up care for therapeutic surgical procedures includes only care that is usually part of the surgical procedure. Complications, exacerbations, recurrence, or the presence of other diseases or injuries requiring additional services should be reported separately.

4.21.1.4 **Separate Procedures**

Some of the procedures or services listed in the CPT codebook that are commonly carried out as an integral component of a total service or procedure have been identified by the inclusion of the term “separate procedure”. The codes designated as “separate procedure” should not be reported in addition to the code for the total procedure or service of which it is considered an integral component.

4.21.1.5 **Biopsy Procedures**

A biopsy of the skin and another surgical procedure performed on the same lesion on the same day must be billed as one procedure.

4.21.1.6 **Repair of Nerves, Blood Vessels, and Tendons with Wound Repairs**

The repair of nerves, blood vessels, and tendons is usually reported under the appropriate system. The repair of associated wounds is included in the primary procedure unless it qualifies as a complex wound, in which case modifier 51 may be applied. Simple exploration of nerves, blood vessels, and tendons exposed in an open wound is also considered part of the essential treatment of the wound closure and is not a separate procedure unless appreciable dissection is required.

4.21.1.7 **Suture Removal**

Billing for suture removal by the operating surgeon is not appropriate as this is considered part of the global fee.

4.21.1.8 **Supplies and Materials**

Supplies and materials provided by the physician (e.g., sterile trays/drugs) over and above those usually included with the office visit may be listed separately using CPT code 99070 or specific HCPCS Level II codes.

4.21.1.9 **Implants**

Implants of any type are to be billed as part of the hospital or ASC billing. Bone morphogenetic protein is an FDA approved biologic fusion and fracture healing aid. Its use in spine and fracture surgery represents the standard of care in our community, and in both on-label and off-label applications is accepted and to be reimbursed to the facility providing the implant, at rates consistent with implant payment rates determined under the respective ASC and hospital reimbursement guidelines.

4.21.1.10 **Aspirations and Injections**

Puncture of a cavity or joint for aspiration followed by injection of a therapeutic agent is one procedure and should be billed as such.

4.21.1.11 **Surgical Assistant**

4.21.1.11.1 **Physician surgical assistant** — For the purpose of reimbursement, a physician who assists at surgery is reimbursed as a surgical assistant. Assistant surgeons should use modifier 80 and are allowed twenty percent (20%) of the maximum reimbursement allowance (MRA) for the procedure(s).

4.21.1.11.2 **Registered Nurse Surgical Assistant or Physician Assistant**

- A physician assistant (PA), or registered nurses (NP) who have completed an approved first assistant training course, may be allowed a fee when assisting a surgeon in the operating room (O.R.).
- The maximum reimbursement allowance for the physician assistant or the registered nurse first assistant (RNFA) is twenty percent (20%) of the surgeon’s fee for the procedure(s) performed.
- Under no circumstances will a fee be allowed for an assistant surgeon and a physician assistant or RNFA at the same surgical encounter.
- Registered nurses on staff in the O.R. of a hospital, clinic, or outpatient surgery center do not qualify for reimbursement as an RNFA.

4.21.1.12 **Operative Reports**

An operative report must be submitted to the payer before reimbursement can be made for the surgeon's or assistant surgeon's services.

4.21.1.13 **Needle Procedures**

Needle procedures (lumbar puncture, thoracentesis, jugular or femoral taps, etc.) should be billed in addition to the medical care on the same day.

4.21.1.14 **Therapeutic Procedures**

Therapeutic procedures (injecting into cavities, nerve blocks, etc.) (CPT codes 20526–20610, 64400, and 64450) may be billed in addition to the medical care for a new patient. (Use appropriate level of service plus injection.) In follow-up cases for additional therapeutic injections and/or aspirations, an office visit is only indicated if it is necessary to re-evaluate the patient. In this case, a minimal visit may be listed in addition to the injection. Documentation supporting the office visit charge must be submitted with the bill to the payer. This is clarified in the treatment guidelines in a more specific manner. Trigger point injection is considered one procedure and reimbursed as such regardless of the number of injection sites. Two codes are available for reporting trigger point injections. Use 20552 for injection(s) of single or multiple trigger point(s) in one or two muscles or 20553 when three or more muscles are involved.

4.21.1.15 **Anesthesia by Surgeon**

In certain circumstances it may be appropriate for the attending surgeon to provide regional or general anesthesia. Anesthesia by the surgeon is considered to be more than local or digital anesthesia. Identify this service by adding modifier 47 to the surgical procedure code.

4.21.1.16 **Therapeutic/Diagnostic Injections**

Injections are considered incidental to the procedure when performed with a related invasive procedure.

4.21.1.17 **Intervertebral Biomechanical Device(s) and Use of Code 22851**

Code 22851 describes the application of an intervertebral biomechanical device to a vertebral defect or interspace. Code 22851 should be listed in conjunction with a primary procedure without the use of modifier 51. The use of 22851 is limited to one instance per single interspace or single vertebral defect regardless of the number of devices applied and infers additional qualifying training, experience, sizing, and/or use of special surgical appliances to insert the biomechanical device. Qualifying devices include manufactured synthetic or allograft biomechanical devices, or methyl methacrylate constructs, and are not dependant on a specific manufacturer, shape, or material of which it is constructed. Qualifying devices are machine cut to specific dimensions for precise application to an intervertebral defect. (For example, the use of code 22851 would be appropriate during a cervical arthrodesis (22554) when applying a synthetic alloy cage, a threaded bone dowel, or a machine cut hexahedron cortical, cancellous, or corticocancellous allograft biomechanical device. Surgeons utilizing generic non-machined bony allografts or autografts are referred to code sets 20930–20931, 20936–20938 respectively.)

4.21.1.18 **Spinal and Cranial Services Require Additional Surgeon**

Certain spinal and cranial procedures require the services of an additional surgeon of a different specialty to gain exposure to the spine and brain. These typically are vascular, thoracic and ENT. The surgical exposure portion of these procedures will be billed, dictated and followed separately by the exposure surgeon for their portion of the procedure. Since the exposure surgeon is required based upon the type of surgery recommended by the treating surgeon, it is intended that an approval for the primary procedure includes the approach, and no separate pre-approval or pre-authorization is required. The exposure surgeon is bound by the fee schedule regarding reimbursement and all other rules delineated above.

4.22 Ambulatory Surgery Centers

4.22.1 Definition

For purposes of this section of the Fee Schedule, "ambulatory surgery center" means an establishment with an organized medical staff of physicians; with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; with continuous physicians and registered nurses on site when the facility is open. An ambulatory surgery center may be a freestanding facility or may be attached to a hospital facility. For purposes of Workers' Compensation reimbursement to ASCs, the facility must be an approved Medicare ASC, or certified by AAA.

4.22.2 Coding and Billing Rules

4.22.2.1 Facility fees for ambulatory surgery must be billed on the UB-04 form.

4.22.2.2 The CPT/HCPCS code(s) of the procedure(s) performed determines the reimbursement for the facility fee. Report all procedures performed.

4.22.2.3 The payment rate for an ASC surgical procedure includes all facility services directly related to the procedure performed on the day of surgery. Facility services include:

- Nursing and technician services
- Use of the facility
- Drugs, biologicals, surgical dressings, splints, casts and equipment directly related to the provision of the surgical procedure
- Materials for anesthesia
- Administration, record keeping and housekeeping items and services.

4.22.2.4 Disposable injection supplies under $75 are included in the facility fee. Those over $75 are reimbursed at 85% of the ASC fee for the item.

4.22.2.5 Separate payment is not made for the following services that are directly related to the surgery:

- Pharmacy
- Medical/surgical supplies other than 5 and 6 above in this section,
- Sterile supplies
- Operating room services
- Ambulatory surgical care
- Recovery room
- Treatment or Observation room

4.22.2.6 Facility fees do not include physician services, x-rays, diagnostic procedures, laboratory procedures, CRNA or anesthesia physician services, prosthetic devices, ambulance services, braces, artificial limbs or DME for use in the patient's home. These items will be reimbursed according to Fee Schedule.

4.22.3 **Modifiers Approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use**

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service: It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service provided above or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for I instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M service on the same date. This circumstance may be reported adding modifier 25 to the appropriate level E/M code. Note: This modifier is not used to report and E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

27 Multiple Outpatient Hospital E/M Encounters on the Same Date: For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding modifier 27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (e.g., hospital emergency department, clinic). **Note:** This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient evaluation and management services provided by the same physician on the same date and performed in multiple outpatient setting(s) (e.g., hospital emergency department, clinic), see Evaluation and Management, Emergency Department, or Preventive Medicine Services codes.

50 Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five digit code.

52 Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period: It may be necessary to indicate that the performance of a procedure or service during the postoperative period was (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the operating or procedure room (e.g., unanticipated clinical condition), see modifier 78.

59 Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier available and use of modifier 59 best explains the circumstances should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service with a non-E/M service with a non-E/M service performed on the same date, see modifier 25.

73 Discontinued Out-Patient Hospital/ Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia: Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of modifier 73. **Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

74 Discontinued Out-Patient Hospital/ Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia: Due to extenuating circumstances or those that threaten the well-being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia (local, regional block(s), general) or after the procedure was started (incision made, intubation started, scope inserted, etc). Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of modifier 74. **Note:** The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.

76 Repeat Procedure or Service by Same Physician: It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

77 Repeat Procedure by Another Physician: The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.

78 Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period: It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first and require the use of an operating or procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period: The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

91 Repeat Clinical Diagnostic Laboratory Test: In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. **Note:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

4.23 Multiple Procedures

4.23.1 **Multiple Procedure Reimbursement Rules**

Multiple procedures performed during the same operative session at the same operative site are reimbursed as follows:

- One hundred percent (100%) of the allowable fee for the primary procedure
- One hundred percent (100%) of the allowable fee for the second and subsequent procedures

4.23.2 **Bilateral Procedure Reimbursement Rule**

Physicians and staff are sometimes confused by the definition of bilateral. Bilateral procedures are identical procedures (i.e., use the same CPT code) performed on the same anatomic site but on opposite sides of the body.

4.23.3 **Multiple Procedure Billing Rules**

- The primary procedure, which is defined as the procedure with the highest RVU, must be billed with the applicable CPT code.
- The second or lesser or additional procedure(s) may be billed by adding modifier 51 to the codes unless the procedure(s) is exempt from modifier 51 or qualifies as an add-on code.

4.24 **Repair of Wounds**

4.24.1 **Definitions**

Wound repairs are classified as simple, intermediate, or complex.

4.24.1.1 **Simple repair.** Simple repair is repair of superficial wounds involving primarily epidermis and dermis or subcutaneous tissues without significant involvement of deeper structures and simple one layer closure/suturing. This includes local anesthesia and chemical or electro cauterization of wounds not closed.

4.24.1.2 **Intermediate repair.** Intermediate repair is repair of wounds that requires layered closure of one or more of the subcutaneous tissues and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure. Single-layer closure of heavily contaminated wounds that require extensive cleaning or removal of particulate matter also constitutes intermediate repair.

4.24.1.3 **Complex repair.** Complex repair is repair of wounds requiring more than layered closure, scar revision, debridement (e.g., traumatic lacerations or avulsions), extensive undermining, stents or retention sutures. It may include creation of the defect and necessary preparation for repairs or the debridement and repair of complicated lacerations or avulsions.

4.24.2 **Reporting**

The following instructions are for reporting services at the time of the wound repair:

4.24.2.1 The repaired wound(s) should be measured and recorded in centimeters, whether curved, angular, or stellate.

4.24.2.2 When multiple wounds are repaired, add together the lengths of those in the same classification (see above) and anatomical grouping and report as a single item. When more than one classification of wound is repaired, list the more complicated as the primary procedure and the less complicated as the secondary procedure using modifier 51.

4.24.2.3 Debridement is considered a separate procedure only when gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue are removed, or when debridement is carried out separately without immediate primary closure (extensive debridement of soft tissue and/or bone).

4.24.2.4 Report involvement of nerves, blood vessels, and tendons under the appropriate system (nervous, musculoskeletal, etc.) for repair. The repair of these wounds is included in the fee for the primary procedure unless it qualifies as a complex wound, in which case modifier 51 applies.

4.24.2.5 Simple ligation of vessels in an open wound is considered part of any wound closure, as is simple exploration of nerves, blood vessels, or tendons.

4.24.2.6 Adjacent tissue transfers, flaps and grafts include such procedures as Z-plasty, W- plasty, V-4-plasty or rotation flaps. Reimbursement is based on the size of the defect. Closing the donor site with a skin graft is considered an additional procedure and will be reimbursed in addition to the primary procedure. Excision of a lesion prior to repair by adjacent tissue transfer is considered “bundled” into the tissue transfer procedure and is not reimbursed separately.

4.24.2.7 Wound exploration codes should not be billed with codes that specifically describe a repair to major structure or major vessel. The specific repair code supersedes the use of a wound exploration code.

4.25 **Musculoskeletal System**

4.25.1 **Casting and Strapping**

This applies to severe muscle sprains or strains that require casting or strapping.

4.25.1.1 Initial (new patient) treatment for soft tissue injuries must be billed under the appropriate office visit code.

4.25.1.2 When a cast or strapping is applied during an initial visit, supplies and materials (e.g., stockinet, plaster, fiberglass, ace bandages) may be itemized and billed separately using the appropriate HCPCS Level II code.

4.25.1.3 When initial casting and/or strapping is applied for the first time during an established patient visit, reimbursement may be made for the itemized supplies and materials in addition to the appropriate established patient visit.

4.25.1.4 Replacement casts or strapping provided during a follow-up visit (established patient) includes reimbursement for the replacement service as well as the removal of casts, splints, or strapping. If a cast is damaged or destroyed and must be replaced, the supplies and the office visit are reimbursed. Office notes should substantiate medical necessity of the visit. Cast supplies may be billed using the appropriate HCPCS Level II code and reimbursed separately.

4.25.2 **Fracture Care**

4.25.2.1 Fracture care is a global service. It includes the examination, restoration or stabilization of the fracture, application of the first cast, and cast removal. Casting material is not considered part of the global package and may be reimbursed separately. It is inappropriate to bill an office visit since the reason for the encounter is for fracture care. However, if the patient requires surgical intervention, additional reimbursement can be made for the appropriate E/M code to properly evaluate the patient for surgery. Use modifier 57 with the E/M code.

4.25.2.2 Reimbursement for fracture care includes the application and removal of the first cast or traction device only. Replacement casting during the period of follow-up care is reimbursed separately.

4.25.2.3 The phrase “with manipulation” describes reduction of a fracture.

4.25.2.4 Re-reduction of a fracture performed by the primary physician may be identified by the addition of modifier 76 to the usual procedure code to indicate “repeat procedure” by the same physician.

4.25.2.5 The term “complicated” appears in some musculoskeletal code descriptions. It implies an infection occurred or the surgery took longer than usual. Be sure the medical record documentation supports the “complicated” descriptor to justify reimbursement.

4.25.3 **Arthroscopy**

Note: Surgical arthroscopy always includes a diagnostic arthroscopy. Only in the most unusual case is an increased fee justified because of increased complexity of the intra-articular surgery performed.

4.25.3.1 Diagnostic arthroscopy should be billed at fifty percent (50%) when followed by open surgery.

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.

4.25.4 **Arthrodesis Procedures**

Many revisions have occurred in CPT coding for arthrodesis procedures. References to bone grafting and fixation are now procedures which are listed and reimbursed separately from the arthrodesis codes. To help alleviate any misunderstanding about when to code a discectomy in addition to an arthrodesis, the statement “including minimal discectomy” to prepare interspace has been added to the anterior interbody technique. If the disk is removed for decompression of the spinal cord, the decompression should be coded and reimbursed separately.

4.25.5 **External Spinal Stimulators Post Fusion**

The following criteria is established for the medically accepted standard of care when determining applicability for the use of an external spinal stimulator.

4.25.5.1 Patient has had a previously failed spinal fusion, and/or

4.25.5.2 Patient is scheduled for revision or repair of pseudo arthrosis, and/or

4.25.5.3 The patient smokes greater than a pack of cigarettes per day and is scheduled for spinal fusion

4.25.5.4 The patient is metabolically in poor health, with other medical comorbidities such as diabetes, Rheumatoid arthritis, lupus or other illnesses requiring oral steroids or cytotoxic medications.

4.25.5.5 Pre certification is required for use of the external spinal stimulator if the planned use falls outside the above indications.

4.25.6 **Carpal Tunnel Release**

The following intra operative services are included in the global service package for carpal tunnel release and should not be reported separately and do not warrant additional reimbursement:

- Surgical approach
- Isolation of neurovascular structures
- Video imaging
- Stimulation of nerves for identification
- Application of dressing, splint, or cast
- Tenolysis of flexor tendons
- Flexor tenosynovectomy
- Excision of lipoma of carpal canal
- Division of transverse carpal ligament
- Use of endoscopic equipment
- Placement and removal of surgical drains or suction device
- Closure of wound

4.26 Radiology

4.26.1 Payment Ground Rules for Diagnostic and Therapeutic Radiological Services

4.26.1.1 General Guidelines

4.26.1.1.1 The maximum allowable payment for health care treatment and procedures shall be the lesser of the health care provider's actual charges or eighty-five percent (85%) of ninety percent (90%) of the 75th percentile of actual charges within the geozip where the service or treatment is rendered, utilizing information contained in employers' and insurance carriers' national databases. If an employer or insurance carrier contracts with a provider for the purpose of providing services under the Act, the rate negotiated in such contract shall prevail.

4.26.1.1.2 Whenever 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 eighty-five percent (85%) of actual charge ("POC 85").

4.26.1.1.3 The payment system will be adjusted yearly pursuant to 19 **Del.C.** §2322B(14).

4.26.1.1.4 The maximum allowed rate column for a radiological procedure includes the professional component (PC) and the technical component (TC). Under no circumstances shall the maximum allowed rate for a procedure be more than the combined value of the TC and the PC. This value is applicable in any situation in which a single charge is made to include both professional services and the technical cost of providing that service. Identification of a procedure without modifier 26 indicates that the charge includes both the “professional” and the “technical” components.

4.26.1.1.5 The PC fee amount represents the value of the professional radiological services of the physician. This component is applicable in any situation in which the physician submits a bill for these professional services only. It does not include the cost of personnel, materials, space, equipment, or other facilities.

4.26.1.1.6 A written report, signed by the interpreting physician, is considered an integral part of a radiological procedure or interpretation and shall not be reimbursed separately. To identify a charge for the PC, use the five-digit CPT procedure code followed by modifier 26. If a “0” fee amount appears in the PC column, the procedure is assumed to be purely technical in nature and no PC charge will be allowed.

4.26.1.1.7 The TC includes the charges for personnel, materials, including ionic contrast media and drugs, film or xerography, space, equipment, and other facility resources. The technical component maximum allowable reimbursement excludes radioisotope cost. To identify a charge for the TC only, use the procedure code followed by modifier TC.

4.26.1.1.8 A complete examination includes all of the necessary views for optimal examination of the body part for the suspected condition. If the reimbursement of multiple single views exceeds the cost of a complete examination, reimbursement shall be based on the complete examination value.

4.26.1.2 Definitions and items unique to radiology are listed below:

4.26.1.2.1 Noninvasive/interventional diagnostic imaging includes standard radiographs, single or multiple views, contrast studies, computerized tomography, and magnetic resonance imaging. In the event that radiographs have to be repeated in the course of a radiographic encounter due to substandard quality, only one unit of service for the code can be billed.

4.26.1.2.2 Interventional/invasive diagnostic imaging—When a contrast can be administered orally (upper GI) or rectally (barium enema), the administration is included as part of the procedure and no administration service is billed. When contrast material is parenterally administered, whether the timing of the injection has to correlate with the procedure or not (e.g., IVP, CT scans, gadolinium), the administration and the injection (e.g., CPT codes 36000, 36406, 36410, and 90772–90774) are included in the contrast studies.

4.26.1.3 **Subject Listings**

Subject listings apply when radiological services are performed by or under the responsible supervision of a physician.

4.26.1.3.1 **Supervision and Interpretation**

When two physicians perform a procedure, the radiological portion of the procedure is designated as "radiological supervision and interpretation." When a physician performs both the procedure and provides imaging supervision and interpretation, a combination of CPT procedure codes outside the 70000 series and imaging supervision and interpretation codes are to be used. Note: The Radiological Supervision and Interpretation codes are not applicable to the radiation oncology subsection.

4.26.1.3.2 **Review of Diagnostic Studies**

No separate charge is warranted for prior studies reviewed in conjunction with a visit, consultation, record review, or other evaluation by the medical practitioner or other medical personnel; neither the professional component value modifier 26 nor the radiological consultation CPT code 76140 is reimbursable. The review of diagnostic tests is included in the evaluation and management codes.

4.26.1.3.3 **Written Report(s)**

A written report, signed by the interpreting physician, should be considered an integral part of a radiological procedure or interpretation.

4.26.1.3.4 **Unbundling of "Entrance" Fees**

Unbundling of fees to free standing diagnostic radiology centers will not be allowed. Any entrance fees billed in addition to the global or testing procedure code will not be reimbursed.

4.26.1.3.5 **Injection Procedure**

Fees include all usual pre- and post-injection care specifically related to the injection procedure, necessary local anesthesia, placement of needle or catheter, and injection of contrast media with or without auto power injection. The phrase "with contrast" used in the codes for procedures performed using contrast for imaging enhancement represents contrast material administered intravascularly, intra-articularly, or intrathecally.

For intra-articular injection, use the appropriate joint injection code. If radiographic arthrography is performed, also use the arthrography supervision and interpretation code for the appropriate joint (which includes fluoroscopy). If CT or MR arthrography is performed without radiographic arthrography, use the appropriate joint injection code, the appropriate CT or MR code ("with contrast" or "without followed by contrast"), and the appropriate imaging guidance code for needle placement for contrast injection.

For spine examinations using computed tomography, magnetic resonance imaging, magnetic resonance angiography, "with contrast" includes intrathecal or intravascular injection. For intrathecal injection, use also CPT code 61055 or 62284. Injection intravascular (IV) contrast material is part of the "with contrast" CT, CTA, MRI, MRA procedure and shall not be reimbursed separately. When introducing additional materials through the same puncture site, reimbursement shall be allowed for the materials only. Title 19 Section 2322B(5) will apply to such charges. Oral and/or rectal contrast administration alone does not qualify as a study "with contrast."

4.26.2 **Payment Modifiers for Diagnostic and Therapeutic Radiological Services**

4.26.2.1 A modifier indicates a service or procedure performed has been altered by some specific circumstance but has not changed its definition or code. The modifying circumstance shall be identified by the appropriate modifier following the procedure code. When two modifiers are applicable to a single code, indicate each modifier on the bill. If more than one modifier is used, place the "Multiple Modifiers" modifier 99 immediately after the procedure code. This indicates that one or more additional modifier codes will follow.

4.26.2.2 Only certain modifiers in each of the categories (Evaluation and Management Services, Anesthesia, Surgery, Pathology/Laboratory, Radiology, General Medicine, and Physical Medicine)

will be recognized for reimbursement purposes. The modifiers listed below may differ from those published by the American Medical Association. Medical providers submitting workers' compensation billing shall use only the modifiers set out in the fee schedule.

4.26.2.3 The following modifiers will be recognized for reimbursement by the fee schedule for diagnostic and therapeutic radiology services codes:

22 Increased Procedural Services: When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, and severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M. Add an additional 20% to the value of the procedure code when billed with this modifier.

26 Professional Component Only: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

50 Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding modifier 50 to the appropriate five-digit code.

52 Reduced Services: Under certain circumstances, a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of modifier 52 signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 Discontinued Procedure: Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure before the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifier 73 and 74 (see modifiers approved for ASC hospital outpatient use).

59 Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier available and use of modifier 59 best explains the circumstances should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service with a non-E/M service with a non-E/M service performed on the same date, see modifier 25.

76 Repeat Procedure or Service by Same Physician: It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure/service.

77 Repeat Procedure by Another Physician: The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated. This situation may be reported by adding modifier 77 to the repeated procedure/service.

99 Multiple Modifiers: Under certain circumstances, two or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure and other applicable modifiers may be listed as part of the description of the service.

LT Left Side: Used to identify procedures performed on the left side of the body.

RT Right Side: Used to identify procedures performed on the right side of the body.

TC Technical Component Only: Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

4.27 Laboratory/Pathology

4.27.1 Payment Ground Rules for Pathology and Laboratory Services

4.27.1.1 General Guidelines

4.27.1.1.1 The maximum allowable payment for health care treatment and procedures shall be the lesser of the health care provider's actual charges or eighty-five percent (85%) of ninety percent (90%) of the 75th percentile of actual charges within the geozip where the service or treatment is rendered, utilizing information contained in employers' and insurance carriers' national databases. If an employer or insurance carrier contracts with a provider for the purpose of providing services under the Act, the rate negotiated in such contract shall prevail.

4.27.1.1.2 Whenever 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 eighty-five percent (85%) of actual charge ("POC 85").

4.27.1.1.3 The payment system will be adjusted yearly pursuant to 19 **Del.C.** §2322B(14).

4.27.1.1.4 Physicians 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 The maximum number of times that drug screening, testing, or the like, may occur is four (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) 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.

4.27.1.2 Services in Pathology & Laboratory

Services are those provided by the pathologist or by the technologists under responsible supervision of a physician. The fees listed in this section include recording of the specimen, performance of the test, and reporting of the result. The fees do not include specimen collection, specimen transfer, or individual patient administrative services.

4.27.1.3 Review of Diagnostic Studies

The medical practitioner or other medical personnel warrant no separate charge for the review of prior studies in conjunction with a visit, consultation, record review, or other evaluation. Neither the professional component modifier 26 nor the pathology consultation CPT codes 80500 and 80502 are reimbursable under this circumstance. The review of diagnostic tests is included in the evaluation and management (E/M) codes.

4.27.1.4 Referral Laboratory Tests

The laboratory tests and services listed in this section when performed by other than the billing physician shall be billed at the value charged by the referral (outside) laboratory under the applicable procedure number with the appropriate modifier 90; the name of the referral laboratory and the charge made by that laboratory should also be identified.

4.27.1.5 Collection and Handling Procedures

Fees assigned to each test represent only the cost of performing the individual test, whether it is manual or automated (mechanized). The collection, handling, and patient administrative services have been assigned separate fees and separate code numbers.

4.27.1.5.1 Report a collection, handling, and patient administrative service separately, where applicable. For venipuncture, see CPT code 36415. For collection of capillary blood specimen, see CPT code 36416. For collection of blood specimen from a completely implantable venous access device, see CPT code 36540. For handling, see CPT codes 99000 and 99001.

4.27.1.5.2 Only the physician or laboratory drawing the blood or obtaining the specimen is entitled to a collection and handling fee.

4.27.1.5.3 Relative value units for specimen collection, handling, and patient administrative service are assigned in relation to the complexity of the process.

4.27.1.5.4 Although there is no billing for the test itself, the physician or laboratory performing the service can report a collection and handling charge. The test ordered and the name of the testing facility should be indicated.

4.27.1.5.5 When collection and handling are performed at the testing facility (laboratory), the laboratory may include separate charges for these services.

4.27.1.6 **Professional Component**

The maximum allowable reimbursement includes the professional component (PC) plus the technical component (TC). This value is applicable in any situation in which a single charge is made to include both professional services and the technical cost of providing that service.

4.27.1.6.1 Identification of a procedure by the five-digit CPT code without modifier 26 indicates that the charge includes both the professional and technical components. The professional component percentage represents the value of the professional pathology services of the physician. This includes: examination of the injured employee, when indicated performance and/or supervision of the procedure, interpretation, and written report of the laboratory procedure, and consultation with he authorized treating physician. This component is applicable in any situation in which the physician submits a bill for these professional services only. It does not include the cost of personnel, materials, space, equipment, or other facilities. To identify the charge for the professional component, use the five-digit CPT code followed by modifier 26.

4.27.1.6.2 The technical component includes the charges for personnel, materials, space, equipment, and other facilities, and should be reported using modifier TC. In no instance will the sum of the charges for the professional and technical components of a service be greater than the value of the total service listed.

4.27.1.7 **Separate or Multiple Procedures**

It is appropriate to designate multiple procedures that are rendered at the same session by separate entries.

4.27.1.8 **Unusual Service or Procedure**

Services that may necessitate skills and time of the physician over and above that usually required should be substantiated by special report (detailed below).

4.27.1.9 **Unlisted Service or Procedure**

When an unlisted service or procedure is provided, the values used should be substantiated by special report (detailed below). Identify by name or description.

4.27.1.10 **Special Report**

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 that may be included are:

- Complexity of symptoms
- Final diagnosis
- Pertinent physical findings
- Diagnostic and therapeutic procedures
- Concurrent problems
- Follow-up care

4.27.2 **Payment Modifiers for Pathology and Laboratory Services**

4.27.2.1 A modifier indicates a service or procedure performed has been altered by some specific circumstance but has not changed its definition or code. The modifying circumstance shall be identified by use of the appropriate modifier following the procedure code. When two modifiers are applicable to a single code, indicate each modifier on the bill. If more than one modifier is used, place the “Multiple Modifiers” code 99 immediately after the procedure code. This indicates that one or more additional modifier codes will follow. Only certain modifiers in each of the categories (Evaluation and Management Services, Anesthesia, Surgery, Pathology/Laboratory, Radiology, General Medicine, and Physical Medicine) will be recognized for reimbursement purposes.

4.27.2.2 The modifiers listed below may differ from those published by the American Medical Association. Providers submitting workers’ compensation billing shall use only the modifiers set out in the fee schedule.

4.27.2.3 The following modifiers will be recognized for reimbursement by the fee schedule for pathology and laboratory codes:

22 Increased Procedural Services: When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, and severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M. Add an additional 20% to the value of the procedure code when billed with this modifier.

26 Professional Component Only: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

53 Discontinued Procedure: Under certain circumstances, the physician may elect to end a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure before the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifier 73 and 74 (see modifiers approved for ASC hospital outpatient use).

59 Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier available and use of modifier 59 best explains the circumstances should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service with a non-E/M service with a non-E/M service performed on the same date, see modifier 25.

90 Reference (Outside) Laboratory: When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.

91 Repeat Clinical Diagnostic Laboratory Test: In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. Note: This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

92 Alternative Laboratory Platform Testing: When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701-86703). The test does not require permanent dedicated space; hence by its design it may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not itself determinative of the use of this modifier.

99 Multiple Modifiers: Under certain circumstances, two or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

TC Technical Component Only: Certain procedures are a combination of a physician component and a technical component. When the technical component is reported separately, the service may be identified by adding modifier TC to the usual procedure number.

4.28 Physical Medicine

4.28.1 Payment Ground Rules for Physical Medicine Services

4.28.1.1 General Guidelines

4.28.1.1.1 Protocols used by physicians in reporting their services are generally described below. Some of the commonalties with other subsections may be repeated here. If no appropriate code is found for medical services performed by a medical provider, use the appropriate unlisted code (e.g., CPT code 99199), and adequately describe the service provided. Chiropractic and physical therapy service reimbursements are explained in this section.

4.28.1.1.2 Supplies and materials provided by the medical provider (e.g., sterile trays), over and above that usually provided during an office visit, or other services rendered, may be charged for separately and coded separately. A physician office visit code may be charged in addition to the code for modalities/procedures only if the accompanying documentation clearly indicates that the physician or medical provider actually examined the worker during the office visit.

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

4.28.1.2.1 CPT code 97001, Physical therapy evaluation, is a one-time-only charge per episode of care. CPT code 97002, Physical therapy re-evaluation, may be charged at the discretion of the clinician based on patient presentation at a particular visit. The use of the 97002 code shall not exceed once per month unless unusual and/or unforeseen circumstances exist.

4.28.1.2.2 CPT code 97003, Occupational therapy evaluation, is a one-time-only charge per episode of care. CPT code 97004, Occupational therapy re-evaluation, may be charged at the discretion of the treating clinician based on patient presentation at a particular visit. The use of the 97004 code shall not exceed once per month unless unusual and/or unforeseen circumstances exist.

4.28.1.3 **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.

4.28.1.4 **Manipulation Codes**

Manipulation performed by physical therapists are billed under the 97140 (manual therapy) CPT code and there is no special modifier necessitated with the use of the 97140 code.

Special codes are designated for use by chiropractors and osteopaths to bill for manipulation services. When billing for manipulation services, licensed chiropractors may bill using CPT codes 98940–98943. Licensed osteopaths may bill using CPT codes 98925–98929. The chiropractic manipulative treatment codes include a pre manipulation patient assessment. Additional evaluation and management (E/M) services may be reported separately using modifier 25, if the injured employee's condition requires a significant, separately identifiable E/M service, which is above and beyond the usual pre service and post service work associated with the procedure.

4.28.1.5 **Fabrication of Orthotics**

Orthotics must be billed separately for professional fitting and supplies. CPT code 97760 must be used for a medical provider or therapist to fabricate orthotics. Custom-made orthotics and prosthetics are exempt from the medical supplies reimbursement formula; however, usual, customary, and reasonable charges will apply or by agreement of the parties. Additional medical supplies may not exceed medical supplies reimbursement formula.

4.28.1.6 **TENS Units**

TENS units (transcutaneous electrical nerve stimulation) must be prescribed by the authorized treating physician. Rental equipment is subject to usual, customary, and reasonable charges or by agreement. Rental equipment is exempt from the reimbursement formula. The purchase of such units will be subject to durable/medical supplies reimbursement formula utilizing the appropriate.

4.28.1.7 Hot/Cold Packs shall be reimbursed at $16.50 for geozip 197/198 and $13.66 for geozip 199, and will adjust each year, pursuant to 19 **Del.C.** §§2322B(3)(d) & (e).

4.28.2 **Payment Modifiers for Physical Medicine Services**

4.28.2.1 A modifier indicates a service or procedure performed has been altered by some specific circumstance but has not changed its definition or code. The modifying circumstance shall be identified by the appropriate modifier following the procedure code. When two modifiers are applicable to a single code, indicate each modifier on the bill. If more than one modifier is used, place the "Multiple Modifiers" modifier 99 immediately after the procedure code. This indicates that one or more additional modifier codes will follow. Only certain modifiers in each of the categories (Evaluation and Management, Anesthesia, Surgery, Pathology/Laboratory, Radiology, General Medicine, and Physical Medicine) will be recognized for reimbursement purposes.

4.28.2.2 The modifiers listed below may differ from those published by the American Medical Association. Medical providers submitting workers' compensation billing shall use only the modifiers set out in the fee schedule.

4.28.2.3 The following modifiers will be recognized for reimbursement by the fee schedule for physical medicine services codes:

22 Increased Procedural Services: When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, and severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M. Add an additional 20% to the value of the procedure code when billed with this modifier.

24 Unrelated Evaluation and Management Service by the Same Physician during a Postoperative Period: The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

26 Professional Component Only: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

52 Reduced Services: Under certain circumstances, a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of modifier 52 signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 Discontinued Procedure: Under certain circumstances, the physician may elect to end a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure before the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

59 Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier available and use of modifier 59 best explains the circumstances should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service with a non-E/M service with a non-E/M service performed on the same date, see modifier 25.

99 Multiple Modifiers: Under certain circumstances, two or more modifiers may be necessary to completely delineate a service. In such situations modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

4.29 **Durable Medical Equipment and Supplies**

4.29.1 Whenever 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 eighty-five percent (85%) of actual charge ("POC 85").

4.29.2 The payment system will be adjusted yearly pursuant to 19 **Del.C.** §2322B(14).

4.29.3 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 – HCPCS Level II Codes.

12 DE Reg. 1515 (06/01/09)
13 DE Reg. 1558 (06/01/10)
14 DE Reg. 1375 (06/01/11)
15 DE Reg. 1761 (06/01/12)
16 DE Reg. 1080 (04/01/13)
17 DE Reg. 322 (09/01/13)

5.0 Utilization Review

5.1 Pursuant to chapter 101, title 29 of the **Delaware Code**, the Department of Labor has developed a utilization review program with the intent of providing reference for employers, insurance carriers, and health care providers for evaluation of health care and charges. The intended purpose of utilization review services is to provide prompt resolution of issues related to treatment and/or compliance with the health care payment system or practice guidelines for those claims which have been acknowledged to be compensable, without the employer or its insurance carrier obtaining legal representation, or incurring the costs associated with legal involvement in the utilization review process.

5.2 An employer or insurance carrier may engage in utilization review to evaluate the quality, reasonableness and/or necessity of proposed or provided health care services for acknowledged compensable claims. Any person conducting a utilization review program for workers' compensation shall be required to contract with the Office of Workers' Compensation once every two (2) years and certify compliance with Workers' Compensation Utilization Management Standards or Health Utilization Management Standards of Utilization Review Accreditation Council ("URAC") sufficient to achieve URAC accreditation or submit evidence of accreditation by URAC.

5.3 At this time, Utilization Review is limited to health care recommendations subject to practice guidelines developed by the HCAP.

5.4 An employer or insurance carrier may request utilization review by complying with all the terms and conditions set forth on the forms attached hereto. Upon completion and submission of the forms, information package and medical records package by the employer or insurance carrier, the designated utilization review company will review treatment to determine if it is in compliance with the practice guidelines developed by the Health Care Advisory Panel and adopted and implemented by the Department of Labor. (See Appendix A)

5.4.1 The utilization review company shall be randomly selected by the Department of Labor. The utilization review company first assigned to the case will remain with that case throughout its duration. The Department of Labor will collect all documentation required to be submitted pursuant to the utilization review process and send such documentation for review to the utilization review company.

5.4.2 If the claim is denied by an employer or insurance carrier for non-compliance with any applicable Practice Guideline, only the first bill for such treatment, and not all subsequent bills for the same service, need be denied and referred to utilization review.

5.4.3 In the instance of a compensable claim where the treatment is outside the applicable Practice Guideline for which the health care provider requests pre-authorization but the employer/carrier advises that it does not pre-authorize treatment, such response should be interpreted as tantamount to a denial of such treatment so that the claimant may file a Petition with the IAB to determine whether the treatment is compensable.

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 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: (a) the surgery is causally related to the work accident, and (b) the surgery is within the Practice Guideline, with specific reference to the Practice Guideline provision relied upon.

5.4.4.1 The 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.

5.4.5 All past, prospective and concurrent health care decisions must be reviewed and a Utilization Review determination made no later than three (3) working days from receipt of the aforementioned information by the company performing the review, for emergency care, but no later than 15 calendar days from receipt of the aforementioned information by the company performing the review.

5.5 If a party disagrees with the findings following utilization review, a petition may be filed with the Industrial Accident Board for *de novo* review.

The decision of the utilization review company shall be forwarded by the Department of Labor, by Certified Mail, Return Receipt Requested, to the claimant, the claimant's attorney of record, the health care provider in question, and the employer or its insurance carrier.

5.6 If there are no current practice guidelines applicable to the health care provided, a party may file a petition with the Industrial Accident Board seeking a determination of the appropriateness of treatment.

15 DE Reg. 1761 (06/01/12)
17 DE Reg. 322 (09/01/13)

APPENDIX A

DELAWARE DEPARTMENT OF LABOR
MEDICAL UTILIZATION REVIEW PROGRAM
REQUEST FOR UTILIZATION REVIEW

(Pursuant to **19 Del.C. §2322 F(j)**)

PLEASE TYPE OR CLEARLY PRINT ALL INFORMATION. All information and addresses must be verified as current and accurate.

1. Date of Request_____
2. WC Number(s)_____ Date(s) of injury_____
3. Nature of Injury/Practice Guideline(s)_____
4. Claimant's Name_____
   Age_____ Sex_____
   Address_____Tel. No._____
   City_____ State_____ Zip_____
5. Employer_____
6. Party Requesting Review _____
   Primary Contact at Party's Office_____
   Email Address_____
   Address_____ Tel. No._____
   City_____ State_____ Zip_____

7(a). Health Care Provider to be Reviewed_____
Specialty (if applicable)_____
Date of first treatment _____
Address_____ Tel. No._____
City_____ State_____ Zip_____

7(b). Health Care Provider to be Reviewed_____
Specialty (if applicable)_____
Date of first treatment _____
Address_____ Tel. No. _____
City_____ State_____ Zip_____

(c) Additional Health Care Providers to be reviewed (list name, specialty, address, etc. on a separate sheet)
(d) Health Care Facility(s) Impacted (e.g. hospital, ambulatory surgery center, etc.) by this retrospective review (list name, address, etc. on a separate sheet)

8. Treatment to be reviewed: Specify the health care service to be reviewed and the timeframe within which the treatment was or will be rendered.

_____
_____
_____
_____

My signature certifies the following: (a) all names and addresses on this form have been verified as current and accurate; (b) two identical copies of associated medical material are being submitted for review; (c) the bill denial for the treatment subject to this review was sent within 30 days of receiving the provider's bill; and (d) all items listed in the table of contents are in each copy of the medical material.

Print Name of Requester Signature of Requester

COPY THIS FORM OR REPRODUCE EXACTLY IN APPEARANCE AND CONTENT.
SEE INSTRUCTIONS ON BACK

REQUIRED CONTENT, PRESENTATION AND BINDING METHOD
FOR ALL MATERIALS SUBMITTED FOR UTILIZATION REVIEW

In accordance with 19 Del.C. §2322 F(j) and the regulations adopted pursuant thereto, all information and medical records submitted to the Department of Labor, Office of Workers' Compensation must represent all of the facts of this case.

INFORMATION PACKAGE · REQUIRED CONTENT

"Completed and signed Request for Utilization Review Form.

"Proof of date of issuance of claim denial (so the Department of Labor is able to verify that Utilization Review was requested within 15 days of the date of the claim denial).

MEDICAL RECORDS PACKAGE· REQUIRED CONTENT

Section 1. All reports, notes, etc., from provider being reviewed from the date of injury or the two (2) year period immediately preceding the treatment to be reviewed, whichever is shorter, and the time frame within which the treatment to be reviewed was or will be rendered, as submitted to the requesting party.

Section 2. All reports, notes, etc., of other treating providers from the date of injury or the one (1) year period immediately preceding the treatment to be reviewed, whichever is shorter, as submitted to the requesting party.

Section 3. All diagnostic test results from the date of injury or the two (2) year period immediately preceding the treatment to be reviewed, whichever is shorter, as submitted to the requesting party.

NOTE Do not include copies of any billing statements or comments/instructions directed to the Utilization Review panel. All material must be presented in identified sections; each section's content must be presented in chronological order.

REQUIRED PRESENTATION AND BINDING METHOD FOR ALL SUBMITTED MATERIALS

a. All submitted material must be presented in two (2) identical bound copies.
b. If tabs are used for the sections, they must be positioned to the right side of the document.

Mail or Deliver to: Department of Labor
Office of Workers' Compensation
4425 N. Market St.
Wilmington, DE 19802
302-761-8200

15 DE Reg. 1167 (02/01/12)

6.0 Forms

6.1 The Physician's Report of Workers' Compensation Injury "Progress" Report is to be completed by the health care provider and provided to the employee, the employer and the employer's insurance carrier, if applicable, upon any material change in the employee's physical capability which impacts the employee's return to work status. The "Progress" Report need not be completed by the health care provider upon each and every visit, but rather only in the instance of any material change in the injured employee's physical capability which impacts the employee's return to work status. "Progress" Reports provided in contravention of the above will not be subject to any charge for completion and submission.

6.2 The Physicians Report of Workers' Compensation Injury "Progress" Report and Instructions (Physicians Form) and complete instructions on completing the form will be available on the Department of Labor web site.

6.3 The Employer's Modified Duty Availability Report and Instructions (Employers' Form) must be completed, pursuant to 19 **Del.C.** §2322E(d). If the employee has returned to full duty, the employer need not complete the form. The Employers' Form and complete instructions will be available on the Department of Labor web site.

11 DE Reg. 1661 (06/01/08)
12 DE Reg. 67 (07/01/08)
12 DE Reg. 1515 (06/01/09)
14 DE Reg. 1375 (06/01/11)
15 DE Reg. 365 (09/01/11)
15 DE Reg. 1761 (06/01/12)
17 DE Reg. 322 (09/01/13)
17 DE Reg. 488 (11/01/13) (Prop.)