ALABAMA DEPARTMENT OF INDUSTRIAL RELATIONS
ADMINISTRATIVE CODE

RULE

480-5-5-.15 **BILL SCREENING**.

(1) **Global Surgery Fees -** Ongoing services prior to surgery shall be covered on a fee-for-services basis. The global surgery allowance shall encompass the actual surgery procedure and normal post-operative services. Post-operative visits after six weeks from the date of surgery shall be reimbursable separately. The six week global period applies only to those codes which have been assigned a 90-day global period by Medicare. Global surgery fees include specialty surgical techniques such as, but not limited to, the use of microscopes, videoscopes or lasers, with the exception of unusual situations or extremely long procedures. Reimbursement, in such cases, shall be handled with appropriate individual consideration for the circumstances. A separate charge for a history and physical examination shall be reimbursable for new patients. Global surgery fee includes any anesthesia administered by the operating surgeon.

(2) **Multiple Surgery Procedures**

(a) For operations performed by the same physician during the same operative session, at the same operative site, reimbursement shall be made at 100 percent (100%) for the procedure with the highest Workers' Compensation fee schedule allowance and 50 percent (50%) of the approved rate for all additional procedures which are medically necessary and not incidental to the other.

(b) For unrelated operations performed by the same physician in different body areas or systems during the same operative session, the multiple procedure reimbursement rule shall apply independently to each body system when the procedures are medically necessary and not incidental to the other procedures.

(c) When bilateral procedures that require preparation of a separate operative site during the same operative session are performed by the same physician, aggregate reimbursement shall be 180 percent (180%) of the allowance of the unilateral procedure.

(d) Certain codes, by the nature of their description, are never to be billed as primary procedures. The value assigned in the fee schedule has already been reduced as a secondary procedure and, therefore, the procedure should be reimbursed at 100 percent (100%) of the allowance. These codes may be identified by the description in the CPT manual specifying each additional service, i.e., 11001, 63091, 63057.

(3) **M.D. Assistant Surgeon -** Medicare guidelines shall be used to determine when payment for M.D. assistant surgeon is permitted. Reimbursement amounts shall be determined by multiplying the reimbursement made to the primary surgeon by 25 percent (25%).

(4) **Non-M.D. Certified Surgeon's Assistant -** Medicare guidelines shall be used to determine situations when payment for non-M.D. Certified Surgeon's Assistant shall be made. Reimbursement amounts shall be made at one-half the rate for M.D. assistant surgeon. Claims shall be billed using the appropriate HCFA modifier indicating services were performed by a non-M.D. Certified Surgeon Assistant.

(5) **Supplies and Materials**

(a) Certain supplies and materials provided by the physician may be listed and reimbursed separately. Braces and splints are reimbursable when they are provided for the treatment of injuries that do not involve fracture or dislocation care. The appropriate HCPCS code should be used. Braces and splints are reimbursable separately for the treatment of fractures or dislocations only in accordance with CPT guidelines. When requested, the provider shall furnish the payer a copy of the vendor=s invoice for the supply item being billed.

(b) Routine inexpensive supplies such as ace bandages, gauze, tongue depressors, adhesive bandages, ointments or creams used in minimal quantities, etc., are not reimbursable as separate items.

(c) Ointments or creams dispensed in quantities intended for repeated use by the patient are reimbursable separately when properly itemized and appropriate.

(d) Sterile trays used in the process of performing minor office surgical procedures are included in the reimbursement for the procedure itself and are not reimbursable as a separate item.

(6) **Minor surgeries and endoscopies:**

(a) When the minor surgery or endoscopy is performed at the time of the initial visit and this procedure constitutes the major service rendered during the initial visit, payment shall be only for that procedure code. If Medicare has assigned a surgical procedure 10-day global period, then this procedure shall have a 10-day global period.

(b) If a significant separately identifiable cognitive service is also documented, the appropriate evaluation and management doe (established or new patient) with modifier –25 is reimbursable. Billing for the evaluation and management code is not appropriate, if the physician only identified the need for the minor surgery or endoscopy procedure.

(7) When a procedure has been specified as a separate procedure (CPT-4 procedure code), the following applies:

(a) Some of the listed procedures are commonly carried out as an integral part of a total service, and, therefore, do not warrant a separate identification.

(b) When, however, such a procedure is performed independent of, and is not related to other services, it may be listed as a separate procedure.

(8) **Cosurgery and Team Surgery**

(a) Cosurgery involves two surgeons usually with different specialties who are performing a single procedure for a specific surgical problem. Payment when reporting the same surgical procedure is allowed at 150 percent (150%), divided between the two surgeons.

(b) Team surgery is when two or more surgeons with different skills are operating for different conditions. The procedure may be performed in the same or different operative site(s) (incisions). Each physician's reimbursement is considered independently. Multiple surgery rules apply to each physician's reimbursement.

(9) **Anesthesia Services -** Employers/agents or UREs shall utilize the current American Society of Anesthesiologists (ASA) Relative Value Guide when determining reimbursement for anesthesiology services:

(a) For determination of basic unit values;

(b) Physical status modifier units as identified in the ASA Relative Value Guide;

(c) Qualifying circumstance units as stated in the ASA Relative Value Guide; and

(d) Time units based upon 15-minute increments and/or fraction thereof.

1. Items listed below shall apply when professional fees are billed separately by either an M.D. anesthesiologist or Certified Registered Nurse Anesthetist (CRNA). When professional services are rendered by the M.D. Anesthesiologist or a CRNA who is in the employ of a facility, these professional services for the employed M.D. Anesthesiologist or employed CRNA shall be billed separately from the facility charges.

(i) When the M.D. anesthesiologist personally performs all anesthesia related services, payment shall be made to the M.D. anesthesiologist at 100 percent (100%) of the full fee schedule amount;

(ii) When the CRNA, who is not in the employ of the M.D. Anesthesiologist or facility and is not under the supervision of an M.D. anesthesiologist, personally performs all anesthesia related services, payment shall be made at 65 percent (65%) of the full fee schedule amount to the CRNA; and

(iii) When the M.D. anesthesiologist supervises a CRNA in the employ of the M.D. anesthesiologist, payment shall be as follows:

(I) Payment shall be made at 100 percent (100%) of the full fee schedule amount to the M.D. anesthesiologist; and

(II) No payment shall be made to the CRNA.

2. When the M.D. anesthesiologist supervises a CRNA in the employ of the facility, payment shall be made at 50 percent (50%) of the full fee schedule amount to the M.D. anesthesiologist. Payment for professional services provided by the CRNA shall be made at 50 percent (50%) of the full fee schedule amount and to the facility.

3. When the M.D. anesthesiologist supervises a CRNA who is not in the employ of an M.D. anesthesiologist or facility, payment shall be made at 50 percent (50%) of the full fee schedule amount to the M.D. anesthesiologist and 50 percent (50%) of the full schedule amount to the CRNA.

4. The M.D. anesthesiologist shall remain within the immediate vicinity of the CRNAs that are receiving medical direction, and shall not simultaneously extend supervision to more than four (4) anesthetists at one time.

5. When the M.D. anesthesiologist is acting as the operative surgeon in

procedures such as pain management and blocks, the physician shall be reimbursed per the Maximum Fee Schedule for Physicians as appropriate for the procedure performed per the CPT-4 manual in current use. The M.D. anesthesiologist, in cases such as this, shall not charge for direction, supervision or performance of any anesthesia services.

6. When the M.D. anesthesiologist is acting as the deliverer of anesthesia for those services not addressed in the ASA Relative Value Guide a relative value of 4 base units shall be assigned with no time. Reimbursement shall be based on the 4 units and the Maximum Fee Schedule for Anesthesia.

7. When the M.D. anesthesiologist is acting as the deliverer of anesthesia for pain blocks a relative value of 4 base units shall be assigned. Billing shall include the 4 base units and the time expended for the performance of the procedure. Reimbursement shall be based on the 4 base units, 2 units of time, and the Maximum Fee Schedule for Anesthesia."

(i) When the operative surgeon requests monitoring by a CRNA, and anesthesia services is dictated by medical necessity, and the CRNA monitors the anesthesia during the flat rate procedure, the CRNA shall be reimbursed at 50 percent (50%) of the Basic Unit Value allowed the M.D. anesthesiologist. The operative surgeon shall justify through documentation the medical necessity of the request.

(ii) When the CRNA is not medically directed by the M.D. anesthesiologist and medical necessity is met, the CRNA shall be reimbursed at 65 percent (65%) of the allowed amount or at 2.6 Basic Value Units per the Maximum Fee Schedule for Anesthesiologists.

8. When the M.D. anesthesiologist places specialized invasive monitoring devices, such as central venous catheters, arterial lines, and flow directed catheters (e.g., Swan-Ganz), the M.D. anesthesiologist shall be reimbursed per the Maximum Fee Schedule for Physicians as appropriate for the procedure performed per the CPT-4 manual in current use.

9. When the M.D. anesthesiologist is responsible for medically necessary postoperative pain management, payment shall be made as follows:

(i) For the insertion of continuous epidural catheter (CPT-4 code 62279) when

placed the day of surgery or during the first postoperative day, provided the catheter was not used to deliver the anesthesia during the surgical procedure. This code includes placement of the catheter and injection of the anesthetic substance. Reimbursement shall be per the Maximum Fee Schedule for Physicians.

(ii) For the daily management of the epidural for a reasonable period of time over the subsequent postoperative days (CPT-4 code 01996). Daily management of the epidural shall not be allowed on the same day as insertion of the catheter.

(iii) Patient Controlled Analgesia (PCA) shall be reimbursed at four (4) basic units for initiation of pumps and evaluation of needs, regardless of the period involved.

(10) **Modifiers** - The CPT-4 Manual identifies all performed procedures that warrant the use of modifiers. Only those modifiers found in the guidelines to each section of the CPT-4 may be applied. Multiple surgery procedures have been addressed in Rule 480-5-5-.15(2). Modifiers shall be used only as medically necessary and appropriate. When multiple procedures are performed by the same provider on the same day or during the same session, reimbursement for Modifier -51 shall be made at 100 percent (100%) for the procedure with the highest Workers' Compensation fee schedule allowance and 50 percent (50%) of the approved rate for all additional procedures which are medically necessary and appropriate and not incidental to the other. Other reimbursement adjustments shall be dependent upon the individual modifier and the Alabama Department of Industrial Relations Administrative Code, Utilization Management and Bill Screening Chapter.

(11) **Psychologist Services** - Psychologist services shall be reimbursed as follows:

(a) Central nervous system assessments/tests, as defined in the Physicians' Current Procedural Terminology Manual, performed by a clinical psychologist shall be reimbursed at 100 percent (100%) of the allowable amount as stated in the Maximum Fee Schedule for Physicians.

(b) All other clinical psychologist services, other than central nervous system assessments/tests, furnished outside of the hospital inpatient setting shall be reimbursed at 75 percent (75%) of the allowable amount as stated in the Maximum Fee Schedule for Physicians.

(c) Central nervous system assessments/tests, if ordered by a physician, performed by a non-clinical psychologist shall be reimbursed at 100 percent (100%) of the allowable

amount as stated in the Maximum Fee Schedule for Physicians. All other services provided by a non-clinical psychologist shall not be reimbursable.

(12) **Physician Assistant/Nurse Practitioner** - Utilization of the physician assistant/nursing practitioner shall be defined as an extension of the authorized treating physician. These providers may perform procedures and treatments at the direction of the authorized treating physician in accordance with their certification and do evaluation and management of patients at a very minimal decision making capacity, such as:

(a) Evaluation and management of a new patient which requires a problem focused history, a problem focused examination, and straightforward medical decision making (CPT code 99201 or subsequent code); or

(b) Evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem is minimal (CPT code 99211 or subsequent code).

1. Any written documentation/report/statement by the physician assistant/nurse practitioner shall be approved and counter-signed by the treating physician within 48 hours or two working days of the visit.

2. If the treating physician employs a physician assistant/nurse practitioner, the M.D. treating physician shall obtain authorization from the employer/agent after the first visit for the physician assistant/nurse practitioner to provide continued service. The authorization shall determine the number of visits which shall require the treating physician's presence, and the number of visits that the physician assistant/nurse practitioner may examine/treat the patient without the presence of the treating physician.

3. The authorized treating physician must personally determine all return to work, work restrictions, maximum medical improvement, impairment ratings, and referrals as these are complicated medical decision issues which are impacted by legal issues within the Workers' Compensation Law.

(2) Reimbursement for the services of the physician assistant/nurse practioner shall be consistent with the following:

(a) The bill for services shall reflect whether a service was rendered by the M.D. physician or the non-physician practitioner. The modifier AN shall be used if services are solely provided by the physician assistant. The appropriate HCPCS modifier shall be

used to indicate services that have solely been provided by the nurse practitioner.

(b) The fee for service shall be 100 percent (100%) of the fee schedule for treatments and procedures as directed by the M.D. physician. The appropriate evaluation and management code may be used when the M.D. physician is providing the services with the physician assistant or nurse practitioner augmenting or assisting in some capacity. If the physician assistant or nurse practitioner is the sole provider of service, then the evaluation and management codes are limited to 99201 or 99211, or subsequent code.

(c) No payment shall be allowed for evaluation and management services should it be determined by the employer/agent that the services were billed improperly and/or that the physician assistant or nurse practitioner was providing services other than simple straightforward evaluation and management services.

(d) Payment is to be made directly to the facility or physician that employs the physician assistant or nurse practitioner. Nurse practitioners who have their own independent practice may bill using the HCFA 1500 claim form and CPT/HCPCS codes.

(13) **NEW AND ESTABLISHED PATIENT** - The guidelines for determining if an injured worker will be classified as a new or established patient for the purposes of coding and billing for medical treatment shall be found in the Evaluation and Management (E/M) Services Guidelines of the Physicians' CPT-4.

(14) **INDEPENDENT MEDICAL EXAMINATION** - Physicians performing an independent medical examination shall code the service using CPT-4 Code 99245, Office Consultation, for the first eighty (80) minutes of time, CPT-4 Code 99354, Prolonged Physician Service, for the next thirty to seventy-four (30 - 74) minutes of time, and CPT-4 Code 99355, Prolonged Physician Service, for each additional thirty (30) minutes or fraction thereof, except pursuant to Code of Alabama, 1975, '25-5-314, Contracts for medical services at mutually agreed rates.

(15) **ERECTILE DYSFUNCTION MEDICATION** - Workers' compensation will cover erectile dysfunction medication when used for the treatment of men with organic erectile dysfunction resulting from a definitive organic disorder as the result of a compensable work related injury. Organic impotence is defined as that which may be reasonably expected to occur following certain traumatic injuries or surgical procedures. Psychological or psychiatric reasons will not be accepted as organic impotence.

(a) Conditions that may result in organic erectile dysfunction are:

1. Spinal cord injuries;

2. Injuries to the genital and lower urinary tract;

3. Severe fracture of the pelvis that resulted in injury to the bladder or urethral pelvic nerves;

4. Surgery of the genital or lower urinary tract;

5. Removal of the rectum causing injuries to nerves or vessels resulting in erectile dysfunction; or

6. Any surgery that may interfere with the pelvic nerves or circulation.

(b) Coverage for up to five (5) tablets per 30 days may be provided if:

1. Treatment is being provided for an accepted workers' compensation claim;

2. One of the above conditions has been satisfied;

3. An evaluation has been conducted by an urologist to determine that an organic erectile dysfunction as herein described does exist; and

4. A letter is received from either the urologist, who performed the above subject evaluation, or from the treating physician stating the medical necessity of erectile dysfunction medication prior to the authorization of the prescription.

(16) **Explanation of Review (EOR)** An EOR shall be issued with each payment for medical services rendered to an injured worker. The EOR at a minimum shall contain the following information:

(a) The medical provider’s name, address, city, state, and zip code;

(b) The claimant’s name, identifying number or patient account number, and the insurer’s claim number;

(c) The employer, if self-insured, or the insurance company’s name, address, city, state, zip code, and phone number;

(d) The review company's name, address, city, state, zip code, and phone number, if applicable;

(e) The third party administrator's name, address, city, state, zip code, and phone number, if applicable;

(f) The date of injury;

(g) The date the review was conducted;

(h) The ICD-10 code that identifies the principal diagnosis;

(i) The medical services that are reviewed:

1. The date the services were rendered;

2. The services shall be identified by the appropriate CPT, HCPCS;

3. The amount charged for each code that is listed;

4. Any adjustment to the billed dollar amount shall be stated and identified as a fee schedule, preferred provider organization (PPO) discount, and/or bill review discount; and

5. The amount recommended for payment.

(j) The reason or justification for the adjustment to the recommended payment amount; and

1. The name of the PPO Agreement, if applicable; or

2. Other specific justification for the adjustment.

(k) The business name, address, city, state, zip code, and phone number of the entity to contact, if the provider disagrees with the recommended payment. The initial and second reconsideration requests shall be directed to the payor or review company, as indicated on the EOR, before requesting assistance from the State.
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