WORKERS' COMPENSATION MEDICAL FEE SCHEDULE

RULE 40.000

40.000 Workers' Compensation Medical Fee Schedule

Rule 40.000, Medical Fee Schedule, identifies medical services and procedures using Current Procedural Terminology (CPT), the Healthcare Common Procedure Coding System (HCPCS) and Current Dental Terminology (CDT). Appendix 1 of Rule 40.000 includes tables for determining fee schedule rates and shall be replaced annually, including to reflect any additions, deletions and modifications to these code sets.

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See Appendix 1 for updated copyright information associated with periodic rate table updates.

40.10 General Provisions

40.011 Authority and Purpose

This rule is promulgated by the Vermont Department of Labor under the authority of 21 V.S.A. § 640(d). It establishes that the liability of an employer to pay for medical services including but not limited to evaluation and management, surgical, hospital, physical medicine, durable medical equipment, dental and nursing services provided to an injured employee shall not exceed the maximum fee for a particular service as provided for in this rule.

40.012 Definitions

(A) "Charge" shall mean the amount billed by the health care provider or health care facility to all payers for the same service, whether under workers' compensation or not.

(B) "CPT code" means a numeric code, included in the CPT manual, used to identify a specific medical service, article or supply.

(C) "Commissioner" means the Commissioner of the Vermont Department of Labor.

(D) "Follow-up Days (FUD)" means the maximum number of days of care

following a surgical procedure that are included in the procedure's maximum allowable payment but does not include care for complications, exacerbations, recurrent, or other diseases or injuries.

(E) "Health care facility" shall mean the same as defined in 18 V.S.A. § 9432(8).

(F) "Health care provider" shall mean the same as defined in 18 V.S.A. § 9432(9).

(G) "Hospital" shall mean the same as defined in 18 V.S.A. § 1902(1) and shall be licensed in its state of domicile.

(H) "Incidental Surgery" means a surgery which is performed on the same patient, on the same day, by the same doctor but is not related to the diagnosis.

(I) "Maximum Allowable Payment" (MAP) means the maximum fee for a procedure listed in Appendix 1, subject to the provisions of section 40.020 of this rule, or the health care facility's or health care provider's charge, whichever is less. For those procedures having no code listed in Appendix 1 of this fee schedule, payment shall not exceed 83% of the charge for the service.

(J) “Mid-level Health Care Professional” shall mean non-physician medical practitioners appropriately licensed, certified and/or accredited as legal and legitimate providers. They shall include, but are not limited to, physician assistants, nurse practitioners, nurse anesthetists, clinical nurse specialists, mental health counselors, medical or clinical social workers, physical therapist assistants and occupational therapist assistants.

(K) "Modifier" means a two-character alphabetic or numeric code that is added to a procedure code to indicate that the service rendered differs in some material respect from the service described in this rule or in the Current Procedure Terminology manual in effect on the date the service was rendered.

(L) "Nursing home," "residential care home," and "therapeutic community residence" shall mean the same as defined in 33 V.S.A. § 7102 and shall be licensed in its state of domicile.

(M) "Health Insurer" means any entity or group of entities that pays benefits for general healthcare services including but not limited to health insurance company, self-insured employer, self-funded group, medical service corporation or managed care organizations.

(N) "Employer" includes any body of persons; corporate or unincorporated, public or private; and the legal representative of a deceased employer, and includes the owner or lessee of premises or other person who is virtually the proprietor or operator of the business there carried on, but who, by reason there being an independent contractor or for any other reason, is not the direct employer of the worker there employed. If the employer is insured, "employer" includes the carrier so far as applicable. (21 V.S.A. § 601(3) and § 687).

(O) "Insurance Carrier", includes any corporation from which an employer has obtained workers’ compensation or guaranty insurance in accordance with the provisions of 21 V.S.A. chapter 9.

(P) "Medical Necessity." Workers' compensation insurers are only responsible for paying for services or items that are medically necessary. Medical necessity is defined as health care services that "are appropriate, in terms of type, amount, frequency, level, setting, and duration to the beneficiary's diagnosis or condition." Medically necessary care must be consistent with generally accepted practice parameters as recognized by health care providers in the same or a similar general specialty as typically treat or manage the diagnosis or condition, and help restore or maintain the claimant's health; or prevent deterioration or palliate the claimant's condition.

40.013 Interpretation

It is the intention of the Vermont Department of Labor that this rule be generally interpreted and administered based on the conventional practices of the licensed health insurers in Vermont, e.g., following the practice of reimbursing for certain procedures based on time increments or specific units.

40.020 Reimbursement

40.021 General Reimbursement Requirements

(A) An employer is not liable for reimbursement for health care services provided to an injured employee in excess of the maximum allowable payment (MAP) provided for in this rule. The maximum allowable payment is the maximum fee for a procedure, supply, service or durable medical equipment listed in Appendix 1 of this rule or, subject to the other provisions of this rule, or the health care facility's or health care provider's charge, whichever is less. For those procedures having no code listed in Appendix 1 of this fee schedule, the maximum allowable payment shall not exceed 83% of the charge for the service.

(B) Reimbursement for an amount less than the maximum allowable payment in Rule 40.000 is allowed, but only in those instances where there is a contract for workers' compensation related services between the employer or insurance carrier and the health care provider that provides for a lower amount.

(C) In accord with 21 V.S.A. § 640(a), the employer/insurance carrier is responsible for payment of reasonable and necessary medical treatment for a work-related injury. Billing for treatment of a work-related injury shall be directed to the employer/insurance carrier. In no event shall the employee be required to provide payment to the medical provider for treatment of a work-related injury deemed compensable nor is the employee required to pay additional reimbursement for medical services which are subject to this fee schedule.

(D) Pre-payment under this schedule is prohibited.

(E) Balance billing the employee for fees in excess of those allowed by this medical fee schedule is prohibited.

(F) The employer/insurance carrier shall pay the health care provider's charge or the maximum allowable payment under this fee schedule, whichever is less, within 30 days of receipt of the bill and legible, supporting documentation. If the claim is held for more than 30 days without payment, then the employer/insurance

carrier must notify the provider in writing as to the status of the claim. When payment for a procedure is denied, the employer/insurance carrier must provide an "Explanation Of Benefits" (EOB)/Remittance Advice to the medical provider within 30 days of receipt of the bill. If the employer/insurance carrier disagrees with the appropriateness of a procedure code billed, it shall request a hearing, in writing, before the Commissioner within 30 days of receipt of the bill. An employer/insurance carrier may not change a billed procedure code unless the medical provider agrees.

(G) Reimbursement shall be limited to duly licensed health care providers for services provided within the scope of their practice. Payment for a service provided by a mid-level health care professional operating under the supervision of another health care professional may be paid either to the mid-level health care professional or the supervising health care professional, but not both, subject to the provisions of paragraph 40.040(E) of this rule.

(H) The health care provider shall maintain documentation for each service provided which is sufficiently detailed to allow for the review of the medical necessity of the service and the appropriateness of the fee charged. This documentation shall include but is not necessarily limited to progress or chart notes, test results, and billing information (CMS-1500 Form and/or UB-04 Form). Individual invoices are not required. Failure to provide documentation when requested may result in delays and/or, with the approval of the Commissioner, denial of reimbursement.

(I) The National Correct Coding Initiative (NCCI) for procedure-to-procedure (PTP) code pair edits and medically unlikely edits (MUE) shall be followed for determining proper billing and reimbursement for medical services. PTP edits prevent improper payment when certain codes are submitted together for covered services. MUEs provide guidance on the maximum number of units of service allowable under most circumstances for a single HCPCS/CPT code billed by a provider on a date of service for a single patient. The NCCI coding initiative was developed and is updated under the direction of the Centers for Medicare and Medicaid Services (CMS) to promote correct coding of health services and prevent payment for improperly coded services. The NCCI is comprised of edits to evaluate claims when a provider bills more than one service for the same patient for the same date of service. It is based on coding conventions in the American Medical Association's Current Procedural Terminology (CPT) book, coding guidelines from national societies, and analysis of medical and surgical practices. The purpose of the NCCI is to ensure that the most comprehensive group of codes is billed rather than the component parts, and to edit codes that cannot reasonably be performed together based on either the definition or anatomical considerations. More information about the NCCI can be found at: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd.

(J) Add-on code edits describe a service that can only be performed in addition to a primary service by the same practitioner. Add-on codes are identified by a + preceding the CPT code in Appendix 1.

(K) Bills submitted by health care providers or health care facilities to employers/insurance carriers for reimbursement of medical services must specify the date and type of service, the appropriate CPT, HCPCS or CDT code in effect at the time of service or the appropriate facility revenue code, the condition treated, and the charges for each service. Health care providers are required to properly bill on form CMS 1500 or form UB-04 and provide the last 4 digits of the patient's Social Security Number, to comply with this requirement. Uncoded bills may be returned for coding.

(L) Durable medical equipment, prosthetics, orthotics, injectable pharmaceuticals, supplies and materials provided by the physician over and above those usually included with the office visit or procedure, as well as other supplies and services, shall be billed using the appropriate HCPCS code when no appropriate CPT code is included in Appendix 1. When no CPT code or HCPCS code exists in Appendix 1, reimbursement shall be made at 83% of billed charge or 120% of cost whichever is less. Individual invoices are not required, but documentation allowing a reasonable determination of what the provider paid for the materials and equipment must be submitted. Durable medical equipment and supplies are not reimbursable if shipped automatically without receiving prior approval from the employer/insurance carrier or the prescribing provider.

(M) Global reimbursement policy: For procedure codes listed in Appendix 1 with 10 follow-up days in the FUD column, any medically necessary care related to that procedure provided in the 10-day period following the procedure is included in the fee listed in Appendix 1. Similarly, when 30 follow-up days are listed, related care provided during the 30-day period following the procedure is included in the fee. For purposes of applying the global reimbursement policy, the day of surgery is counted as day 0. Any medically necessary care related to the procedure and provided after the 10- or 30-day period may be separately billed in addition to the procedure.

(N) The rate table appendix shall be updated on an annual basis based on the following:

(1) The Vermont professional conversion factors shall be updated by a percentage equal to the Medicare Economic Index (MEI) factor for the year the rates become effective, not to exceed 3% in any year.

(2) The Vermont multiplier applied to the CMS Outpatient Prospective Payment System (OPPS) to develop rates for outpatient hospital and ambulatory surgery center facility services shall be updated by the Medicare Outpatient Facility PPS market basket index for the year in which the rates become effective, not to exceed 3% in any year and shall be capped when the multiplier reaches 200%.

(3) The Vermont base rate for inpatient facility services shall be updated by a percentage equal to the CMS Inpatient Hospital PPS market basket index for the year in which the rates become effective, not to exceed 3% in any year.

(4) The CMS market basket indices are updated each year and can be found on CMS.gov at https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-data. Go to the link titled: Actual Regulation Market Basket Updates

40.022 Hospital and Ambulatory Surgery Center (ASC) Reimbursement

Unless otherwise specified in this rule, the maximum allowable payment for facility services provided to an employee shall be based on the information provided in Appendix 1 or the amount charged, whichever is less. For those procedures having no code listed in Appendix 1 of this fee schedule, the maximum allowable payment shall not exceed 83% of the charge for the service.

(A) Outpatient hospital and ASC maximum allowable payment amounts are included in Appendix 1 on the same line as the professional fees in each service area. Facility services provided by ASCs are reimbursed at the same level as outpatient hospitals. Reimbursement includes all facility services directly related to the procedure performed on the day of treatment, including nursing and technician services, use of the facility, surgical dressings, splints, casts and equipment directly related to the provision of the procedure.

(1) Implantable devices shall be reimbursed separately at the maximum allowed payment amount using the HCPCS codes listed in Appendix 1 or the amount charged, whichever is less. If there is no corresponding code, reimbursement shall be 120% of cost. Individual invoices are not required, but documentation allowing a reasonable determination of what the provider paid for the device must be submitted.

(2) When a hospital bills for outpatient physical or occupational therapy services on a UB-04 form, the maximum reimbursement is based on the professional fees listed in Appendix 1.

(3) Payment for multiple procedures is based on Medicare's hospital Outpatient Prospective Payment System (OPPS) status indicators (SI), which provide information about the circumstances under which a separate facility fee may be paid or is bundled with other facility services. The status indicator for each code is included in the SI column of the applicable rate tables in Appendix 1. Detailed information about status indicators, including definitions of how they are used, can be found in CMS OPPS Addendum D1: www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/regulations-notices/cms-1809-p

(4) Hospitals and ASCs shall be reimbursed the lesser of the sum of billed charges for all services that are bundled with the primary code or the maximum allowed payment for the primary procedure. The definitions of bundled services can be found in Section 40.022(A)(3) above.

(5) Hospital services with a status indicator of J1 are bundled with all other services with a J1 status indicator. The primary (most expensive) J1 service shall be reimbursed based on the fee schedule amount. There is no additional reimbursement for other codes with a status indicator of J1 on the claim.

(B) Inpatient hospital facility services shall be reimbursed the maximum allowed payment based on diagnosis related groups (DRGs) listed in Appendix 1 or the amount charged, whichever is less.

(1) The DRG amount includes all facility services provided in conjunction with the hospital stay, with the exception of implantable devices, which are eligible for separate reimbursement.

(2) Implantable devices shall be reimbursed separately at the maximum allowed payment amount using the HCPCS codes listed in Appendix 1 or the amount charged, whichever is less. If there is no corresponding code, reimbursement shall be 120% of cost. Individual invoices are not required, but documentation allowing a reasonable determination of what the provider paid for the device must be submitted.

40.023 Nursing Home Reimbursement

Nursing home reimbursement, residential care home reimbursement, and therapeutic community residence reimbursement shall be negotiated and reimbursement rates agreed upon by the facility and employer/insurance carrier prior to admission to the facility.

40.024 Prescription Drug Reimbursement

(A) Prescription drug reimbursement shall be the lower of the charge for the prescription drug or the average wholesale price (AWP), as determined by the Red Book manual or its equivalent, plus a $5.00 dispensing fee.

(B) The provisions of 18 V.S.A., chapter 91, subchapter 1, Generic Drugs, shall apply.

(C) Home Intravenous Drugs/Infusion Therapy. The provider shall be accredited by the Joint Commission on Accreditation of Healthcare Organizations as a home care provider of intravenous services under the Standards for Accreditation of Home Care. Reimbursement shall be a negotiated per diem rate agreed upon by the provider and employer/insurance carrier prior to service being provided plus reimbursement for the prescription drug.

(1) Per diem rates are billable for the dates on which home infusion therapy is administered and shall include:

(a) Intravenous Solutions;

(b) Pharmacy Professional Services including compounding, dispensing, clinical management, consultations and 24 hour, 7 day a week availability;

(c) Ancillary Medical Supplies including all syringes, tubing, bags, cassettes, supplies necessary to maintain IV catheter patency;

(d) Durable Medical Equipment (DME) delivery, set-up, instruction, maintenance (24 hour, 7 day a week availability), replacement and removal as appropriate; and

(e) waste disposal.

(2) Drug reimbursement shall be the amount charged or AWP, whichever is less.

(3) Nursing services shall be coordinated through a home health agency by the infusion therapy provider. If services for initial patient assessment and claimant/care giver education and training are billed by the home health agency, no reimbursement shall be provided to the infusion therapy provider for these services. These services are reimbursed on an hourly basis.

40.025 Reimbursement for Procedures, Articles, and Supplies not listed in Appendix 1

For those procedures, articles, and supplies having no code listed in Appendix 1, or not otherwise addressed by written sections of this rule, the maximum allowable payment shall not exceed 120% of cost to the provider or 83% of the charge, whichever is less.

40.030 Modifiers

(A) The modifier codes recognized by these rules are defined in accord with the AMA CPT Manual, in effect on the date of service, or defined by CMS for HCPCS modifiers.

(B) A modifier code shall be used to describe any unusual circumstances or services that arise in the treatment of a work-related injury or illness.

40.040 Anesthesia Guidelines

Reimbursement to the health care provider applies only when the anesthesia is personally administered by an anesthesiologist, certified registered nurse anesthetist or anesthesiology assistant who remains in constant attendance during the procedure, for the sole purpose of rendering such anesthesia service.

(A) The maximum allowed payment for anesthesia services includes preoperative and postoperative visits, the administration of the anesthetic and the administration of fluids and/or blood incident to the anesthesia or surgery.

(B) Reimbursement will be determined by the addition of the base unit value, time units and modifying units (if any) and multiplying this sum by a conversion factor of $50.79 per unit. The definition of the unit components is included in paragraph 40.040(F). Base unit values are listed in Appendix 1.

(Base Unit Value amount + time units + modifying units, if any) x $50.79 = Reimbursement amount

(C) Anesthesia care may include, but is not limited to general, regional, monitored anesthesia care, supplementation of local anesthesia, or other supportive services in order to afford the patient the optimal anesthesia care prescribed.

(D) Specialized forms of monitoring (e.g., intra-arterial, central venous, and Swan-Ganz) are not included and will be reimbursed separately based on the appropriate medical or surgical fee schedule.

(E) With respect to anesthesia care team payments for claims from two separate billing entities, the total payment to the anesthesia care team is the same as the payment level for an individually performing anesthesiologist or health care provider, with 50% of the total payment paid to each of the billing entities.

(F) Definition of the Unit Components.

(1) Relative Unit Value: The relative unit value (RUV) includes usual pre and post-operative visits, the administration of fluids and/or blood incident to the anesthesia care and interpretation of non-invasive monitoring (ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry). When multiple surgical procedures are performed during a single anesthetic administration the highest relative unit value should be used. The relative unit value will be applied to each CPT anesthesia code as outlined at the conclusion of this section and as listed in Appendix 1.

(2) Time Units: Anesthesia time begins when the anesthesiologist, or other qualified individual, physically starts to prepare the patient for induction of anesthesia in the operating room (or its equivalent) and ends when the anesthesiologist, or other qualified individual, is no longer in constant attendance (i.e., when the patient may be safely under postoperative supervision).

(3) One time unit is allowed for each 15-minute time interval, or fraction thereof.

(4) Reimbursement for Pain Management Services: Reimbursement for pain management services (evaluation and management, medical or surgical services) will be separate from any reimbursement for anesthesia services. Reimbursement for services for pain management will be based on the fees listed in Appendix 1 for the appropriate evaluation and management, medical or surgical procedure codes.

(5) Modifying Units: Physical status modifying units will be reimbursed if the patient is ranked in one of the following three categories:

RANK	UNIT VALUE
P-3 - A patient with severe systemic disease	1
P-4 - A patient with severe systemic disease that is a constant threat to life	2
P-5 - A moribund patient who is not expected to survive without the operation.	3

Other modifying units will be available for the following qualifying circumstances described in the CPT:

CPT	UNIT VALUE
99100 - Anesthesia for a patient of extreme age, under	1

CPT	UNIT VALUE
one year and over seventy.	
99116 - Anesthesia complicated by utilization of total body hypothermia.	5
99135 - Anesthesia complicated by utilization of controlled hypotension.	5
99140 - Anesthesia complicated by emergency conditions (an emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part).	2

40.050 Radiology Guidelines

(A) The maximum fee for a radiology procedure is either the global or, where appropriate, the professional component (26) or the technical component (TC). These are found in Appendix 1 under the radiological maximum fee.

(B) When two bills are submitted for a radiological procedure, the professional component shall be identified by using modifier code 26. The technical component, identified by modifier TC, covers materials and facilities/space for the diagnostic or therapeutic service.

(C) Billings for radiologic procedures are not reimbursable without a report of findings.

40.060 Surgical Guidelines

(A) For surgical procedures that usually mandate a variety of attendant services, the reimbursement allowances are based on a global reimbursement concept. Global reimbursement covers the performance of the basic service and the range of care required before and after surgery. The range of post-surgical care or follow-up days is indicated in the column titled FUD in the rate tables found in Appendix 1.

10- and 30-day global reimbursement policy: For procedure codes listed in Appendix 1 with 10 follow-up days in the FUD column, any medically necessary care related to that procedure provided in the 10-day period following the procedure is included in the fee listed in Appendix 1. Similarly, when 30 follow-up days are listed, related care provided during the 30-day period following the procedure is included in the fee. For purposes of applying the global reimbursement policy, the day of surgery is counted as day 0. Any medically necessary care related to the procedure and provided after the 10- or 30-day period may be separately billed in addition to the procedure.

Fees for a procedure listed in Appendix 1 shall include all of the following:

(1) Pre-operative visits after the decision to operate. For major procedures, this includes pre-operative visits the day before the surgery. For minor procedures, this includes pre-operative visits on the surgery day.

(2) Intra-operative services, normally a necessary part of a surgical procedure.

(3) All other medical or surgical services the surgeon provides during the post-operative period because the complications don't require more trips to the operating room.

(4) Follow-up post-operative recovery period visits.

(5) Post surgical care. The number of follow-up days (FUD) is indicated in the fee schedule which will determine the normal range of post-surgical care for that particular procedure.

(6) Removal of sutures. Miscellaneous services, like dressing changes, local incision care, operative pack removal, cutaneous sutures and staples removal, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and urinary catheter removal, routine peripheral intravenous lines, nasogastric and rectal tubes; and tracheostomy tube changes and removals.

An evaluation and management (E&M) service shall not be billed in addition to a minor procedure unless the E&M service was for a significant, separately identified reason. In this instance, Modifier 25 should be reported with the appropriate E&M CPT procedure code.

Exceptions to the global reimbursement policy may warrant additional reimbursement for services including but not limited to:

(1) When a preoperative visit is the initial visit and prolonged detention or evaluation is necessary to prepare the patient or to establish the need for a particular type of surgery.

(2) When a procedure would normally be performed in the office, but circumstances mandate hospitalization.

(3) Surgeon's first evaluation to find the need for major surgeries.

(4) Other providers' related surgery services, except when the surgeon and the other providers agree on a transfer of care.

(5) Visits unrelated to the surgical diagnosis procedure unless the visits happen because of surgery complications.

(6) Underlying condition treatment or an added treatment course that's not part of normal surgery recovery.

(7) Diagnostic tests and procedures, including diagnostic radiological procedures.

(8) Distinct surgical procedures that happen during the post-operative period that aren't reoperation or complications treatment.

(9) Treatment for post-operative complications when the patient returns to the operating room (OR).

(10) If a less extensive procedure fails, the patient needs a more extensive procedure. Documentation substantiating the medical necessity of the additional

services rendered shall be submitted with the medical bill.

(B) An incidental surgery which is not part of the primary procedure performed, and for which there is no diagnostic evidence relating it to the injury, shall not be paid under the Workers' Compensation system.

(C) Reimbursement for the concurrent services of two or more health care providers may be warranted for:

(1) Identifiable medical services provided preoperatively, during the surgical procedure, or in the postoperative period.

(2) Surgical Assistants - In Appendix 1, an entry in the “ASST” column shall identify the procedures that are eligible for reimbursement to an assistant surgeon. Modifier 80, 81 or 82 shall be used to identify physicians who assist at surgery and reimbursement must not exceed 25% of the total surgical procedure. Modifier AS shall be used to identify non-physician surgical assistants and reimbursement must not exceed 15% of the total surgical procedure.

(3) Two Surgeons

(a) Certain circumstances may require the skills of two surgeons (usually with different specialties) to perform surgery on the same patient during the same operative session to complete a single surgical procedure code.

(b) Modifier 62 identifies when two surgeons work together as primary surgeons performing distinct part(s) of a single reportable procedure and shall be reported with the procedure code. Each provider must submit an individual claim for services.

(c) Reimbursement to each surgeon shall be the amount charged or 62.5% of the maximum allowed payment in Appendix 1, whichever is less.

(4) A Surgical Team. Some highly complex procedures require the concomitant services of several physicians, often of different specialties. Such complex services may also involve other highly skilled and specially trained personnel, as well as various types of sophisticated equipment. This type of complicated procedure may be carried out under the "surgical team" concept with a single, global reimbursement for the total service. The charges should be supported by a written report and include itemization of the physician services, paramedical personnel and equipment included in the charge.

(D) Multiple or Bilateral Procedures

(1) When multiple or bilateral procedures are provided at the same operative session, the first major procedure should be coded as listed on one line of the CMS -1500 claim form and the additional procedure(s) on the following line(s) with modifier 50 or 51.

(2) The maximum allowed payment for all services shall be the maximum allowed payment of the major procedure in addition to 50% for the secondary

procedure, and 25% for each lesser procedure thereafter. The lesser procedure(s) should be coded using the appropriate modifier 50 (bilateral procedure) or 51 (multiple procedures).

(3) Except when specifically stated, initial dressings, immobilization, or casting is included in the basic allowance for the basic procedure.

(4) Codes that are exempt from Modifier 51 are identified in Appendix 1 with ⃠ preceding the code.

(5) "Add-On" codes are identified in Appendix 1 with + preceding the code.

40.070 Dental Services

Dental providers, licensed in the state where they practice, may be paid for dental services. Dental providers include dentists, oral and maxillofacial surgeons, orthodontists, hospitals and dental clinics. Services provided by dental hygienists and dental assistants must be billed by the licensed dentist, orthodontist or oral surgeon overseeing these practitioners.

The maximum allowed payment shall be the amount listed in Appendix 1 for the service provided. If there is no code listed in Appendix 1, payment shall be 83% of the provider's charge.

Laboratory procedures are included with the maximum allowed payment listed in Appendix 1 for the associated dental procedure. No additional reimbursement shall be due for laboratory procedures.

Underlying conditions, such as periodontal disease, and prophylaxis or routine care unrelated to the compensable injury or illness shall not be comprehensively covered. They may be covered, however, only as required to successfully complete treatment related to the compensable injury or illness.

40.080 Good Cause Exception

If an employee or medical provider demonstrates to the satisfaction of the Commissioner that reasonable and necessary treatment, or a related medical service, is not reasonably available at a fee consistent with this fee schedule, including if the treatment will be provided out of state, the Commissioner may authorize reimbursement for those procedures at a rate higher than that permitted in the fee schedule. The Commissioner's office shall respond to requests for exceptions within 21 days of the day of the request.

40.090 Psychotherapy Services

The reimbursement policy for the practitioner performing psychotherapy services is as follows:

(A) M.D. and D.O. level Psychiatrists and Clinical Psychologists shall receive the maximum allowed payment for a procedure, listed in Appendix 1, or the practitioner's charge, whichever is less;

(B) Clinical Social Workers, Medical Social Workers, Mental Health Counselors

or other practitioners certified and licensed to provide psychotherapy services in the state of Vermont shall receive 85% of the maximum allowed payment listed in Appendix 1, or the practitioner's charge, whichever is less.

The level of licensure of the practitioner providing the service shall be indicated on the billing form.

40.100 Fee Adjustments for Physical Medicine and Rehabilitation Modalities; Applicable Only To Supervised and Constant Attendance Modalities

Maximum allowed payments for physical medicine and rehabilitation modalities that require supervised or constant attendance only are determined according to the following payment schedule when one or more modalities are provided to the patient on the same day. (This section does not apply to hospital reimbursement.)

100% of the fee for the most expensive modality;

75% of the fee for the second most expensive modality;

50% of the fee for the third most expensive modality and each additional modality thereafter.

All modalities after the first most expensive shall be coded by adding modifier 51 to the appropriate procedure code.

All other therapeutic procedure codes shall be paid in accord with Appendix 1 or, if the procedure code is not listed in Appendix 1, reimbursement shall be 83% of the provider’s charge.

40.110 Fees for Depositions, Permanent Impairment Ratings, Independent Medical Exams and Supplemental Reports

40.111 Fees for Depositions

(A) Any health care provider who gives deposition or hearing testimony under oath shall use code 99075. Reimbursement shall be at a rate of $500.00 or more as negotiated by the parties for the first hour. Additional time shall be reimbursed $125.00 per 15-minute increment or 25% of the negotiated rate per 15-minute increment.

(B) The party requesting the deposition assumes responsibility for payment of the witness fee unless the costs of the deposition is included as part of an award. The costs for witness fees shall be considered inclusive of an award of the deposition cost.

(C) Health care providers shall receive a maximum of $500.00 for a canceled deposition. The party canceling the deposition is responsible for the incurred costs. No charge will be paid if the deposition is canceled and the health care provider is notified at least three business days before the scheduled deposition date.

40.112 Permanent Impairment Ratings

A health care provider who provides a permanent impairment rating in accordance with 21 V.S.A. § 648 shall be licensed in the State of Vermont and use code 99455 (if the treating health care provider) or 99456 (if other than the treating health care provider). Reimbursement includes time spent reviewing medical records and shall be

at a rate of $500.00 or more as negotiated by the parties for the first hour. Additional time shall be reimbursed $125.00 per 15-minute increment or 25% of the negotiated rate per 15-minute increment.

40.113 Independent Medical Exams

A health care provider who provides an independent medical exam in accordance with 21 V.S.A. § 667 shall be licensed in the State of Vermont and use code 99456. Reimbursement includes time spent reviewing medical records and shall be at a rate of $500.00 or more as negotiated by the parties for the first hour. Additional time shall be reimbursed $125.00 per 15-minute increment or 25% of the negotiated rate per 15-minute increment.

40.114 Fees for Supplemental Reports

(A) Health care providers shall be reimbursed for providing supplemental reports that are in addition to the documentation required under paragraph 40.021(H) of this rule. Supplemental reports shall be identified by using CPT 99080 and appropriately billed on a CMS-1500 form.

(B) Reimbursement for supplemental reports is limited to $10.00 per page with the total not to exceed $70.00. The party requesting the supplemental reports assumes responsibility for payment.

40.120 Fraud

Workers' compensation insurers are only responsible for paying for services that are actually provided and that are medically necessary. In filing a claim for reimbursement, the CPT code should be chosen that most accurately describes the service that was provided. It is a felony under Vermont law, 13 V.S.A. § 2024, knowingly to do, attempt, or aid and abet in any of the following when seeking or receiving reimbursement from a workers' compensation insurer:

(A) File a claim for services which were not rendered;

(B) File a false claim;

(C) File a claim for unauthorized items or services;

(D) Bill the beneficiary, or the beneficiary's family for an amount in excess of that allowed by law or regulation;

(E) Fail to credit the state or its agent for payments received from social security, insurance or other sources;

(F) Receive unauthorized payment.

Suspected fraud should be reported to the Workers' Compensation and Safety Division of the Vermont Department of Labor.