JUGE NAPOLITANO
GUILBEAU RULI FRIEMAN APLC

NOTICE OF INTENT

Workforce Commission
Office of Workers' Compensation

Medical Treatment Guidelines
(LAC 40:I.Chapters 25, 27 & 51)

The Louisiana Workforce Commission does hereby give notice of its intent to amend certain portions of the Medical Guidelines contained in the Louisiana Administrative Code, Title 40, Labor and Employment, Part I, Workers' Compensation Administration, Subpart 2, Medical Guidelines, Chapter 25, Chapter 51, & Chapter 27, Section 2717. The purpose of this amendment is to update the medical reimbursement rules in accordance to a reoccurring maintenance schedule and add consistency throughout the guidelines. Chapter 25 is repealed as a whole while its language is combined in revised sections of Chapter 51. Previous promulgated sections are repealed and replaced in Chapter 51. This Rule is promulgated by the authority vested in the director of the Office of Workers' Compensation found in R.S. 23:1291 and R.S. 23:1310.1(C).

Title 40
LABOR AND EMPLOYMENT
Part I. Workers' Compensation Administration
Subpart 2. Medical Guidelines

Chapter 25. Hospital Reimbursement Schedule, Billing Instruction and Maintenance Procedures Repealed

~~Editor's Note: Other Sections applying to this Chapter can be found in Chapter 51.~~

AUTHORITY NOTE: Promulgated in accordance with RS 23:1291.
HISTORICAL NOTE: Repealed by the Louisiana Workforce Commission, Office of Workers' Compensation, LR

~~**§§2501-2503. Reserved.**~~

~~**§2505. Hospital Inpatient Reimbursement**~~

~~A. Reimbursement for inpatient hospital services will be limited to the lesser of covered billed charges or the per diem amount. The per diem rate assigned to the Standard Metropolitan Statistical Area in which the services are rendered will be applied to inpatient days by type of service, either medical or surgical.* The reimbursement amount will be reduced by charges for noncovered items and services.~~

~~NOTE: *The diagnosis/procedure code requiring the greatest resource consumption (severity) should be used to assign the correct category.~~

~~B. Using the following Per Diem Rate Schedule, the formula for calculating payment amount is:~~

~~Per Diem Rate x Inpatient Days = per Diem Amount~~

~~1. If billed charges > per diem amount, pay per diem amount less noncovered charges.~~
~~2. If billed charges < per diem amount, pay billed charges less noncovered charges.~~

~~Per Diem Rate Schedule~~

SMSA*	Medical per Diem	Surgical per Diem
Alexandria	$1212	$1628
Baton Rouge	$1125	$2015
Houma-Thibodaux	$ 908	$1697
Lafayette	$1009	$1655
Lake Charles	$ 946	$1645
Monroe	$1050	$1654
New Orleans	$1186	$2059
Nonmetropolitan	$ 771	$1570
Shreveport	$1198	$1629
*Please refer to Exhibit I for listing of hospitals within each SMSA.		

C. A provider formally approved by Medicare as a rural referral center will be recognized as such under these rules, and will be reimbursed under the same per diem rate as that of the SMSA assigned to the provider by the Medicare Geographic Classification Review Board.

D. Exhibit 1

Hospitals by Area

Alexandria	Monroe	New Orleans	Nonmetropolitan
Bayou Rapides	Glenwood Regional Medical Center	Childrens Hospital	Abbeville General
Byrd Memorial	HCA North Monroe Hospital	De La Ronde Hospital	Abrom Kaplan Memorial
Rapides General	Lincoln General	Doctors Hospital of Jefferson	Acadia Saint Landry
St. Frances Cabrini	St. Francis Medical Center	East Jefferson General	Allen Parish
	St. Erlington Hospital	Elmwood Medical Center	American Legion Hospital
		Eye, Ear, Nose and Throat	Assumption General
Baton Rouge	Lake Charles	Highland Park Hospital	Bienville General
Ascension Hospital	Beauregard Memorial	Hotel Dieu Hospital	Bogalusa Community
Baton Rouge General Medical	Dequincy Memorial	Humana Hospital—New Orleans	Bunkie General
Lane Memorial	Humana Hospital—Lake Charles	Jo Ellen Smith/F. Edward Hebert	Caldwell Memorial
Medical Center of Baton Rouge	Lake Charles Memorial	Lakeside Hospital	Citizens Medical Center
Our Lady of the Lake	St. Patrick Hospital	Meadowcrest Hospital	Dauterive Hospital
Prevost Memorial Hospital	West Calcasieu—Cameron	Mercy Hospital of New Orleans	Desoto General
Riverview Medical Center		New Orleans General	East Carroll Parish
River West Medical Center	Shreveport	Northshore Regional Medical	Franklin Foundation
Seventh Ward Community	Bossier Medical Center	Ochsner Foundation	Franklin Parish
Westpark Community Hospital	Doctors Hospital	Pendleton Memorial Methodist	Hardtner Medical Center
Womans Hospital	Highland Hospital	River Parishes Hospital	Homer Memorial
	Humana Hospital—Springhill	Slidell Memorial	Hood Memorial
	LSU Medical Center	Southern Baptist Hospital	Humana Hospital—Marksville
Houma-Thibodaux	Minden Medical Hospital	St. Charles Hospital	Humana Hospital—Oakdale
Lady of the Sea General	North Caddo Memorial	St. Charles Hospital/Luling	Humana Hospital—Ville Platte
St. Anne General	Physicians and Surgeons	St. Jude Medical Center	Humana Hospital—Winn Parish
Terrebonne General	Riverside Community	St. Tammany Parish	Iberia General
Thibodaux Hospital	Schumpert Hospital	Touro Infirmary	Jackson Parish
	Willis Knighton Medical	Tulane Medical Center	Jennings American Legion
		United Medical Center	L.S. Huckabay Medical Memorial
Lafayette		West Jefferson Medical Center	Lakewood Hospital
Doctors Hospital of Opelousas			Lasalle General
Gary Memorial Hospital			Madison Parish
Hamilton Medical Center			Merryville General
Lafayette General Hospital			Moosa Memorial Hospital
Opelousas General Hospital			Morehouse General
Our Lady of Lourdes			Natchitoches Parish
Womens and Childrens Hospital			Pointe Coupee General
			Richland Parish—Delhi
			Richland Parish—Rayville
			Riverland Medical Center
			Riverside Medical Center
			Sabine Medical Center
			Savoy Memorial Hospital
			South Cameron Memorial
			St. Helena Parish
			St. James Parish
			Tri Ward General
			Union General
			West Carroll Memorial
			West Feliciana Parish

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.
HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).

§2507. Outpatient Reimbursement

A. Outpatient hospital and ambulatory surgery services will be reimbursed at covered charges less a 10 percent discount. The formula for calculating payment amount is:

(Billed Charges) - (Noncovered Charges) = Covered Charges x 0.90 = Payment Amount

B. If a patient is admitted as an outpatient, however; is in the hospital overnight, this will be considered outpatient services. When patient is in hospital by midnight census of day two, this becomes an inpatient admission, thus services are paid at per diem rate. In addition, all procedures which can safely be performed as outpatient procedures shall be reimbursed as such. (Reference the Utilization Review Procedures, Chapter 27).

C. For a hospital admission to be subject to inpatient reimbursement, it must be medically necessary and not solely for the convenience of the payor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).

§2509. Psychiatric and Chemical Dependency Reimbursement

A. Inpatient. Reimbursement for inpatient psychiatric and/or chemical dependency unit services will be limited to the lesser of covered billed charges or the per diem amount.

1. The uniform statewide per diem rates will be applied to inpatient days by type of service, either psychiatric or chemical dependency.

2. The reimbursement amount will be reduced by charges for noncovered items and services.

Per Diem Rate Schedule	
Psychiatric Services	$799
Chemical Dependency Unit Services	$597

3. Using the above per diems, the formula for calculating payment amount is the same as that for acute care inpatient services found in §2505.B.1.

B. Outpatient. Psychiatric and chemical dependency services rendered on an outpatient basis by professional providers such as medical doctors, Ph.D. psychologists, and social workers will be reimbursed based on the medical reimbursement schedule for related CPT-4 Procedure Codes promulgated by the state of Louisiana, Office of Workers' Compensation. Any facility fees associated with providing these professional services will be reimbursed at covered charges less a 10 percent discount. The formula for calculating payment amount is:

(Billed Charges) - (Noncovered Charges) = Covered Charges x 0.90 = Payment Amount

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).

§2511. Rehabilitation Services Reimbursement

A. Inpatient. Reimbursement for inpatient rehabilitation facility services will be limited to the lesser of covered billed charges or the per diem amount.

1. The uniform statewide per diem rate will be applied to inpatient days by type of facility, either hospital based or freestanding.

2. The reimbursement amount will be reduced by charges for noncovered items and services.

Per Diem Rate Schedule	
Hospital Based Rehabilitation Facility	$ 704
Freestanding Rehabilitation Facility	$1225

3. Using the above per diems, the formula for calculating payment amount is the same as that for inpatient hospital services found in §2505.B.1.

B. Outpatient. Rehabilitation services rendered on an outpatient basis by professional providers such as medical doctors, physical therapists, occupational therapists, and speech therapists will be reimbursed based on the customary and reasonable fee schedule for related CPT-4 procedure codes promulgated by the state of Louisiana, Office of Workers' Compensation. Any facility fees associated with delivery of these professional services will be reimbursed at covered charges less a 10 percent discount. The formula for calculating payment is:

(Billed Charges) - (Noncovered Charges) = Covered Charges x 0.90 = Payment Amount

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).

§2513. Skilled Nursing and Intermediate Facility Reimbursement

A. Reimbursement for skilled nursing facility or intermediate care (swing bed) facility services will be limited to the lesser of covered billed charges or the per diem amount.

1. The uniform statewide per diem rates will be applied to inpatient days by type of facility, either hospital based or freestanding.

2. The reimbursement amount will be reduced by charges for noncovered items and services.

Per Diem Rate Schedules	
Skilled Nursing Facility	
Hospital Based	$294
Freestanding	$ 69
Intermediate Care Facility	
Hospital Based	$224
Freestanding	$ 63

3. Using the above per diems, the formula for calculating payment amount is the same as that for inpatient hospital services found in §2505.B.1.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).

§2515. Hospice Services Reimbursement

A. Hospice care services will be reimbursed at the lesser of covered billed charges or the per diem, per shift, or per hour rate.

1. The uniform statewide rates depicted in the table below will be applied by type of facility, either hospital based or freestanding.

2. The four categories of service are defined by the intensity of care, the skill level of the caregiver, and the place of service as follows.

a. Routine Home Care. The hospice is paid the routine home care rate for each day the patient is under the care of the hospice and not receiving one of the other categories of hospice care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day, and is also paid when the patient is receiving hospital care for a condition unrelated to their terminal condition.

b. Continuous Home Care. Continuous home care is to be provided only during a period of crisis. A period of crisis is a period in which a patient requires continuous care which is primarily nursing care to achieve management of acute medical symptoms.

i. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care.

ii. A minimum of eight hours of care must be provided during a 24 hour day which begins and ends at midnight. This care need not be continuous.

iii. Continuous home care is covered when it is provided to maintain an individual at home during a medical crisis. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine home care.

c. Respite Care. Respite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time. Payment for the sixth and any subsequent days is to be made at the routine home care rate.

d. General Inpatient Care. Payment at the inpatient rate is made when general inpatient care is provided. None of the other fixed payment rates are applicable for a day on which the patient receives hospice inpatient care.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).

§2517. Hospice Care Rate Schedule

A. Schedule

	Routine	*Continuous	Respite	General Inpatient
Hospital Based	$114	$28	$117	$504
Freestanding	$116	$29	$120	$513
*(Continuous Home Care is an hourly rate. All others are per diems)				

B. The formulas for calculating payment amount by category of service are:

1. routine home care, respite care and general inpatient care:

Per Diem Rate x days = Per Diem Amount;

a. if billed charges > per diem amount, pay per diem amount less noncovered charges;

b. if billed charges < per diem amount, pay billed charges less noncovered charge;

2. continuous home care—the rate quoted is an hourly rate. As defined above, to be covered, continuous home care must be provided for a minimum of eight hours.

Hourly Rate x Hours of Care Provided = Payment Amount

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).

§2519. Outlier Reimbursement and Appeals Procedures

A. Automatic Outliers. Inpatient hospital acute care services falling within certain diagnosis code ranges will be reimbursed outside the normal per diem reimbursement method. These atypical admissions will be paid at covered billed charges less a 15 percent discount. Conditions requiring acute care inpatient hospital services that are work related and are recognized as "automatic outliers" are:

1. AIDS: ICD-10 diagnosis code B20;

2. Acute Myocardial Infarction: ICD10 diagnosis codes: I213, I214, I220, I221, I222, I228, I229; I2101, I2102, I2109, I2111, I2119, I2121, I2129; and

3. severe burns: ICD-10 diagnosis codes: T2030XA, T20311A, T20312A, T20319A, T2032XA, T2033XA, T2034XA, T2035XA, T2036XA, T2037XA, T2039XA, T2070XA, T20711A, T20712A, T20719A, T2072XA, T2073XA, T2074XA, T2075XA, T2076XA, T2077XA, T2079XA; T2130XA, T2131XA, T2132XA, T2133XA, T2134XA, T2135XA, T2136XA, T2137XA, T2139XA, T2170XA, T2171XA, T2172XA, T2173XA, T2174XA, T2175XA, T2176XA, T2177XA, T2179XA; T2230XA, T22311A, T22312A, T22319A, T22321A, T22322A, T22329A, T22331A, T22332A, T22339A, T22341A, T22342A, T22349A, T22351A, T22352A, T22359A, T22361A, T22362A, T22369A, T22391A, T22392A, T22399A, T2270XA, T22711A, T22712A, T22719A, T22721A, T22722A, T22729A, T22731A, T22732A, T22739A, T22741A, T22742A, T22749A, T22751A, T22752A, T22759A, T22761A, T22762A, T22769A, T22791A, T22792A, T22799A; T23301A, T23302A, T23309A, T23311A, T23312A, T23319A, T23321A, T23322A, T23329A, T23331A, T23332A, T23339A, T23341A, T23342A, T23349A, T23351A, T23352A, T23359A, T23361A, T23362A, T23369A, T23371A, T23372A, T23379A, T23391A, T23392A, T23399A, T23701A, T23702A, T23709A, T23711A, T23712A, T23719A, T23721A, T23722A, T23729A, T23731A, T23732A, T23739A, T23741A, T23742A, T23749A, T23751A, T23752A, T23759A, T23761A, T23762A, T23769A, T23771A, T23772A, T23779A, T23791A, T23792A, T23799A; T24301A, T24302A, T24309A, T24311A, T24312A, T24319A, T24321A, T24322A, T24329A, T24331A, T24332A, T24339A, T24391A, T24392A, T24399A, T24701A, T24702A, T24709A, T24711A, T24712A, T24719A, T24721A, T24722A, T24729A, T24731A, T24732A, T24739A, T24791A, T24792A, T24799A; T25311A, T25312A, T25319A, T25321A, T25322A, T25329A, T25331A, T25332A, T25339A, T25391A, T25392A, T25399A, T25711A, T25712A, T25719A, T25721A, T25722A, T25729A, T25731A, T25732A, T25739A, T25791A, T25792A, T25799A; T2600XA, T2601XA, T2602XA, T2610XA, T2611XA, T2612XA, T2620XA, T2621XA, T2622XA, T2630XA, T2631XA, T2632XA, T2640XA, T2641XA, T2642XA, T2650XA, T2651XA, T2652XA, T2660XA, T2661XA, T2662XA, T2670XA, T2671XA, T2672XA, T2680XA, T2681XA, T2682XA, T2690XA, T2691XA, T2692XA; T270XXA, T271XXA, T272XXA, T273XXA, T274XXA, T275XXA, T276XXA, T277XXA; T281XXA, T282XXA, T283XXA, T2840XA, T28411A, T28412A,

T28419A, T2849XA, T285XXA, T286XXA, T287XXA, T288XXA, T28911A, T28912A, T28919A, T2899XA; T300; T304; T310, T320; T3110, T3210; T3111, T3211; T3120. T3220; T3121, T3221; T3122, T3222; T3130, T3230; T3131, T3231; T3132, T3232; T3133, T3233; T3140, T3240; T3141, T3142, T3143, T3243; T3144, T3244; T3150, T3250; T3152, T3252; T3151, T3251; T3154, T3254; T3153, T3253; T3155, T3255; T3160, T3260; T3161, T3261; T3162, T3262; T3163, T3263; T3164, T3264; T3165, T3265; T3166, T3266; T3170, T3270; T3171, T3271; T3172, T3272; T3173, T3273; T3174, T3274; T3175, T3275; T3176, T3276; T3177, T3277; T3180, T3280; T3181, T3281; T3182, T3282; T3183, T3283; T3184, T3284; T3185, T3285; T3186, T3286; T3187, T3287; T3188, T3288; T3190, T3290; T3191, T3291; T3192, T3292; T3191, T3293; T3194, T3294; T3196, T3296; T3195, T3295; T3197, T3297; T3198, T3298; T3199, T3299.

B. Appeal Procedures. Special reimbursement consideration will be given to cases that are atypical in nature due to case acuity causing unusually high charges when compared to the provider's usual case mix. This appeal process applies to workers' compensation cases paid under the per diem reimbursement formula limiting the payment amount to the lesser of per diem or covered billed charges.

1. The following general criteria will be applied to determine when a case, originally paid at the per diem rate, may be appealed:

a. total charges for an inpatient hospital surgical admit are greater than or equal to $100,000;

b. total charges for an inpatient hospital medical admit are greater than or equal to $75,000;

c. average per day charge for any case (inpatient hospital, rehabilitation, SNF, etc.) equates to 1.75 times the applicable per diem rate.

2. When a provider determines that a case falls within the appealable criteria, a request for review may be submitted to the carrier/self-insured employer.

3. If denied, a provider may then file a formal appeal with the Office of Workers' Compensation using the Special Reimbursement Consideration Appeal Form (LDOL-WC-3000) (see §2519.B.7.a.Exhibit II). Forms are available upon request from the Office of Workers' Compensation at the address shown on the sample form. Procedures for filing an appeal and documentation required are provided on the form.

4. Final determination as to acceptance of a case for special reimbursement rests solely with the state of Louisiana, Office of Workers' Compensation.

5. If approved, the provider will be reimbursed at covered billed charges less a 15 percent discount.

6. The formula for calculation of the reimbursement amount for both automatic outliers and approved appeal cases is:

(Billed Charges) - (Noncovered Charges) = Covered Charges x 0.85 = Payment Amount

7. All workers' compensation claims paid outside the per diem reimbursement method either as automatic outliers or as Special Reimbursement Consideration Appeal cases are subject to on-site bill audit. Bill audits are governed by the rules and procedures found in the Utilization Review Procedures Manual. Please refer to that manual for details.

a. Exhibit II

EXHIBIT II

Louisiana Department of Employment & Training
Office of Workers' Compensation
P. O. Box 94040
Baton Rouge, LA 70804-9040

SPECIAL REIMBURSEMENT CONSIDERATION APPEAL

INSTRUCTIONS: Please provide the following information and return Parts 1 and 2 intact with the required medical records to the address shown below. Send Part 3 to the Workers' Compensation insurance carrier. Retain the last copy for your files. It should be understood that an appeal is not a guarantee of additional reimbursement.

DATE	WORKERS' COMPENSATION CARRIER NAME AND ADDRESS

HOSPITAL INFORMATION

HOSPITAL NAME			
ADDRESS		CITY	
CONTACT PERSON	TITLE	TELEPHONE NO.	EXT.

PATIENT INFORMATION

PATIENT NAME		SOCIAL SECURITY NUMBER	
EMPLOYER NAME AND ADDRESS		DATES OF SERVICE	
PATIENT ADDRESS	CITY	STATE	ZIP CODE
DIAGNOSIS AND SURGICAL PROCEDURES			
WAS ADMISSION PRE-CERTIFIED? ☐ YES ☐ NO	IF NO, HAS OFFICE OF WORKERS' COMPENSATION BEEN NOTIFIED OF THE ADMISSION? ☐ YES ☐ NO		

MEDICAL INFORMATION

The following information **must** be submitted with an appeal for special reimbursement consideration.

- Entire medical record
- Itemization of charges
- All supporting information which could substantiate percentage of charge reimbursement

STATE OFFICE OF WORKERS' COMPENSATION USE ONLY

SPECIAL CASE CONSIDERATION ☐ **APPROVED** ☐ **DENIED**

NAME	TITLE	REIMBURSEMENT RATE
REASON		

SEND THIS FORM TO:

Louisiana Department of Employment & Training
Office of Workers' Compensation
P. O. Box 94040
Baton Rouge, La 70804-9040

LDET-WC-3000

~~AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.~~
~~HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR 41:981 (May 2015), repromulgated LR 41:1774 (September 2015), amended LR 42:283 (February 2016).~~

~~§2521. Hospital Billing Instructions~~

A. Introduction

1. The purpose of this document is to facilitate the billing process for hospital services.

2. For an overview of the workers' compensation program and policies covering treatment of compensable work-related injuries and illnesses, please refer to the carrier/self-insured employer.

B. Verification of Coverage. The carrier/self-insured employer is responsible for 100 percent of the maximum allowable reimbursement rate for covered services rendered for treatment of compensable conditions. The claimant is not required to contribute a copayment and does not have to meet any deductibles.

1. Prior to the provision of medical services, supplies, or other nonmedical services the determination that the illness, injury, or condition is work-related must be made, and must be accomplished in the following manner:

a. carrier/self-insured employer should be contacted for verification of coverage/liability;

b. the name and title of the individual verifying coverage/liability must be recorded in the claimant's records;

c. denial of coverage/liability must be immediately communicated to the claimant.

2. Those procedures identified in this reimbursement schedule as noncovered are not billable to the claimant if rendered in treatment of compensable conditions unless the claimant is informed beforehand that he will be responsible for the charges.

3. In certain circumstances, the provider collects his fees from the claimant because he is unsure or unaware of the occupational nature of the injury or condition. If the provider decides to bill the workers' compensation carrier/self-insured employer after compensability has been established, he must, to the best of his knowledge, make certain that the claimant has not already filed for reimbursement. If the claimant has not filed, the provider should bill the carrier/self-insured employer and reimburse the claimant. To avoid duplicate billings, the provider should file for the claimant, billing the full amount; or, the claimant should bill the full amount himself.

4. For covered services, if there is a difference between the provider's billed amount and the Office of Workers' Compensation maximum allowable reimbursement, the claimant, employer, and carrier cannot, under any circumstances, be billed for the difference.

C. Pre-Certification

1. Pre-certification is required for all admissions.

2. Please refer to the Managed Care Program Section of the Utilization Review Manual for definitions and requirements.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).

§2523. Required Information for Billing Inpatient Services

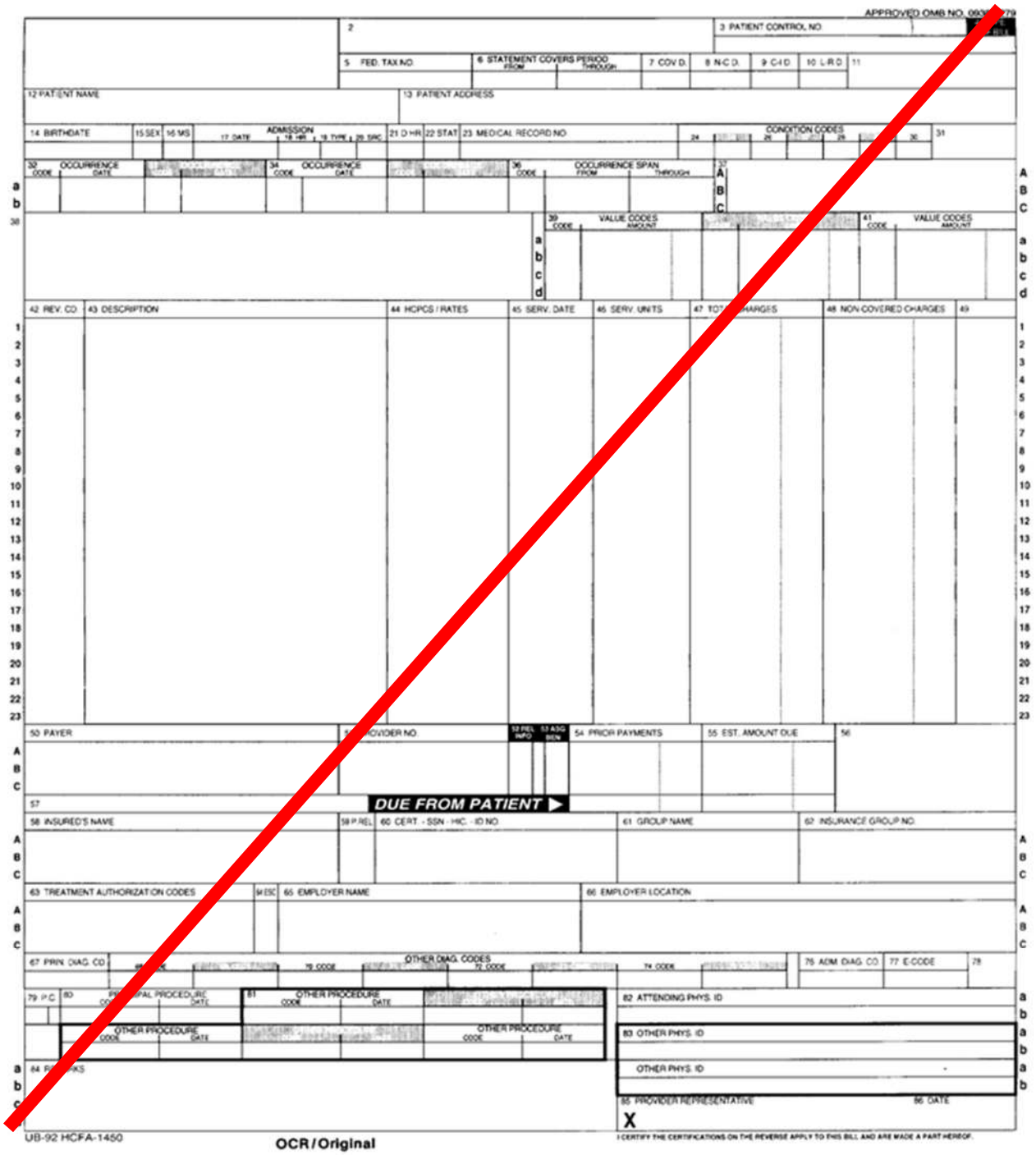
A. Itemization

1. Billing for hospital and other institutional type services must be submitted on a UB-92 Form as developed and implemented by the National Uniform Billing (UB-92) Committee. A copy of this form is on the last page of this Section.

2. Please itemize inpatient charges with the applicable UB-92 revenue codes. The use of all inclusive accommodation and ancillary revenue codes is not acceptable. These codes may contain services which are noncovered.

3. Invalid revenue codes which are not assigned or defined in the UB-92 manual are not allowed.

4. Sample UB-92 Form



~~AUTHORITY NOTE: Promulgated in accordance with R.S. 23:121034.2.~~
~~HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).~~

~~§2525. Inpatient Services Not Billable on the UB-92~~

A. The following inpatient services are not billable on the UB-92 Form unless they are customarily billed in that manner:

1. durable medical equipment when charges exceed $150;
2. orthotic/prosthetic appliance when charges exceed $150 (Pacemakers and other surgically implanted devices may be billed on UB-92);
3. ambulance;
4. psychiatric/psychological treatments and services;
5. therapeutic services;
6. professional services customarily billed separately must be billed on the HCFA-1500 Claim Form; and
7. separate sets of billing instructions have been developed for the following services:
   a. professional services (including chiropractor and physical therapy);
   b. durable medical equipment and supplies;
   c. prosthetic and orthotic equipment;
   d. medical transportation (ambulance);
   e. respiratory therapy; and
   f. nursing/home health and attendant services.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.
HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).

§2527. Inpatient Revenue Codes Not Billable on the UB-92

A. The following revenue codes must be billed on the HCFA-1500 Form as professional services.

Revenue Code(s)	Description
290	Durable Medical Equipment (DME) General Classification (Except charge under $150)
291	DME—Rental
292	DME—Purchase
299	DME—Other Equipment
540-549	Ambulance Services
900-909	Psychiatric/Psychological Treatments
910-919	Psychiatric/Psychological Services
940-949	Therapeutic Services
960-989	Professional Fees

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.
HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).

§2529. Required Information for Billing Outpatient Services

A. Itemization. Please itemize outpatient charges with the applicable revenue codes. The use of all-inclusive ancillary revenue codes is not acceptable.

B. Reports. Supporting documentation of services rendered may be attached to billings for outpatient services. Such reports are:

1. emergency room reports;
2. operative reports, if surgery was performed; and
3. discharge summary, if surgery was performed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).

§2531. Outpatient Services Not Billable on the UB-92

A. The following services are not billable on the UB-92 Form unless they are customarily billed in that manner:

1. ambulance;
2. psychiatric/psychological treatments and services;
3. therapeutic services;
4. all professional services including those provided by salaried personnel that are customarily billed separately and those provided in connection with emergency room service. These type of professional services must be billed on the HCFA-1500 Form;
5. outpatient clinic services; and
6. all outpatient durable medical and prosthetic/orthotic items.

B. Separate sets of billing instructions/fee schedules have been developed for the following services:

1. professional services (including chiropractor and physical therapy);
2. durable medical equipment and supplies;
3. prosthetic and orthotic equipment;
4. medical transportation (ambulance);
5. respiratory therapy;
6. nursing/home health and attendant services; and
7. ambulance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).

§2533. Outpatient Revenue Codes Not Billable on the UB-92

A. The following revenue codes must be billed on the HCFA-1500 Form.

Revenue Code(s)	Description
274	Medical/Surgical Supplies Prosthetics
277	Medical/Surgical Supplies Take Home Oxygen
290	Durable Medical Equipment (DME) General Classification
291	DME Rental
292	DME Purchase
299	DME Other Equipment
500-539	Outpatient Services, Clinic, Free-Standing Clinic and Osteopathic Services
570-599	Home Health Services
540-549	Ambulance Services
550-559	Skilled Nursing
820-859	Dialysis Service
860-879	Not Assigned
880-889	Miscellaneous Dialysis Services

900-909	Psychiatric/Psychological Treatments
910-919	Psychiatric/Psychological Services
940-949	Therapeutic Services
960-989	Professional Fees

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.
HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).

§§2535-2537. Reserved.

§2539. Annual Maintenance

A. To ensure that the reimbursement for the procedures are as fair as possible, the Office of Workers' Compensation will require the self insured employer or carrier to submit the following information for claims incurred in the preceding period. This information will be reviewed and any changes to the maximum allowable reimbursement rates will be published.

B. Information Required. The information required for calculation of the reimbursement schedule will include:

Information	Field Length	Type
FIP Parish Code	3	Numeric
Provider Name	35	Alpha Numeric
Charge Amount	10	Numeric
Type of Service: Medical vs. Surgical*	30	Alpha
Length of Stay	4	Numeric
IP/OP indicator	1	Alpha
*The diagnosis/procedure code requiring the greatest resource consumption (severity) should be used to assign the correct category.		

C. Communication Format. The following is the current format, however, the Office of Workers' Compensation will establish the format on an annual basis to facilitate the review:

1. magnetic tape;
   a. tape 9 tract, 8.5 inch to 10.5 inch reels with silver mylar reflector (standard reels) with write ring removed;
   b. recording density—1600 or 6250 bytes per inch;
   c. recording code—Extended Binary Coded Decimal Interchange Code (EBCDIC);
   d. header record must identify submitter and position of each field in the record;
   e. tape must have a leading tape mark and an end of file mark. The external label must identify the submitter, the date submitted, the tape number with identification of the total number of tapes submitted and the descriptive narrative of the information contained within the records;
2. diskettes:
   a. a 5.25 inch diskette (floppy disk) that is IBM PC-DOS compatible with the following attributes:
      i. double sided;
      ii. double density;
      iii. soft sectored;
      iv. 9 sectors per track; and
      v. 40 tracks per diskette;

b. a 3.5 inch, 720K diskette, that is IBM PC-DOS compatible with the following attributes:
i. double sided; and
ii. double density;
c. the external label must identify the submitter, the date submitted, the diskette number with identification of the total number of diskettes submitted and the descriptive narrative of the information contained within the records.
AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.
HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).

§§2541-2553. Reserved.

§2599. Appendix A—F.I.P.S. Area Codes
Appendix A

Appendix A

F.I.P.S. Area Codes

001 Acadia	045 Iberia	089 St. Charles
003 Allen	047 Iberville	091 St. Helena
005 Ascension	049 Jackson	093 St. James
007 Assumption	051 Jefferson	095 St. John the Baptist
009 Avoyelles	053 Jefferson Davis	097 St. Landry
011 Beauregard	055 Lafayette	099 St. Martin
013 Bienville	057 Lafourche	101 St. Mary
015 Bossier	059 LaSalle	103 St. Tammany
017 Caddo	061 Lincoln	105 Tangipahoa
019 Calcasieu	063 Livingston	107 Tensas
021 Caldwell	065 Madison	109 Terrebonne
023 Cameron	067 Morehouse	111 Union
025 Catahoula	069 Natchitoches	113 Vermillion
027 Claiborne	071 Orleans	115 Vernon
029 Condordia	073 Ouachita	117 Washington
031 DeSoto	075 Plaquemines	119 Webster
033 East Baton Rouge	077 Pointe Coupee	121 West Baton Rouge
035 East Carroll	079 Rapides	123 West Carroll
037 East Feliciana	081 Red River	125 West Feliciana
039 Evangeline	083 Richland	127 Winn
041 Franklin	085 Sabine	998 Out of State
043 Grant	087 St. Bernard	

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

~~HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).~~

Chapter 27. Utilization Review Procedures

§2717. Medical Review Guidelines

A. - B.2. …

C. Functions of Medical Review. The carrier/self-insured employer should use a program of prevention and detection to guarantee the most appropriate and economical use of health care resources for claimants.

1. - 2.f. …

3. Medical Necessity

a. ...

i. clinically appropriate, in terms of type, frequency, extent, site, and duration, and effective for the patient's illness, injury, or disease; ~~and~~

ii. in accordance with the medical treatment schedule and the provisions of L.S.A.-R.S. 23:1203.1.;

iii. consistent with the diagnosis and treatment of a condition or complaint;

iv. not solely for the convenience of the patient, family, hospital, or physician; and

v. furnished in the most appropriate and least intensive type of medical care setting required by the patient's condition.

~~b. To be medically necessary, a service must be:~~

~~i. consistent with the diagnosis and treatment of a condition or complaint; and~~

~~ii. in accordance with the Louisiana medical treatment schedule; and~~

~~iii. not solely for the convenience of the patient, family, hospital or physician; and~~

~~iv. furnished in the most appropriate and least intensive type of medical care setting required by the patient's condition.~~

~~c.~~b. Services not related to the diagnosis or treatment of a work related illness or injury are not payable under the workers' compensation laws and shall be the financial responsibility of the claimant, and in appropriate cases, his health insurance carrier.

4. - 9. …

D. -D. 2. …

AUTHORITY NOTE: Promulgated in accordance with RS 23:1291.

HISTORICAL NOTE: Promulgated by the Department of Employment and Training, Office of Workers' Compensation, LR 17:263 (March 1991), repromulgated LR 17:653 (July 1991), amended by the Louisiana Workforce Commission, Office of Workers' Compensation, LR 38:1036 (April 2012), repromulgated LR 38:1293 (May 2012). amended by the Louisiana Workforce Commission, Office of Workers' Compensation, LR

Chapter 51. Medical Reimbursement Schedule

Editor's Note: The following Sections of this Chapter are applicable and shall be used for the Chapters in this Part governing reimbursement. These specific Chapters are: Chapter 25, Hospital Reimbursement; Chapter 29, Pharmacy; Chapter 31, Vision Care Services; Chapter 33, Hearing Aid Equipment and Services; Chapter 35, Nursing/Attendant Care and Home Health Services; Chapter 37, Home and Vehicle Modification; Chapter 39, Medical Transportation; Chapter 41, Durable Medical Equipment and Supplies; Chapter 43, Prosthetic and Orthopedic Equipment; Chapter 45, Respiratory Services; Chapter 47, Miscellaneous Claimant Expenses; Chapter 49, Vocational Rehabilitation Consultant; Chapter 51, Medical Reimbursement Schedule; and Chapter 53, Dental Care Services.

~~**§5101. Statement of Policy**~~

~~A. It is the intent of this reimbursement schedule to limit to the mean of the usual and customary charge all fees for medical services, supplies, and other non-medical services delivered to workers' compensation claimants, as authorized by law.~~

~~B. The law provides that an employer or compensation insurer owes to an injured worker 100 percent of the medical fees incurred in the treatment of work-related injuries or occupational diseases [hereinafter referred to as "illness(es)"].~~

~~1. It is therefore the policy of the Office of Workers' Compensation that medical bills for services should be sent to the carrier/self-insured employer for payment. Fees for covered services in excess of the amounts allowable under the terms of this schedule are not recoverable from the employer, insurer, or employee.~~

~~2. It is also deemed to be in the best interest of all of the parties in the system that fees for services reasonably performed and billed in accordance with the reimbursement schedule should be promptly paid. Not paying or formally contesting such bills by filing LDOL-WC-1008 (Disputed Claim for Compensation) with the Office of~~

~~Workers' Compensation within 30 days of the date of receipt of the bill may subject the carrier/self-insured employer to penalties and attorneys' fees.~~

~~3. If claimant is receiving treatment for both compensable and noncompensable conditions only those services provided in treatment of compensable conditions should be listed on invoices submitted to the carrier/self-insured employer unless the noncompensable condition (e.g., hypertension, diabetes) has a direct bearing on the treatment of the compensable condition. In addition, payments from private payers for noncompensable conditions should not be listed on invoices submitted to the carrier/self-insured employer. If a provider reasonably does not know the workers' compensation status, or the workers' compensation insurer has denied coverage, the provider will not be penalized for not complying with this rule. Upon notification or knowledge of workers' compensation eligibility, the provider will comply with these regulations prospectively.~~

~~4. Statements of charges shall be made in accordance with standard coding methodology as established by these rules, ICD-10-CM, ICD-10-PCS, HCPCS, CPT-4, CDT-1, NDAS coding manuals. Unbundling or fragmenting charges, duplicating or over itemizing coding, or engaging in any other practice for the purpose of inflating bills or reimbursement is strictly prohibited. Services must be coded and charged in the manner guaranteeing the lowest charge applicable. Knowingly and willfully misrepresenting services provided to workers' compensation claimants is strictly prohibited.~~

~~5. Providers should take reasonable steps to ensure that only those services provided are billed to the carrier/self-insured employer. Violation of this provision may subject provider/practitioner to mandatory audit of all charges.~~

~~6. Bills for a particular charge item may not be included in subsequent billings without clear indication that they have been previously billed.~~

~~7. These rules are to be used in conjunction with Chapter 27 rules on utilization review procedures.~~

~~8. Sales taxes and other state mandated taxes are required to be reimbursed in addition to other procedure, supplies or medical services.~~

~~AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.~~

~~HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR 40:375 (February 2014), LR 42:288 (February 2016).~~

§5101 Introduction and Guidelines

A. Purpose and Scope

1. This Medical Reimbursement Schedule Chapter (the "Fee Schedule"), including the accompanying rules, are intended to establish the maximum level of reimbursement and uniform payment guidelines for reimbursing qualified health care providers for the treatment of injured employees. In accordance with the statutes and regulations established by the State of Louisiana, the fee schedule is deemed to represent usual and customary reimbursement amounts for the specific services rendered.

2. Employers, insurance carriers, self-insurers, or other payors shall use these rules for the purpose of approving and reimbursing medical charges submitted by physicians, hospitals, ambulatory surgery centers and other qualified health care providers for services performed in the treatment of work-related injuries or illnesses.

B. Format of the Fee Schedule

1. This fee schedule (Chapter 51) is comprised of sub-sections which outline general rules and guidelines (Introduction and Guidelines; General Payment Policies; Coding Standards; Billing Instructions; Reporting Requirements), ten distinct sections based on the category or type of service rendered (Evaluation and Management Services; Anesthesia Services; Surgical Services; Diagnostic and Therapeutic Radiological Services; Pathology and Laboratory Services; General Medicine Services; Physical Medicine Services; Outpatient Facility; Inpatient Facility; Hospice Care) and a comprehensive section defining the Maximum Reimbursement Allowances. Each category of service has separate instructions.

2. The fee schedule is divided into these sections for structural purposes only. Providers are to use the specific section(s) that contains the procedure(s) they perform or the service(s) they render. In the event a rule/guideline contained in one of the specific service sections conflicts with a general rule/guideline, the specific section rule/guideline will supersede, unless otherwise provided elsewhere in this Chapter.

C. Key Terms and Definitions.

AA— Anesthesiology Assistant

ADA— American Dental Association

AMA— American Medical Association

Ambulatory Surgery Center (ASC) — a distinct entity that operates exclusively to furnish outpatient surgical services to patients who need no hospitalization and for whom the expected duration of services is less than 24 hours following admission. ASC patients should not need active medical monitoring at midnight on the day of the procedure. ASC services must be provided by or under the supervision of a physician, dentist, or other provider having medical staff privileges in the ASC.

AS — Assistant Surgeon

AWP — Average Wholesale Price

Bill — a claim submitted by a provider to a payor for payment of health care services provided in connection with a covered injury or illness.

Bill adjustment — a reduction of a fee on a provider's bill, or other alteration of a provider's bill.

BR — By Report

C/SIE — Carrier/Self—Insured Employer

Carrier — 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.

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

CDT — Current Dental Terminology, a medical code set maintained and copyrighted by the American Dental Association, which is used for reporting dental services.

Claimant — the individual person seeking medical services for a work-related illness or injury.

CMS — Centers for Medicare & Medicaid Services

CMS-1500 — the paper professional billing form and instructions (formerly referred to as a HCFA-1500) that are used by non-institutional providers and suppliers to bill for outpatient services.

CNS — Clinical Nurse Specialist

CPT (Current Procedural Terminology) — a set of codes, descriptions, and guidelines developed by the American Medical Association, intended to describe procedures and services performed by physicians and other health care professionals. Each procedure or service is identified with a five-digit code. CPT codes may also be referred to as HCPCS Level I codes.

Commission — the Louisiana Workforce Commission (LWC).

Consultation — 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.

Covered injury or illness — an injury or illness for which treatment is mandated under the Louisiana Workers' Compensation Statutes (R.S. 23:1020.1B.(1) and (2)).

Critical care — 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.

CRNA — Certified Registered Nurse Anesthetist

CT — Computerized Tomography

Day — means a continuous 24-hour period unless otherwise defined

Diagnostic procedure — a service that helps determine the nature and causes of a disease or injury.

Durable Medical Equipment (DME) — specialized equipment designed to stand repeated use, appropriate for home use, and used solely for medical purposes.

ED — Emergency Department

Electronic Bill — a bill submitted electronically from the health care provider, health care facility, or third—party biller/assignee to the payor.

E/M — Evaluation and Management Services

Expendable medical supply — a disposable article that is needed in quantity on a daily or monthly basis.

EOR/EOMB — Explanation of Review (EOR) or Explanation of Medical Benefits (EOMB) is the documentation sent by the payor to the health care provider, health care facility, or third-party biller/assignee to explain payment or denial of a medical bill.

Fee Schedule — includes all sections and subsections as defined in Chapter 51, Medical Reimbursement Schedule from the Louisiana Administrative Code, Title 40 Labor and Employment, Part I. Workers' Compensation Administration, Subpart 2. Medical Guidelines.

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

Follow-up days (FUD) — the days of care following a surgical procedure which are included in the procedure's maximum allowable reimbursement amount, but which do not include follow up care related to complications. The follow-up day period begins on the day of the surgical procedure(s).

FCE — Functional Capacity Evaluation

Health care provider (HCP)— a hospital, a person, corporation, facility, or institution licensed by the state to provide health care or professional services as a physician, hospital, dentist, registered or licensed practical nurse, pharmacist, optometrist, podiatrist, chiropractor, physical therapist, occupational therapist, psychologist, graduate social worker or licensed clinical social worker, psychiatrist, or licensed professional counselor, and any officer, employee, or agent thereby acting in the course and scope of his employment.

Health care review — the review of a health care case, bill, or both by the payor or the payor's agent.

HCPCS — the Healthcare Common Procedure Coding System, an alpha-numeric medical code set maintained by the Centers for Medicare and Medicaid Services used for reporting services, durable medical equipment, prosthetics, orthotics, and supplies. CPT codes are Level I HCPCS codes. HCPCS codes may also be referred to as HCPCS Level II codes.

HIPAA — Health Insurance Portability and Accountability Act, federal legislation that includes provisions that mandate electronic billing in the Medicare system and establishes national standard electronic file formats and code sets.

Hospital Outpatient — the portion of a hospital that provides services to sick or injured individuals who do not require hospitalization. Hospital outpatient services may include rehabilitation services, diagnostic and therapeutic (both surgical and non-surgical) services, laboratory tests, an emergency room or outpatient clinic, ambulatory surgical procedures and/or medical supplies.

ICD-10-CM — International Classification of Diseases, Tenth Revision, Clinical Modification

Incidental — services and supplies which are commonly furnished as an integral part of the primary service or procedure and not reimbursed separately.

Incidental Surgery — surgery performed through the same incision, on the same day, by the same doctor, not increasing the difficulty or follow-up of the main procedure, or not related to the diagnosis.

Independent medical examination (IME) — a consultation provided by a physician to evaluate a patient. This evaluation may include an extensive record review and physical examination of the patient and requires a written report.

Inpatient services — services rendered to a person who is admitted to a hospital as an inpatient.

LOS – Length of Stay

LWC — Louisiana Workforce Commission

Maximum Allowable Reimbursement (MAR) — the maximum amount allowed for medical services as set forth in this Chapter.

Medically Necessary — see LAC40:I.2717. Medical Review Guidelines for the definition of medically necessary consistent with the provisions of R.S. 23:1203.1.

Medical Consultant — a physician or other health care professional with expertise in the area for which medical or other treatment determinations need to be made regarding acceptable, safe medical care and treatment as well as appropriate reimbursement for the services rendered.

Medical record — 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 — a piece of durable medical equipment or an expendable medical supply.

MRI — Magnetic Resonance Imaging

NCCI — National Correct Coding Initiative

NDC — National Drug Code, the code set used to identify medication dispensed by pharmacies.

Nonprescription Drugs or Over-the-Counter Medications (OTC) — Medicines or drugs which are sold without a prescription, and which are prepackaged for use by the consumer and labeled in accordance with the requirements of the statutes and regulations of this state and the federal government

NP — Nurse Practitioner

Observation care — a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.

Operative report — the practitioner's written description of the surgery or procedure.

Orthotic equipment — an apparatus designed to support, align, prevent, or correct deformities, or improve the function of a moveable body part.

Orthotist — a person skilled in the construction and application of orthotic equipment.
OTC — Over-the-Counter medications
Outpatient service — services provided to patients at a time when they are not hospitalized as inpatients.
OWCA – Office of Workers' Compensation Administration
PA — Physician Assistant
Payor/Payer — the entity responsible, whether by law or contract, for the payment of the medical expenses incurred by a claimant as a result of a work-related injury. The payor may be the carrier, employer, self-insured group, or third-party administrator (TPA). Payor may also be referenced as C/SIE.
PC – Professional Component.
PE — Physician Extenders.
Pharmacy — the place where the science, art, and practice of preparing, preserving, compounding, dispensing, and giving appropriate instruction in the use of drugs is practiced.
Practitioner — a person licensed, registered, or certified as a health care provider.
Prescription — an order by a prescribing practitioner for a prescription or nonprescription drug to be filled, compounded, or dispensed by a pharmacist.
Primary procedure — the therapeutic procedure most closely related to the principal diagnosis, and in billing, the code with the highest unit that is neither an add-on code nor a code exempt from modifier 51 shall be considered the primary procedure.
Procedure — a unit of health service.
Procedure code — 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.
PROF MAR — Professional Maximum Allowable Reimbursement.
Prosthesis — an artificial substitute for a missing body part.
Prosthetist — a person skilled in the construction and application of prostheses.
Provider — a facility, health care organization, or a health care provider who provides medical care or services.
RNFA — Registered Nurse First Assistant.
Secondary procedure — 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.
Special report — a report requested by the payor to explain or substantiate a service or clarify a diagnosis or treatment plan.
Specialist — a board-certified practitioner, board-eligible practitioner, or a practitioner otherwise considered an expert in a particular field of health care service by virtue of education, training, and experience generally accepted by practitioners in that field of health care service.
TC— Technical Component
Usual and Customary (U&C) — the general prevailing amount for a medical service based on what providers in Louisiana usually charge for the same or similar medical service. As provided in R.S.23:1034.2, the mean of the U&C amount is included when determining the reasonable or generally accepted reimbursement amount for a specific medical service as defined in this fee schedule. The U&C amount is not the same as the provider's billed charge.
UB-04 — the paper hospital, institutional, or facility billing form used for hospital billing.

D. Recognized Providers

1. As defined in L.S.A.-RS 23:1021, a "health care provider" means a hospital, a person, corporation, facility, or institution licensed by the state to provide health care or professional services as a physician, hospital, dentist, registered or licensed practical nurse, pharmacist, optometrist, podiatrist, chiropractor, physical therapist, occupational therapist, psychologist, graduate social worker or licensed clinical social worker, psychiatrist, or licensed professional counselor, and any officer, employee, or agent thereby acting in the course and scope of his employment.
2. The health care providers covered by this fee schedule include, but are not limited to:
   i. Physicians and Surgeons;
   ii. Limited Licensed Practitioners to include oral and maxillofacial surgeons, chiropractors, podiatrists, dental surgeons, optometrists, and clinical psychologists.
   iii. Non-Physician Practitioners to include, but not limited to, physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, physicians' assistants, nurse practitioners, certified registered nurse anesthetists, and medical or clinical social workers.
3. Physician Extenders (PE) – Clinical Nurse Specialist (CNS), Certified Registered Nurse Anesthetist (CRNA), Nurse Practitioner (NP), or Physician Assistant (PA)

i. The clinical nurse specialist (CNS), certified registered nurse anesthetist (CRNA), nurse practitioner (NP), or physician assistant (PA), if qualified by training and experience as determined by the supervising physician, may perform medical treatments, diagnostic procedures, or other delegated duties and tasks which are allowable by law, approved by the state licensing board, and which fall within the normal scope of practice of the supervising physician.

ii. While the supervising physician is responsible for the overall direction and management of the professional activities of the CNS, CRNA, NP, or PA, the supervising physician is not required to physically be on site at the time of service. However, if the supervising physician is not physically present with the CNS, CRNA, NP, or PA, he or she must be immediately available to the CNS, CRNA, NP, or PA for consultation purposes by telephone or other effective, reliable means of communication.

iii. The federal tax ID number for the supervising physician is to be used on bills for services rendered by a PE. When professional services are directly performed by a CNS, CRNA, NP, or PA, the reimbursement shall be 80 percent of the fee schedule MAR or the provider's charge, whichever is less.

4. Physical Therapists – Services performed by a physical therapist possessing a doctorate degree or five years of licensed clinical practice experience may implement physical therapy treatment without a prescription or referral. Such physical therapist treating a patient without a prescription or referral must refer the patient to an appropriate healthcare provider if, after thirty days of physical therapy treatment, the patient has not made measurable or functional improvement. Physical therapist who do not possess a doctorate degree and/or do not have five years of licensed clinical practice experience may provider services only under the direction of the authorized treating physician detailing the type, frequency, and duration of therapy to be provided. No physical therapist may render a medical diagnosis of disease. Physical therapists shall not be reimbursed for office visits. See Section 5124, Physical Medicine Services for more information.

5. Occupational Therapists – Services performed by an occupational therapist shall be under the direction of the authorized treating physician detailing the type, frequency, and duration of therapy to be provided. Occupational therapists shall not be reimbursed for office visits. See Section 5124, Physical Medicine Services for more information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR 40:375 (February 2014), LR 42:288 (February 2016). amended by the Workforce Commission, Office of Workers' Compensation Administration, LR

~~**§5103. Introduction**~~

~~A. This document is primarily intended to facilitate the establishment of the maximum allowable reimbursement for all physician, chiropractic, physical and occupational therapy, pharmacy, hospital, vision care, hearing aid equipment, nursing/attendant care and home health, home and vehicle modification, medical transportation, durable medical equipment, prosthetic, and orthopedic equipment, respiratory, miscellaneous claimant expenses, vocational rehabilitation and dental care services.~~

~~B. For an overview of the Workers' Compensation Program and all policies and procedure concerning treatment of compensable work related injuries and illnesses, please refer to the carrier/self-insured employer.~~

~~AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.~~

~~HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).~~

§5103 General Payment Policies

A. Covered Services and Liability

1. Verification of Coverage - The Payor is responsible for 100 percent of the maximum allowable reimbursement rate for covered services rendered for treatment of compensable conditions. The claimant is not required to contribute a copayment and does not have to meet any deductibles. If there is a difference between the provider's billed amount and this fee schedule's maximum allowable reimbursement, the claimant, employer, and/or carrier cannot, under any circumstances, be billed for the difference. Services identified in this fee schedule as noncovered and/or non-compensable are not billable to the claimant if rendered in the treatment of compensable conditions unless the claimant is informed beforehand that he/she will be responsible for the fees.

2. Prior to the provision of medical services, supplies or other nonmedical services a determination that the illness, injury, or condition is work-related must be made and must be accomplished in the following manner:

i. Payor should be contacted for verification of coverage/liability;
ii. The name and title of the individual verifying coverage/liability must be recorded in the claimant's records;
iii. Denial of coverage/liability must be immediately communicated to the claimant.

3. If the health care provider collects fees from the claimant because he/she is unaware of the occupational nature of the injury or condition when treatment is rendered, the health care provider must, to the best of his/her ability, make certain that the payor does not receive duplicate billings from the provider and the claimant. The provider should file for the full amount on behalf of the claimant and then reimburse the claimant; or, the claimant should bill the payor for the full amount directly.

4. If the claimant is receiving treatment for both compensable and non-compensable conditions, only those services provided in the treatment of compensable conditions should be listed on invoices submitted to the payor unless the non-compensable condition (e.g., hypertension, diabetes) has a direct bearing on the treatment of the compensable condition. In addition, payments for non-compensable conditions should not be listed on invoices submitted to the payor for compensable conditions. If a provider reasonably does not know the workers' compensation status, or the workers' compensation insurer has denied coverage, the provider will not be penalized for not complying with this rule. Upon notification or knowledge of workers' compensation eligibility, the provider will comply with these regulations prospectively.

5. Whenever a claimant is eligible for Medicare or payment from another third-party payor and is also eligible for workers' compensation medical benefits, the payor is always the primary payor, the payor of first resort. Services related to compensable conditions should be billed to the payor before attempting to collect from the third-party payor.

B. Treatment Guidelines and Prior Authorization

The rules set forth in this Chapter are to be applied in conjunction with the rules set forth in LAC40:I.Chapter 27, Utilization Review Procedures. The L.S.A.-R.S. 23:1142 establishes a monetary limit for nonemergency medical care. The statute further provides significant penalties for a carrier/self-insured employer's arbitrary and capricious refusal to approve necessary care beyond that limit. In addition to all other rules and procedures, the provider who provides care under the "medical emergency" exception must demonstrate that it was a "medical emergency" as outlined in the Utilization Review Procedures. For additional instructions, please refer to LAC40:I.Chapter 27.

C. Out-of-State Treatment - All necessary drugs, supplies, hospital care and services, medical and surgical treatment, and any nonmedical treatment recognized by the laws of this state as legal shall be performed at facilities within the state when available.

1. Prior authorization must be obtained from the payor for referral to out-of-state providers. The documentation required in the authorization must include the name and location of the out-of-state provider along with supporting documentation to show that the service being provided cannot be performed within the state, or it is closer to the patient's domicile to have services performed out-of-state.

2. The maximum reimbursement allowances defined in this fee schedule are applicable to medical services rendered outside the state of Louisiana for accidents and injuries subject to the Louisiana Workers' Compensation Act.

3. Out-of-State Injuries - An injured worker may receive medical services in Louisiana for injuries incurred in an out-of-state accident.

i. If the injured worker is receiving care and treatment in Louisiana pursuant to the Louisiana Act, the reimbursement is subject to the requirements and amounts defined in this fee schedule regardless of the site of injury.

ii. If the injured worker receives benefits from another state, while also seeking benefits in Louisiana, the benefits paid by the other state will be credited towards any payments due under the Louisiana Act.

4. Providers may contact the carrier to determine if the claimant benefits are provided pursuant to Louisiana law or the law of another state.

5. If the patient is receiving treatment under the Workers' Compensation Law of another state, this manual may not apply. It will apply if a timely claim is made under the Louisiana Workers' Compensation Act for the same accident and injuries and the benefits paid under the Workers' Compensation Law of another state is credited against what the patient would receive under the Louisiana Workers' Compensation Act.

D. Carrier Responsibilities

1. Reimbursement Determinations – Payors must utilize the expertise of a Medical Consultant in making determinations pertaining to acceptable, safe medical care and treatment as well as appropriate reimbursement for the services rendered. These medical consultants should have expertise in the areas for which medical or other treatment determinations are made.

2. Payors may not change, alter, delete, or obscure any diagnosis, procedure or service category codes reported by a provider. If a payor questions a service reported by a provider, the payor must contact the provider for clarification and/or additional documentation to substantiate the service in question.

3. Explanation of Review (EOR) – Payors must provide an EOR to the health care provider whenever the reimbursement amount differs from the amount billed by the provider. The EOR must accompany any payment that is being made.

i. The EOR must contain appropriate identifying information so the provider can relate a specific reimbursement to the applicable claimant, the services billed and the date of service. When possible, the payor should cite the specific rule upon which the final adjustment(s) were made.

ii. Acceptable EORs include copies of the bill as well as computerized or manually produced forms. Every EOR must include the applicable explanation code along with a written description of the explanation code for each line of service that has been adjusted.

iii. A payor must use the listed EOR codes and descriptors below to explain why a provider's charge has been reduced or disallowed.

iv. A payor may develop additional EOR codes, if necessary, to explain an adjustment but must furnish to the provider a written explanation of each EOR code used.

v. In all cases, the payor must clearly and specifically detail the reasons for an adjustment including references to applicable provisions of the Fee Schedule or other source(s) used as the basis for the adjustment(s).

001	These services are not reimbursable under the Workers' Compensation Program.
002	Charges exceed maximum allowance.
003	Charge is included in the basic surgical allowance.
004	Surgical assistant is not routinely allowed for this procedure. Documentation of medical necessity required.
005	This procedure is included in the basic allowance of another procedure.
006	This procedure is not appropriate to the diagnosis.
007	This procedure is not within the scope of the license of the billing provider.
008	Equipment of services are not prescribed by a physician.
009	Exceeds reimbursement limitations.
010	This service is not reimbursable unless billed by a physician.
011	Incorrect billing form.
012	Incorrect or incomplete license number of billing provider.
013	Medical report required for payment.
014	Documentation does not justify level of service billed.
015	Place of service is inconsistent with procedure billed.
016	Invalid procedure code.

E. Disputed Reimbursement Reconsideration

1. When, after examination of the EOR, a health care provider is dissatisfied with a payor's reduction or denial of a billed charge for any service, the provider may make a written request for reconsideration within 60 days from receipt of the EOR. The request must include a copy of the bill in question, the payor's EOR and any supporting documentation to substantiate the charge/service in question.

2. Upon receipt of a request for reconsideration, the payor must review and re-evaluate the original bill and accompanying documentation using its own medical consultant as necessary and respond to the provider within 60 days of the date of the receipt of the request. The payor's response to the provider must explain the reason(s) for the decision and cite the specific rule upon which the final adjustment(s) were made.

3. If the health care provider finds the result of the payor's reconsideration unsatisfactory, the provider may request the Office of Workers' Compensation Administration, Medical Services Section to resolve the disputes which involves the interpretation of the reimbursement policies and allowable reimbursement contained in the fee schedule.

a. The health care provider should file a formal appeal with the Office of Workers' Compensation using the Special Reimbursement Consideration Appeal Form (LWC-WC-3000)(see LAC 40:II.5129). Forms are available upon request from the Office of Workers' Compensation at the address shown on the sample form. Procedures for filing the appeal and documentation required are provided on the form. The written request for resolution of a disputed reimbursement along with the completed Special Reimbursement Consideration Appeal form must be submitted to the Office of Workers' Compensation Administration within 60 days of the payor's reconsideration or 90 days from the provider's requested date for reconsideration when no response from the payor was received.

b. Requests for resolving disputes should be sent to:

Office of Workers' Compensation
Medical Services Section
P.O. Box 94040
Baton Rouge, LA 70804-9040

F. Deposition and Witness Fees - Any health care provider who gives deposition shall be allowed a witness fee. Procedure Code 99075 must be used to bill for a deposition. Reimbursement for a deposition should be a specific amount mutually agreed upon and in writing, in advance of the event. Fees may be at an hourly rate or a flat rate. Disputes over these fees will be resolved in the same manner and subject to the same procedures as established for dispute resolution of claims for workers' compensation benefits. Disputes over these fees will be resolved using form LWC-WC-1008 (Disputed Claim for Compensation).

G. Copies of Records and Reports - Health care providers must submit copies of records and reports to payors, employers, claimants, a claimant's attorney, and the Office of Workers' Compensation Administration upon request. Providers can facilitate the timely processing of claims and payment for services by submitting appropriate documentation to the payor when requested.

1. Copies to Payors - Health care providers are entitled to recover a reasonable amount, not to exceed $1 per page, to cover the cost of copying documents which have been requested by a payor.

a. Certain procedure code descriptors require the submission of records and/or reports with the bill and/or claim. No copy charges should be billed by the provider for these required records and reports.

b. No copy charges should be billed for documentation which is submitted by the provider but was not specifically requested by the payor.

c. Health care providers may not charge a separate fee for medical reports that are required to substantiate the medical necessity of a service.

2. Copies to Claimants – Health care providers must furnish an injured employee and his/her attorney copies of his/her records and reports at the same time as copies are being furnished to the employer or payor at no expense to the claimant. If additional copies are requested by the claimant or his/her attorney, a copy charge may be billed to the employee or his/her attorney not to exceed $0.50 per page.

3. X-ray, Microfilm and other nonpaper records – Health care providers may charge the actual direct cost of copying nonpaper records.

4. The OWCA may charge $0.25 per page for reproducing records. This fee must be paid in advance.

H. Other Payment Policies

1. Prompt Payment – It is in the best interest of all parties that fees for services reasonably performed and billed in accordance with the reimbursement schedule be promptly paid. Not paying or formally contesting such bills by filing LWC-WC-1008 (Disputed Claim for Compensation) with the OWCA within 30 days of the date of receipt of the bill may subject the payor to penalties and attorney's fees should the Workers' Compensation Judge (WCJ) ultimately determine that such failure to pay is arbitrary and capricious or without reasonable cause.

2. Sales Tax – Sales taxes and other state mandated taxes are required to be reimbursed in addition to other procedure, supplies or medical service expenses.

3. Supplies and Materials

a. Supplies and materials provided by the health care provider (e.g., sterile trays/drugs) over and above those usually included within the office visit may be listed separately using CPT code 99070. Supplies and materials over $50 will be reimbursed at invoice cost plus 20 percent. Specialized supplies and DME may require a copy of the invoice be sent to the payor.

b. CPT Code 99080 is not to be used to complete required workers' compensation forms, to complete required documentation to substantiate medical necessity, to sign affidavits or to certify medical record forms. CPT Code 99080 may be used for billing of a special report such as an independent medical examination report.

4. Plastic and Metallic Implants – Plastic and metallic implants and non-autogenous graft materials are reimbursed at invoice cost plus 20 percent. A manufacturer's original invoice with the cost of the material must be submitted to the payor with the bill. If the manufacturer's original invoice cannot be produced, reimbursement shall be made by the payor using the prevailing charges for implants/graft materials used in similar procedures as determined by the payor based upon data which is specific to Louisiana.

5. Missed Appointments – A health care provider shall not receive payment for a missed appointment unless the appointment was arranged by the payor or the employer. If the payor or employer fails to cancel the appointment no less than 72 hours prior to the time of the appointment and the provider is unable to arrange for a substitute appointment for that time, the provider may bill the payor for the missed appointment.

6. Dispensing Physician Services – Reimbursement to a health care provider for dispensing medications, drugs or chemicals is limited to providers who are licensed through the State Board of Medical Examiners for dispensing such items. The health care provider is only allowed to dispense medication until he/she is informed by the payor that he/she may not do so. Payment shall be made in accordance with the Pharmacy Reimbursement Schedule, LAC40:I.Chapter 29.

7. Procedure Codes Not Listed in the Rules – If a procedure is performed for which the 5-digit CPT code is not listed in the current maximum allowable reimbursement table (Section 5157), the health care provider may use a valid CPT code and submit a narrative report to the payor explaining the use of a code/descriptor not contained in the maximum allowable reimbursement table. The Maximum Allowable Reimbursement for professional services for which the CPT code is not listed in Section 5157 may be a negotiated rate between the payor and provider.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR

~~**§5105. Verification of Coverage**~~

~~A. The carrier/self-insured employer is responsible for 100 percent of the maximum allowable reimbursement rate for covered services rendered for treatment of compensable conditions. The claimant is not required to contribute a co-payment and does not have to meet any deductibles.~~

~~1. Prior to the provision of medical services, supplies, or other non-medical services the determination that the illness, injury, or condition, is work related must be made, and must be accomplished in the following manner:~~

~~a. carrier/self-insured employer should be contacted for verification of coverage/liability;~~

~~b. the name and title of the individual verifying coverage/liability must be recorded in the claimant's records;~~

~~c. denial of coverage/liability must be immediately communicated to the claimant.~~

~~2. Those procedures identified in this reimbursement schedule as noncovered are not billable to the claimant if rendered in treatment of compensable conditions unless the claimant is informed beforehand that he will be responsible for the charges.~~

~~3. In certain circumstances, the provider collects his fees from the claimant because he is unsure or unaware of the occupational nature of the injury or condition. If the provider decides to bill the workers' compensation carrier/self-insured employer after compensability has been established, he must, to the best of his knowledge, make certain that the claimant has not already filed for reimbursement. If the claimant has not filed, the provider should bill the carrier/self-insured employer and reimburse the claimant. To avoid duplicate billings, the provider should file for the claimant, billing the full amount; or, the claimant should bill the full amount himself.~~

~~B. For covered services, if there is a difference between the provider's billed amount and the Office of Workers' Compensation maximum allowable reimbursement, the claimant, employer and carrier cannot under any circumstances, be billed for the difference.~~

~~AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.~~

~~HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).~~

§5105 Coding Standards

A. Coding Systems

1. Diagnosis Coding - The most current version of the International Classification of Diseases 10th Revision, Clinical Modification (ICD-10-CM) in effect at the time service is rendered or provided shall be the authoritative diagnostic coding guide, unless otherwise specified in this Chapter.

2. Procedure Coding

a. Inpatient - The most current version of the International Classification of Diseases 10th Revision, Clinical Modification/Procedure Coding System (ICD-10-CM/PCS) in effect at the time service is rendered or provided shall be the authoritative coding guide, unless otherwise specified in this Chapter.

b. Outpatient

i. The most current version of the American Medical Association's Current Procedural Terminology (CPT®) in effect at the time service is rendered or provided shall be the authoritative coding guide, unless otherwise specified in this Chapter.

ii. The most current version of HCPCS codes developed by CMS in effect at the time service is rendered or provided shall be the authoritative coding guide for durable medical equipment, prosthetics, orthotics, and other medical supplies (DMEPOS), unless otherwise specified in this Chapter.

c. Dental -The most current version of the American Dental Association's CDT: Dental Procedure Codes in effect at the time service is rendered or provided shall be the authoritative coding guide, unless otherwise specified in this Chapter.

B. Modifiers. Modifiers augment CPT codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier which is a two-digit alpha/numeric code placed after the usual procedure code, separated by a hyphen. If more than one modifier is needed, place the multiple modifiers code 99 after the procedure code to indicate that two or more modifiers will follow. The use of modifiers does not imply or guarantee that a provider will receive reimbursement as billed.

1. Modifier 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, severity of patient's condition, physical and mental effort required). This modifier should not be appended to an E/M service. Louisiana guidelines require a report explaining the medical necessity of the situation must be submitted with the claim to the payor. This modifier would be used in unusual circumstances only and is not appropriate to use for billing of routine procedures. Use of this modifier does not guarantee additional reimbursement.

2. 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.

3. Modifier 24 - Unrelated Evaluation and Management Services by the Same Physician or Other Qualified Health Care Professional during a Postoperative Period. The physician or other qualified health care professional 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.

4. Modifier 25 - Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional 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 above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable 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 services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. Note: This modifier is not used to report an 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.

5. Modifier 26 - Professional Component (PC). Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

6. Modifier TC - Technical Component. Certain procedures are a combination of a professional 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. Technical component charges are institutional charges and not billed separately by physicians.

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

8. Modifier 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.) Modifier 47 would not be used as a modifier for the anesthesia procedures.

9. Modifier 50 - Bilateral Procedure. Unless otherwise identified in the listings, bilateral procedures that are performed at the same session, should be identified by adding modifier 50 to the appropriate 5-digit code.

10. Modifier 51- Multiple Procedures. When multiple procedures, other than E/M Services, physical medicine and rehabilitation services, or provision of supplies (e.g., vaccines), are performed at the same session by the same individual, 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). This modifier should not be appended to designated "add-on" codes (see Section 5106.F).

11. Modifier 52 - Reduced Services. Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. 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. 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 wellbeing of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

12. Modifier 53 - Discontinued Procedure. Under certain circumstances the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the wellbeing 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 individual for the discontinued procedure. 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 wellbeing of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

13. Modifier 54 - Surgical Care Only. When one physician or other qualified health care professional 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.

14. Modifier 55 - Postoperative Management Only. When one physician or other qualified health care professional performed the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

15. Modifier 56 - Preoperative Management Only. When one physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

16. Modifier 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.

17. Modifier 58 - Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional 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. For treatment of a problem that requires a return to the operating/procedure room, (e.g., unanticipated clinical condition), see modifier 78.

18. Modifier 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 performed on the same day. Modifier 59 is used to identify procedures/services other than 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/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 is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. 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.

19. Modifier 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 if 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 also be reported with modifier 62 added. If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

20. Modifier 66 - Surgical Team. Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians or other qualified health care professionals, 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 individual with the addition of modifier 66 to the basic procedure number used for reporting services.

21. Modifier 76 - Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional. It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. This modifier should not be appended to an E/M service.

22. Modifier 77 - Repeat Procedure by Another Physician or Other Qualified Health Care Professional. It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. This modifier should not be appended to an E/M service.

23. Modifier 78 - Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional 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 requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)

24. Modifier 79 - Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional during the Postoperative Period. The individual 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.)

25. Modifier 80 - Assistant Surgeon. Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s). Reimbursement is 20 percent of the maximum allowable reimbursement.

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

27. Modifier 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).

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

29. Modifier 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. 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.

30. Modifier 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, and 87389). 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.

31. Modifier 95 - Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System. Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction. The modifier 95 appended to a code indicates it was performed by telemedicine/telehealth methods. Services should be reimbursed the same amount as the exact same codes without the modifier. If the payor requires a Place of Service (POS) code for telemedicine/telehealth, code 02 may be used.

32. 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.

33. Modifier QX – CRNA Service with medical direction by a physician.

34. Modifier QY – Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist.

35. Modifier QZ – CRNA service without medical direction by a physician.

C. Correct Coding Standard - All services performed shall be coded and billed in accordance with the standard coding systems defined in Section 5106.A. To promote national correct coding methodologies and to control improper coding leading to inappropriate payment, the State of Louisiana adopts the National Correct Coding Initiative (NCCI) edits defined by CMS to identify services that are commonly performed together and that should not be billed separately when the services are provided at the same encounter. CMS annually updates the NCCI Policy Manual. The complete list of NCCI edits is available on the CMS website at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html. When a conflict between the NCCI edits and the guidelines and coding policies defined in Chapter 51 Medical Reimbursement Schedule arise, the guidelines and policies dictated in Chapter51 will prevail. Knowingly and willfully misrepresenting services provided to workers' compensation claimants is strictly prohibited.

D. Unlisted Procedures – CPT contains codes for unlisted procedures. Use these codes only when there is no procedure code that accurately describes the service rendered. A report is required as these services are reimbursed By Report (see Section 5105. E).

E. By Report Services (BR)

1. By report refers to the method by which the reimbursement for a procedure is determined by the payor when a service or procedure is performed by the provider that does not have an established maximum allowable reimbursement (MAR) amount.

2. Reimbursement for procedure codes listed as "BR" must be determined by the payor based on documentation submitted by the provider in a special report attached to the claim form. This required documentation to substantiate the medical necessity of a procedure does not warrant a separate fee. Information in this report must include, as appropriate:

   a. a complete description of the actual procedure or service performed;
   b. the amount of time necessary to complete the procedure or service performed;
   c. accompanying documentation that describes the expertise and/or equipment required to complete the service or procedure.

3. Reimbursement of "BR" procedures by the payor should be based on the following:

   a. review of the submitted documentation;
   b. recommendation of the payor's medical consultant;
   c. the payor's review of the prevailing charges for like procedures based upon data which is specific for Louisiana charges.

F. Add-on Codes – CPT identifies procedures that are always performed in addition to the primary procedure and designates them with a + symbol. These add-on codes are never reported for stand-alone services but are reported secondarily in addition to the primary procedure. Specific language is used to identify add-on procedures

such as “each additional” or “list separately in addition to primary procedure.” Add-on codes are exempt from the multiple procedure concept (see Modifier 51 in Section 5105). Add-on codes are reimbursed at 100 percent of the maximum allowable reimbursement or the provider’s charge, whichever is less.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Workforce Commission, Office of Workers’ Compensation Administration, LR

~~**§5107. Other Payer Liabilities**~~

~~A. Whenever a claimant is eligible for Medicare or payment from another third party payer and is also eligible for workers' compensation medical benefits, the carrier/self-insured employer is always the primary payer, the payer of first resort. Services related to compensable conditions should be billed to the carrier/self-insured employer before attempting to collect from the third party payer.~~

~~B. If a claimant is receiving treatment for both compensable and noncompensable medical conditions, only those services provided in treatment of compensable conditions should be listed on claims and invoices submitted to the carrier/self-insured employer. In addition, payments from private payers for noncompensable conditions should not be listed on invoices submitted to the carrier/self-insured employer.~~

~~C. Charges for noncompensable conditions are collectible by the provider from any other third party payer, subject to the limitations and exclusions contained in the third payer's policy.~~

~~AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.~~

~~HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).~~

§5107 Billing Instructions

A. Inpatient and Outpatient Facility Services – Health care facilities must bill using the most current paper or electronic forms which are authorized by CMS. The electronic version, 837i or the paper form UB-04 (CMS-1450) is required. Services must be itemized. The use of all-inclusive accommodation and ancillary revenue codes is not acceptable. Additional coding and billing guidelines specific to certain categories may be found in the applicable facility services sections of this fee schedule.

B. Professional Services – Health care providers, with the exception of dentists, billing for outpatient professional services must bill using the most current paper or electronic forms which are authorized by CMS, regardless of the site of service. The electronic version, 837p or the paper form CMS-1500 is required. Additional coding and billing guidelines specific to certain coding categories may be found in the applicable professional services sections of this fee schedule.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Workforce Commission, Office of Workers’ Compensation Administration, LR

~~**§5109. Prior Authorization**~~

~~A. The Louisiana Workers' Compensation Statutes (R.S. 23:1142) establishes a monetary limit for nonemergency medical care. The statute further provides significant penalties for a carrier/self-insured employer's arbitrary and capricious refusal to approve necessary care beyond that limit. (See Chapter 27 Utilization Review Procedures, §2715.A and B). In addition to all other rules and procedures, the provider or practitioner who provide care under the "medical emergency" exception must demonstrate that it was a "medical emergency" as outlined in the Utilization Review Procedures, cited above. For additional instructions, please refer to the respective section of the schedule.~~

~~AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.~~

~~HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).~~

§5109 Evaluation and Management (E/M) Services

A. General Ground Rules

1. Classification of Evaluation and Management (E/M) Services: 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 physician work varies by type of service, place of service, and the injured worker's status.

2. New versus Established Patient:

a. A new patient is one who has not received any professional services from the provider or another provider of the same specialty who belongs to the same group practice, within the past three years. A new patient is also defined as a patient who is being seen and evaluated for a new workers' compensation related illness or injury.

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

c. In the instance where a provider is on call for or covering for another provider, the patient's encounter will be classified as it would have been by the provider who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty as the physician.

d. No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

3. Level of Service: The appropriate level of E/M service is based on the level of medical decision making defined for each service or the total time spent on E/M services on the date of service. Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the other E/M services when counseling and/or coordination of care dominates the service. Documentation in the medical record must support the level of E/M service reported.

a. For office visits and other outpatient visits, time is based on the amount of time spent face to face with the patient and not the time the patient is in an examining room.

b. For inpatient hospital care, time is based on unit floor time. This includes the time the physician is present on the patient's hospital unit and at the bedside rendering services. This also includes time spent reviewing the patient's chart, writing additional notes, and communicating with other professionals and/or the patient's family.

c. Medical Decision Making (MDM) includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. The four types of MDM are straightforward, low, moderate, and high. MDM in the office or other outpatient services codes is defined by three elements:

i. The number and complexity of problems(s) that are addressed during the encounter.

ii. The amount and/or complexity of data to be reviewed and analyzed.

iii. The risk of complications and/or morbidity or mortality of patient management decisions made at the visit, associated with the injured worker's problem(s), the diagnostic procedure(s), and treatment(s).

4. Consultations: A consultation is a service rendered by a specialist at the request of the treating provider or other appropriate source seeking further evaluation and/or an opinion on how to proceed in the management of a patient's illness. A consulting physician shall only initiate diagnostic and/or therapeutic services with approval from the authorized treating physician. A detailed narrative report is required and shall accompany the bill. The reimbursement for a consultation includes payment for the report and separate reimbursement for the report will not be provided. Following a consultation, if the consulting physician assumes responsibility for management of all or any part of the injured worker's condition(s), the injured worker becomes an "established patient" under the care of the consulting physician. Subsequent services must be billed and reimbursed under the appropriate visit codes, not consultation codes.

5. Hospital Discharge Day Management - Reimbursement for code 99238 will not be made in addition to another hospital visit billed by the same physician on the same day for the same patient.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR

~~Editor's Note: In addition, the following Sections of this Chapter are applicable and shall be used for the other chapters in this Part governing reimbursement. These specific Chapters are: Chapter 31, Vision Care Services; Chapter 33, Hearing Aid Equipment and Services; Chapter 35, Nursing Attendant Care and Home Health Services; Chapter 39, Medical Transportation; Chapter 41, Durable Medical Equipment and Supplies; Chapter 43, Prosthetic and Orthopedic Equipment; Chapter 45, Respiratory Services; Chapter 47, Miscellaneous Claimant Expenses; and Chapter 49, Vocational Rehabilitation Consultant.~~

~~**§5111. Billing Instructions**~~

~~A. The HCFA 1500 Form is to be used by health care providers except dentist, pharmacy, hospital (unless otherwise stated), and for home and vehicle modifications for billing services provided to workers' compensation claimant. Do not use any other form. A sample HCFA 1500 Claim Form and detailed instruction for proper completion of the form follows.~~

~~B. Bills for services rendered should be sent directly to the party responsible for reimbursement. Please do not send your bills directly to the Office of Workers' Compensation as this will delay your payments.~~

~~C. Instructions for use of HCFA 1500 Form:~~

~~1. provide the claimant's full name and address;~~

~~2. indicate the Social Security number; this cuts down on errors and helps correlate the billing to the appropriate file;~~

~~3. identify correct date of injury, if possible;~~

~~4. complete name and address of the employer, not just an individual's name;~~

~~5. name of the insurance carrier;~~

~~6. the attending physician should indicate the date the claimant's disability should begin;~~

~~7. the attending physician should list all diagnoses and claimant's complaints;~~

~~8. the date of the visit, the service(s) or procedure(s) performed and charges;~~

~~9. provider's complete name and address;~~

~~10. provider's identification number, i.e., tax identification number (TIN) or Social Security number.~~

~~AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.~~

~~HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).~~

§5111 Anesthesia Services

A. General Ground Rules - The amount payable for anesthesia services will be the lessor of the actual charge or the Maximum Allowable Reimbursement (MAR) as calculated using the factors defined in this section.

1. Global Service - 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.

2. Multiple Procedures - When multiple surgical procedures are performed during the same period of anesthesia, only the highest base unit allowance of the various surgical procedures should be used.

3. Non-anesthetic Procedures - When a non-anesthetic procedure is performed by anesthesiologist, they should use the surgical or medical code and fee established for that code. Anesthesia units and conversion factors are to be used only when the primary purpose of the service is to anesthetize the patient so that the surgical procedure can be performed.

4. Unlisted Service - 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 (BR).

5. More than one Anesthesiologist - When it is necessary to have a second anesthesiologist, the necessity should be substantiated by report. The second anesthesiologist will receive five base units + time units x the conversion factor (calculation of total anesthesia value).

6. Appropriate Coding - Anesthesiologists or CRNAs 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 payor. Application of the appropriate modifier to the bill for service is the responsibility of the provider, regardless of the place of service. For detailed information on anesthesia modifiers, refer to Section 5105.B.

7. Criteria for Reimbursement - Anesthesia services may be billed for any one of the three following circumstances:

a. An anesthesiologist provides total and individual anesthesia service.

b. An anesthesiologist directs a CRNA.

c. Anesthesia provided by a CRNA working independent of an anesthesiologist's supervision is covered when all the following conditions are met.

i. the service falls within the CRNA's scope of practice and scope of license as defined by law.

ii. the service is reasonable and medically necessary.

iii. the service is supervised by a licensed health care provider who has prescriptive authority.

iv. the service is provided under one of the following conditions: in accordance with the clinical privileges individually granted by the hospital or other health care organization;

(a). the doctor performing the procedure requiring the service specifically requests the service of a CRNA;

(b). the patient requiring the service specifically requests the service of a CRNA;

(c). the services are provided by a CRNA in connection with a medical emergency; or

(d). no anesthesiologist is on staff or an anesthesiologist is unable to provide the service.

8. Field Avoidance - Any procedure around the head, neck, or shoulder girdle that requires field avoidance or any procedure compromising the anesthesia administration (e.g., requiring a position other than supine or lithotomy) has a minimum base value of five units regardless of any lesser base value assigned to such procedures. In this case, a medical report must be attached to document the special unit.

9. Anesthesia Administered by other than an Anesthesiologist or CRNA - Anesthesia fees are not payable when local infiltration, digital block or topical anesthesia is administered by the operating surgeon or surgical assistants. Such services are included in the value for the surgical procedure.

B. Anesthesia Value Components

1. Base Units - Base units are relative values for anesthesia procedures as specified in the American Society of Anesthesiologists' (ASA) Relative Value Guide®. Base units reflect the complexity of the service and include pre- and postoperative visits, intubation, and care by the anesthesiologist/anesthesia professional during the procedure, the administration of fluids and/or blood, the usual monitoring services and extubation. See Table 1 in Section 5157 for a list of the base units for each CPT code.

2. Time Units - Anesthesia time begins when the anesthesiologist or CRNA starts physically to prepare the patient for the induction of anesthesia in the operating room area (or in an equivalent area) and ends when the patient is placed under postoperative supervision. Anesthesia time units are computed by allowing one unit for each 15 minutes or significant fraction thereof of anesthesia time. Five minutes or greater is considered a significant portion of a time unit for calculating additional time units of less than 15 minutes.

3. Physical Status Modifiers - The following physical status modifiers are consistent with the ASA ranking of patient physical status and distinguish various levels of complexity of the anesthesia service provided. All anesthesia services are reported by use of the anesthesia five-digit procedure codes (00100 - 01999) with the appropriate physical status modifier appended. Under certain circumstances, when another established modifier(s) is appropriate, it should be used in addition to the physical status modifier.

Physical Status Modifier	**Description**	**Additional 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

4. Qualifying Circumstances - Anesthesia services may be provided under difficult circumstances based on factors such as the extraordinary condition of the patient, unusual risk factors, patient age and management of body temperature or blood flow. More than one qualifying circumstance may be selected. These procedures would not be reported alone; they are add-on codes reported in addition to another anesthesia procedure or service.

CPT Code	Description	Additional Units
99100	Anesthesia for patient of extreme age, younger than 1 year and older than 70	1
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 (specify)	2
(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.)		

C. Calculating Anesthesia Maximum Allowable Reimbursement - The maximum allowable reimbursement (MAR) for anesthesia is calculated by adding the base unit value, the number of time units, any applicable modifier and/or unusual circumstances units, and multiplying the sum by a dollar amount (conversion factor) allowed per unit. The conversion factor for anesthesia services provided under this fee schedule is $50

(Base units + time units + modifying units) x conversion factor = MAR

1. When multiple surgical procedures are performed during the same period of anesthesia, use the base units for the highest/most complex anesthesia service and the time units applicable for the entire period of anesthesia time.

2. When the anesthesiologist provides an anesthesia service directly, payment will be the lesser of the billed charge or 100 percent of the calculated MAR.

3. Payment for covered anesthesia services provided by a CRNA will be the lesser of the actual billed charge or 85 percent of the calculated MAR. The CRNA's services should be billed using Modifier QZ.

4. Where a single anesthesia procedure involves both a physician's medical direction service and the service of the medically directed CRNA, the payment amount for the service of each is 50 percent of the allowance otherwise recognized had the service been furnished by the anesthesiologist alone.

a. Use Modifier – QX if medical direction by physician.

b. Use Modifier – QY if medical direction for one CRNA by anesthesiologist.

c. Reimbursement shall not be made to either the anesthesiologist or the CRNA until the insurer has received and reviewed the bill and the anesthesia report from both providers.

d. Reimbursement shall never exceed 100 percent of the maximum amount an anesthesiologist would have been allowed under the Medical Fee Schedule Allowance had the anesthesiologist or physician alone performed the services.

e. Medical supervision, as opposed to medical direction, occurs when the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedures. No additional reimbursement shall be made for general supervisory services rendered by the anesthesiologist or other physician.

5. Example MAR Anesthesia Calculation: The MAR for anesthesia time of two hours for CPT code 01382, anesthesia for arthroscopic procedure of knee joint, for a 45-year-old patient with severe systemic disease would be calculated as follows:

Base Units = 3
Time Units = 8 (four units per hour for two hours)
Physical Status Modifier = P3 or one additional unit
Qualifying Circumstance = not applicable or no additional units
MAR Calculation = (3+8+1) * $50.00 = $600

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR

~~**§5113. Coding System**~~

~~A. Diagnosis Coding. The International Classification of Diseases, Tenth Revision (ICD-10-CM) is the basis of diagnosis coding. These are the disease codes in the international classification, tenth revision, clinical modifications published by the U.S. Department of Health and Human Resources.~~

~~B. Helpful Hints for Diagnosis Coding~~

~~1. To ensure accurate payment, always report the primary diagnosis code on the claim form.~~

~~2. Each diagnosis code should be reported when services for multiple diagnosis are filed on the same claim form.~~

~~3. All digits of the appropriate ICD-10-CM code(s) should be reported.~~

~~4. The date of accident should always be reported if the ICD-10-CM code is for an accident diagnosis.~~

~~5. It is important to provide a complete description of the diagnosis if an appropriate ICD-10-CM code cannot be located.~~

~~C. Procedure Codes. HCPCS (pronounced "hick picks") is the acronym for the HCFA (Health Care Financing Administration) common coding system. This system is a uniform method for health care providers and medical suppliers to code professional services, procedures and supplies. HCPCS contains three unique coding systems, each called a level and numbered I, II and III respectively.~~

~~1. Level I. Level I is the American Medical Association's CPT (Physicians' Current Procedural Terminology) which is developed and maintained by the AMA. The CPT is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and are used for processing claims. Each procedure or service is identified with a five digit code.~~

~~2. Level II. HCPCS National Level II codes are alphanumeric codes which start with a letter followed by four numbers. These codes can be used in addition to CPT codes when services are provided at the same time or during the same visit. All services, procedures, supplies, materials and injections should be properly documented in the medical record.~~

~~3. Level III. This level is often used to describe new services, supplies or materials or to report procedures and services which have been deleted from CPT. These level III codes are not to be used for Workers' Compensation claims.~~

~~AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.~~

~~HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR 42:288 (February 2016).~~

§5113. Surgical Services

A. General Ground Rules

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 before and after surgery.

a. The global reimbursement includes:

i. the initial evaluation or consultation by a surgeon will be paid separately. The pre-operative policy will include all pre-operative visits, in or out of the hospital, by the surgeon beginning the day before the surgery;

ii. local anesthesia, such as infiltration, digital or topical anesthesia;

services such as dressing changes, local incisional care, removal of operative packs, removal of cutaneous sutures, staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines nasogastric and rectal tubes, and change and removal of tracheostomy tubes;

iii. normal, uncomplicated follow-up care for the time periods indicated in the follow-up days (FUD) column to the right of each procedure code as defined in the Maximum Allowance Reimbursement table in Section 5157. 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. Follow-up days are specified by procedure. The day of surgery is day one when counting follow-up days. Follow-up days are defined as follows:

Indicator	Meaning
000	Zero-day post-operative period. E/M visits on the same day as the procedure are included in the procedure unless a separately identifiable service is reported with an appropriate modifier.

010	10-day post-operative period. E/M visits on the same day as procedures and during the 10-day post-operative period are included in the procedure, unless a separately identifiable service is reported with an appropriate modifier.
090	90-day post-operative period. E/M visits on the same day as procedures and during the 90-day post-operative period are included in the procedure, unless a separately identifiable service is reported with an appropriate modifier.
MMM	Maternity service. Global service days concept does not apply.
XXX	Global concept does not apply.
YYY	Identifies procedures with variable service where global days are determined By Report.
ZZZ	Identifies "add-on" services. Procedure code is related to another service and included in the global period of the other service.

2. Follow-Up Care for Diagnostic Procedures – Follow-up care for diagnostic procedures, e.g., endoscopy, arthroscopy, injections procedures for radiography; includes only care that is related to the recovery from the diagnostic procedure itself. Care of the condition for which the diagnostic procedure was performed or of other concomitant condition is not included and may be reimbursed in accordance with the services provided.

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 concurrent with the procedure(s) or during the listed period of normal follow-up care may warrant additional charges. The payor is responsible only for services related to the compensable injury or illness unless the non-compensable condition has a direct bearing on the treatment of the compensable condition.

4. Additional Surgical Procedure(s) - When an additional surgical procedure(s) is carried out within the listed period of follow-up care for a previous surgery, each follow-up period specific to each surgery continues concurrently with each service maintaining its original timeline.

5. Unique Techniques - A surgeon is not entitled to an extra fee for a unique technique. It is inappropriate to use Modifier-22 unless the procedure is significantly more difficult than indicated by the description of the code.

6. Surgical Destruction - Surgical destruction is part of a surgical procedure, and different methods of destruction are not ordinarily listed separately unless the technique substantially alters the standard management of a problem or condition. Exceptions under special circumstances are provided for by separate code numbers.

7. Incidental Procedure(s) - An additional charge for an incidental procedure (e.g., incidental appendectomy, incidental scar excisions, puncture of ovarian cysts, simple lysis of adhesions, simple repair of hiatal hernia, etc.) is not customary and does not warrant additional reimbursement.

8. 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.

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

10. Joint Manipulation under Anesthesia - There is no charge for manipulation of a joint under anesthesia when it is preceded or followed by a surgical procedure on that same day by that surgeon or associate. However, when manipulation of a joint is the scheduled procedure and it indicates additional procedures are necessary and appropriate, 50 percent of the manipulation may be allowed.

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

12. Surgical Assistant - An individual who has the necessary qualifications to participate in a particular operation and actively assist in performing the surgery.

a. Physician Surgical Assistant - A physician who assists at surgery may be reimbursed as a surgical assistant. Assistant surgeons should use modifier-80 and are allowed the lesser of the billed amount or twenty percent (20%) of the maximum allowable reimbursement amount for the procedure(s). The assistant surgeon's name should be listed on the operative report.

b. Non-Physician Assistant-at-Surgery - Qualified Physician Assistant, Nurse Practitioner, or Surgical Technician may be reimbursed as an assistant-at-surgery. The assistant-at-surgery should be billed using modifier-

AS and are allowed the lesser of the charged amount or 13 percent of the maximum allowable reimbursement amount for the procedure(s). Services provided by an assistant-at-surgery should be submitted with the bill by the primary surgeon.

Reimbursement for a surgical assistant shall be based on medical necessity. If a procedure does not usually require the use of an assistant, documentation of medical necessity must be submitted with the claim form.

13. Operative Reports - An operative report must be submitted to the payor before reimbursement can be made for the surgeon's or assistant surgeon's services.

14. 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.

15. Therapeutic Procedures - Therapeutic procedures (injecting into cavities, nerve blocks, etc.) (20526-20611; 64400-64450; 64455-64484) 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 payor. Reimbursement for therapeutic injections will be made according to the multiple procedure rule. Trigger point injection is considered one procedure and reimbursed as such regardless of the number of injection sites.

16. 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 the Modifier-47 to the surgical code. Only base anesthesia units are allowed (See Anesthesia, Section 5111).

B. Multiple Procedures

1. Multiple Procedure Reductions - When more than one procedure is performed during the same operative session at the same operative site or multiple procedures are performed during the same operative session through multiple incisions for the same operative procedure the following reimbursement applies:

a. 100 percent for the primary procedure;
b. 60 percent for the second procedure;
c. 40 percent for the third procedure;
d. 25 percent for fourth and fifth procedures; and

each procedure after the fifth procedure will be paid by special report.

2. Bilateral Procedure Reductions - When bilateral procedures are performed that require preparation of separate operative sites, e.g., bilateral carpal tunnel, the second (or bilateral) site will be reimbursed as follows:

a. 75 percent for the primary procedure at the secondary site;
b. 60 percent for the second procedure at the secondary site;
c. 40 percent for the third procedure at the secondary site; and
d. 25 percent for fourth and fifth procedures at the secondary site.

3. Different Area Multiple Procedures - When multiple surgical procedures are performed in different areas of the body during the same operative sessions and the procedures are unrelated (i.e., abdominal hernia repair and a knee arthroscopy), the multiple procedure reimbursement rule will apply independently to each area. Modifier-51 must be added.

4. Multiple Endoscopic Procedures - When multiple endoscopic procedures are performed, the major procedure is reimbursed at 100 percent. If a secondary procedure is performed through the same opening/orifice, 50 percent is allowable as a multiple procedure. However, diagnostic procedures during the same session and entry site are incidental to the major procedure, which should be coded for the deepest penetration. Generally, no payment will be made for an office visit on the same day in addition to the endoscopic procedure unless a documented, separately identifiable service is furnished.

5. Add-on Procedures - CPT identifies procedures that are always performed in addition to the primary procedure. These add-on codes are never reported for stand-alone services but are reported secondarily in addition to the primary procedure. Specific language is used to identify add-on procedures such as “each additional” or “list separately in addition to primary procedure.” Add-on codes are exempt from the multiple procedure concept (see Modifier 51 in Section 5105). Add-on codes are reimbursed at 100 percent of the maximum allowable reimbursement or the provider’s charge, whichever is less.

C. Wound Repair

1. Wound repair (closure) procedures may be accomplished by one or more of the following techniques: sutures, staples, or tissue adhesives. Wound closure or dressing may also include adhesive strips. When adhesive strips are the only method of closure, the service is reported using the appropriate E/M code. The repair of wounds may be classified as simple, intermediate, or complex:

a. Simple Repair: Surgical closure of a superficial wound, requiring single layer closure of the skin (epidermis, dermis, or subcutaneous tissue). Local anesthesia is included. Simple repair includes chemical or electrocauterization.

b. Intermediate Repair: Surgical closure of a wound requiring closure of one or more of the deeper subcutaneous tissue and non-muscle fascia layers in addition to suturing the skin. Simple wounds with heavy contamination that require extensive debridement may also be considered to require intermediate repair.

c. Complex Repair: Surgical closure of a wound requiring more than layered closure of the deeper subcutaneous tissue and fascia (i.e., debridement, scar excision, placement of stents or retention sutures, and sometimes site preparation or undermining that creates the defect requiring complex closure). Excision of benign or malignant lesions is not inherent in complex repairs.

2. Report repair of nerves, blood vessels and tendons using codes from the appropriate system (Nervous, Cardiovascular, Musculoskeletal). The repair of these structures includes wound repair unless it qualifies as a complex wound, in which case modifier 51 should be appended as appropriate.

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.

D. Burns, Local Treatment

1. Procedure code 16000 must be used when billing for treatment of first degree burns when no more than local treatment of the burned surfaces is required.

2. Procedure codes 16020–16030 must be used only when billing for treatment of second- and third-degree burns.

3. Major debridement of foreign bodies, grease, epidermis, or necrotic tissue may be billed separately using CPT codes 11000–11047.

4. In order to accurately identify the proper procedure code and substantiate the descriptor for billing, the exact percentage of the body surface involved, and the degree of the burn must be specified in the proper section on the billing form or by attaching a special report.

5. Percentage of body surface burned is defined as follows:

a. “Small” means less than 9 percent of the body area

b. “Medium” means 9 to 18 percent of the body area

c. “Large” means greater than 18 percent of the body area

6. Any claim submitted that does not indicate the degree of burn and exact percentage of body area involved must be returned to the physician for this additional information. Grafting of burned areas must be billed separately under the appropriate skin grafting procedures. (See procedure codes 15050–15261).

7. Hospital visits, emergency room visits, or critical care visits provided by the same physician on the same day as the application of burn dressings will be reimbursed as a single procedure at the highest level of service.

E. Soft Tissue Injury Care

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

2. When a cast or strapping is applied during an initial visit, supplies and materials used such as stockinette, plaster, fiberglass, ace bandages, etc., may be itemized and billed separately using procedure code 99070.

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. Replacement casts or strapping provided during a follow-up visit (established patient) include reimbursement for the replacement service as well as the removal of casts, splints, or strapping. Follow-up visit charges may be reimbursed in addition to replacement casting and strapping only when additional significantly identifiable medical services are provided. Office notes should substantiate the medical necessity of the visit. Supplies and materials may be billed using procedure code 99070 and reimbursed separately.

5. When replacement casting and strapping procedures are not performed during follow-up visits, the services should be billed under the appropriate established patient visit code in the evaluation and management section.

F. Microsurgery

1. The surgical microscope is employed when the surgical services are performed using the techniques of microsurgery. CPT code 69990 Microsurgical techniques requiring use of operating microscope, is an add-on code reported separately (without modifier 51 appended) in addition to the code for the primary procedure performed.

2. Do not use 69990 for visualization with magnifying loupes or corrected vision. When a magnifying loupe or magnifying binoculars are used during a surgical procedure, no additional payment will be made for the use of the magnifying instrument.

G. Nerve Blocks

1. When a nerve block is performed for diagnostic or therapeutic purposes, select the appropriate code from CPT codes 62320–62327 or 64400–64530.

2. Reimbursement for therapeutic injections will be made according to the multiple procedure rules.

3. Refer to LAC40:I.Chapter 21. Pain Medical Treatment Guidelines for additional guidelines of therapeutic nerve blocks.

4. Medications such as steroid, pain medication, etc. may be separately billed and reimbursed using code 99070. The name, dosage and volume of the medication must be identified. Refer to the LAC40:I.Chapter 29. Pharmacy Reimbursement Schedule, Billing Instruction and Maintenance Procedures for additional information.

5. When a nerve block for anesthesia is provided by the operating room surgeon, the procedure codes listed in the Anesthesia section must be followed.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR 42:288 (February 2016), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR

~~§5115. Surgery Guidelines~~

~~A. General Guidelines~~

~~1. Global Surgery. 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 before and after surgery. The global reimbursement includes:~~

~~a. the initial evaluation or consultation by a surgeon will be paid separately. The pre-operative policy will include all pre-operative visits, in or out the hospital, by the surgeon beginning the day before the surgery;~~

~~b. local anesthesia, such as infiltration, digital or topical anesthesia;~~

~~c. normal, uncomplicated follow-up care for the time periods indicated in the follow-up days 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. Follow-up days are specified by procedures. The day of surgery is day one when counting follow-up days;~~

~~d. the global fee will include services such as dressing changes, local incisional care, removal of operative packs, removal of cutaneous sutures, staples, lines, wires, tubes, drains, casts and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines nasogastric and rectal tubes, and change and removal of tracheostomy tubes.~~

~~2. Follow-Up Care for Diagnostic Procedures. Follow-up care for diagnostic procedures, e.g., endoscopy, arthroscopy, injections procedures for radiography; includes only care that is related to the recovery from the diagnostic procedure itself. Care of the condition for which the diagnostic procedure was performed or of other concomitant condition is not included and may be charged for in accordance with the services provided.~~

~~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 concurrent with the procedure(s) or during the listed period of normal follow-up care may warrant additional charges. The workers' compensation carrier is responsible only for charges related to the compensable injury or illness unless the noncompensable condition has a direct bearing on the treatment of the compensable condition.~~

~~4. Additional Surgical Procedure(s). When an additional surgical procedure(s) is carried out within the listed period of follow-up care for a previous surgery, the follow-up periods will continue concurrently to other normal terminations.~~

~~5. Operating Microscope. Additional reimbursement for the use of an operating microscope (excluding loupes or other magnifying devices) will be allowed when the listed code does not state the use of the microscope is inherent in the procedure.~~

~~6. Unique Techniques. A surgeon is not entitled to an extra fee for a unique technique. It is inappropriate to use Modifier 22 unless the procedure is significantly more difficult than indicated by the description of the code.~~

~~7. Surgical Destruction. Surgical destruction is part of a surgical procedure, and different methods of destruction are not ordinarily listed separately unless the technique substantially alters the standard management of a problem or condition. Exceptions under special circumstances are provided for by separate code numbers.~~

8. Incidental Procedure(s). An additional charge for an incidental procedure (e.g., incidental appendectomy, incidental scar excisions, puncture of ovarian cysts, simple lysis of adhesions, simple repair of hiatal hernia, etc.) is not customary and does not warrant additional reimbursement.

9. Endoscopic Procedures. When multiple endoscopic procedures are performed, the major procedure is reimbursed at 100 percent. If a secondary procedure is performed through the same opening/orifice, 50 percent is allowable as a multiple procedure. However, diagnostic procedures during the same session and entry site are incidental to the major procedure, which is coded per the deepest penetration. Generally, no payment will be made for a visit on the same day in addition to the endoscopic procedure unless documented, separately identifiable service is furnished.

10. 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.

11. 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.

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

13. Joint Manipulation under Anesthesia. There is no charge for manipulation of a joint under anesthesia when it is preceded or followed by a surgical procedure on that same day by that surgeon or associate. However, when manipulation of a joint is the scheduled procedure and it indicates additional procedures are necessary and appropriate, 50 percent of the manipulation may be allowed.

14. 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. These supplies and materials over $50 will be reimbursed at invoice cost plus 20 percent. Specialized supplies and DME may require a copy of the invoice be sent to the C/SIE.

15. Plastic and Metallic Implants. Plastic and metallic implants or non-autogenous graft materials supplied by the physician are to be reimbursed at invoice cost plus 20 percent. An invoice with the cost of the material must be submitted to the C/SIE with the bill.

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

17. Assistant at Surgery. An assistant at surgery is an individual who has the necessary qualifications to participate in a particular operation and actively assist in performing the surgery.

a. A physician who assists at surgery may be reimbursed as a surgical assistant. The surgical assistant must bill separately from the primary physician. Modifier-80 should be used. Reimbursement should be 20 percent of the allowable reimbursement amount for the procedure(s). The assistant surgeon's name should be listed on the operative report.

b. Payment for physician assistant, nurse practitioner or surgical technicians will be made only to the employer not to the individual. Reimbursement is limited to 65 percent of the allowable amount for M.D. assistant surgeons.

c. Reimbursement for assistants at surgery shall be based on medical necessity. If a procedure usually does not require the use of an assistant, documentation of medical necessity shall be submitted with the claim form.

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

19. 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.

20. Therapeutic Procedures. Therapeutic procedures (injecting into cavities, nerve blocks, etc.) (20550-20610; 64400-64450) 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 carrier/SIE. Reimbursement for therapeutic injections will be made according to the multiple procedure rule. Trigger point injection is considered one procedure and reimbursed as such regardless of the number of injection sites.

21. 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 the Modifier 47 to the surgical code. Only base anesthesia units are allowed (See Anesthesia, §5117).

B. Multiple Procedures

1. Multiple Procedure Reimbursement Rule. When more than one procedure is performed during the same operative session at the same operative site and also multiple procedures performed during the same operative session through multiple incisions for the same operative procedure the following reimbursement applies:

a. 100 percent for the primary procedure;

b. 60 percent for the second procedure;

c. 40 percent for the third procedure;

d. 25 percent for fourth and fifth procedures; and

e. each procedure after the fifth procedure will be paid by special report.

2. Bilateral Procedure Reimbursement Rule. When bilateral procedures are performed that require preparation of separate operative sites, e.g., bilateral carpal tunnel, the second (or bilateral) site will be reimbursed as follows:

a. 75 percent value for the primary procedure at the remote site;

b. 60 percent for the second procedure at the remote site;

c. 40 percent for the third procedure at the remote site; and

d. 25 percent for fourth and fifth procedures at the remote site.

3. Multiple Procedure Reimbursement. When multiple surgical procedures are performed in different areas of the body during the same operative sessions and the procedures are unrelated (i.e., abdominal hernia repair and a knee arthroscopy), the multiple procedure reimbursement rule will apply independently to each area. Modifier 51 must be added.

C. Burns, Local Treatment

1. Degree of Burns

a. Code 16000 must be used when billing for treatment of first degree burns when no more than local treatment of burned surfaces is required.

b. Codes 16010-16030 must be used when billing for treatment of second and third degree burns only.

c. The claim form must be accompanied by a report substantiating the services performed.

d. Major debridement of foreign bodies, grease, epidermis, or necrotic tissue may be billed separately under Codes 11000-11001. Modifier-51 does not apply.

e. In order to identify accurately the proper procedure code and substantiate the descriptor for billing, the exact percentage of the body surface involved and the degree of the burn must be specified on the claim form submitted or by attaching a special report.

f. The following definitions apply to Codes 16010-16030.

Small—less than 9 percent of the body area.

Medium—9-18 percent of the body area.

Large—greater than 18 percent of the body area.

g. Claims submitted without specification of the degree of burn and exact percentage of body area involved must be returned to the physician for this additional information.

h. Hospital visits, emergency room visits, or critical care visits provided by the same physician on the same day as the application of burn dressings will be reimbursed as a single procedure at the highest level of service, except in case of an asterisk.

D. Nerve Blocks

1. Diagnostic or Therapeutic

a. When a nerve block is performed for diagnostic or therapeutic purposes, the appropriate procedure code must be billed (62274-62279 or 64400-64530). It is inappropriate to use base and/or time units even when performed by an anesthesiologist.

b. Medications such as steroid, pain medication, etc., may be separately billed using Code 99070.

i. The name of the medication(s), dosage, and volume must be identified.

ii. Medication will be reimbursed at a reasonable cost.

2. Anesthetic

a. When a nerve block for anesthesia is provided by the operating room surgeon, the procedure codes listed in §5117, Anesthesia, must be followed.

E. Surgery Modifiers

1. Modifier codes may be used by providers to identify procedures or services that are modified due to specific circumstances.

~~2. Modifiers listed in the CPT must be added to the procedure code when the service or procedure has been altered from the basic procedure described by the descriptor.~~

~~3. When Modifier 22 is used to report an unusual service, a report explaining the medical necessity of the situation must be submitted with the claim to the C/SIE. It is not appropriate to use Modifier 22 for routine billing.~~

~~4. The use of modifiers does not imply or guarantee that a provider will receive reimbursement as billed. Reimbursement for modified services or procedures must be based on documentation of medical necessity and must be determined on a case by case basis.~~

~~F. Starred Procedures (starred in CPT book). Certain small surgical services involve a readily identifiable surgical procedure but include variable pre- and post-operative services (e.g., incision and drainage of an abscess, injection of a tendon sheath, manipulation of a joint under anesthesia). Because of the indefinite pre- and post-operative services, the usual "package" concept of surgical services cannot be applied. These procedures are identified in the CPT by a star (*) following the procedure code number.~~

~~AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.~~

~~HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).~~

§5115 Diagnostic and Therapeutic Radiological Services

A. General Ground Rules - The amount payable for Radiological services will be the lessor of the actual charge or the Maximum Allowable Reimbursement (MAR) as calculated using the factors defined in this section. For Facility billing and reimbursement, see Outpatient Facility Section 5123.

1. Global Fee - A global fee includes both the professional component for the radiologist and the technical component needed to accomplish the procedure. Explanations of the professional component and the technical component are listed below. The values as listed in the MAR column of Section 5157 represent the global reimbursement. Under no circumstances shall the global MAR for a procedure be more than the combined value of the professional component (modifier 26) and the technical component (modifier TC).

2. Professional Component - The professional component represents the reimbursement allowance of the professional radiological services of the physician and is identified by the use of modifier 26. This includes examination of the patient when indicated, performance or supervision of the procedure, interpretation and written report of the examination, and consultation with the referring physician. In the majority of hospital radiology departments, the radiologist submits a separate statement to the patient for professional services rendered, which are listed as the professional component. PC Values in the rate table of Section 5157 are intended for the services of a radiologist 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.

3. Technical Component - The technical component includes charges made by the institution or clinic to cover the services of technologists and other staff members, the film, contrast media, chemicals and other materials, and the use of the space and facilities of the x-ray department. To identify a charge for a technical component only, use the five-digit code followed by HCPCS modifier TC.

4. Review of X-rays – CPT code 76140, Consultation on x-ray examination made elsewhere, written report, will only be paid when there is a documented need for the service (e.g., a second opinion is required for a radiological procedure) and when performed by a radiologist or physician certified to perform radiological services. Reimbursement is limited to the PC Amount listed in the Fee Schedule for the radiological procedure. Billing code 76140 is not appropriate in the following circumstances because review of the x-rays is inherent to the evaluation and management code:

a. the physician, during the course of an office visit or consultation, reviews an x-ray made elsewhere;

b. the treating or consulting physician reviews x-rays at an emergency room or hospital visit;

5. Additional X-rays - No payment shall be made for additional x-rays when recent x-rays are available except when supported by adequate information regarding the need to retake x-rays. The use of photographic or digital media and/or imaging is not reported separately, but is considered to be a component of the basic procedure and shall not merit any additional payment.

6. Comparison X-rays - Comparison x-rays are reimbursable when appropriate. Any repeat comparison x-ray requires prior approval and will not be reimbursed without prior approval.

7. Contrast Material

a. Complete procedures, interventional radiological procedures, or diagnostic studies involving injection of contrast media include all usual pre-injection and post-injection services (e.g., necessary local anesthesia, placement of needle catheter, injection of contrast media, supervision of the study, and interpretation of results).

b. Providers must determine whether the use of ionic or non-ionic contrast media is appropriate for the individual patient. No additional payment will be made for the use of non-ionic contrast media. Supplies are considered incidental to the administration of the contrast and are not separately reimbursable.

c. When contrast can be administered orally (upper G.I.) or rectally (barium enema), the administration of contrast is included as part of the procedure and not separately reimbursed.

d. When an intravenous line is placed simply for access in the event of a problem with a procedure or for administration of contrast, it is considered part of the procedure and is not separately reimbursed.

8. Supervision and Interpretation Only - A code designated as "Supervision and Interpretation only" is used to indicate radiological services provided by a radiologist and staff, in conjunction with services provided by another physician (i.e., injection, insertion of catheter). In this instance, a physician other than the radiologist should bill using the appropriate procedure code and the radiologist should bill using the appropriate "Supervision and Interpretation" only code. If the radiologist and staff provide both portions of the service, report both the Supervision and Interpretation code and the appropriate procedure code

9. Written Report(s) – A written report, signed by the interpreting physician, should be considered an integral part of a radiological procedure or interpretation, and must be submitted with the billing.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR

§5117. Anesthesia

A. General. The total anesthesia allowance is calculated by adding the basic value units, time value units, plus any applicable modifier unit values and/or unusual qualifying circumstances units and multiplying the sum by a dollar amount allowed per unit.

1. Basic Units. A basic unit is listed for most procedures. The allowable basic units are shown in the following schedule. When multiple surgical procedures are performed during the same period of anesthesia, only the greater basic unit allowance of the various surgical procedures will be used as the base. The basic value for each procedure includes pre- and post-operative visits, administration of fluids and/or blood incident to the anesthesia care and interpretation of noninvasive monitoring (EKG, temperature, blood pressure, oximetry capnography and mass spectrometry). When multiple surgical procedures are performed during the same period of anesthesia, only the highest base unit allowance of the various surgical procedures will be used.

2. Time Units. Time begins when the anesthesiologist begins to prepare the patient anesthesia care in the operating room or in a equivalent area. Time ends when anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision. The anesthesia time units will be calculated in 15-minute intervals, or portions thereof, equaling one time unit. In each instance, five minutes or greater is considered a significant portion of a time unit. No additional time units are allowed for recovery room time and monitoring.

3.a. Modifier Units. Physical status modifiers are represented by the letter "P" followed by a single digit defined below.

i.	Healthy Patient	0
ii.	Patient with mild systemic disease	0
iii.	Patient with severe systemic disease	1
iv.	Patient with severe systemic disease threat to life	2
v.	A moribund patient who is not expected to survive without the operation	3
vi.	A declared brain-dead patient whose organs are being removed for donor purposes	0
The above six levels are consistent with the American Society of Anesthesiologist (ASA) ranking of patient physical status.		
Example: 00100-P1		

4. Qualifying circumstances warrant additional value due to unusual events. The following list of CPT-4 codes and the corresponding anesthesia unit values may be listed if appropriate. More than one code may be necessary. The unit value listed is added to the existing anesthesia base units.

CPT-4		Units

99100	Anesthesia for patient of extreme age, under one year and over 70	1
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 (specify)	2
(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.)		

5. Any procedure around the head, neck or shoulder girdle requiring field avoidance or any other procedure requiring a position other than supine or lithotomy, has a basic value of 5.0 units regardless of any lesser value assigned to such procedure. A medical report must be attached to document the special unit.

6. Unlisted Service or Procedure. When an unlisted service or procedure is provided, the value should be substantiated "by report." These services are shown in this schedule as "BR."

7. Procedures Listed without Specified Unit Values. "BR" in the value column indicates that the value of this service is to be determined "by report" because the service is too unusual or variable to be assigned a unit value.

8. 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 (time units + base units).

9. More Than One Anesthesiologist. When it is necessary to have a second anesthesiologist, the necessity should be substantiated by report "BR." It is recommended that the second anesthesiologist receive 5 base units + time units (calculation of total anesthesia value).

10. Amount Payable

a. The amount payable for anesthesia services will be the lesser of the actual charge or $50 times the total allowed units as determined by this schedule and the above guidance.

b. The total anesthesia allowance is calculated by adding the basic unit value, the number of time units, plus any applicable modifier and/or unusual circumstance units and multiplying the sum by the $50 allowed per unit.

c. When non-anesthetic procedures are performed by anesthesiologist, they should use the surgical or medical code and fee established for that code. Anesthesia units and conversion factors are to be used only when the primary purpose of the service is to anesthetize the patient so that the surgical procedure can be performed.

d. Trigger point injection is considered one procedure and is reimbursed as such regardless of the number of injection sites.

B. Reimbursement Guidelines for Anesthesia Services. Anesthesia services may be billed for any one of the three following circumstances.

1. An anesthesiologist provides total and individual anesthesia service.

2. An anesthesiologist directs a CRNA.

3. Anesthesia provided by a CRNA working independent of an anesthesiologist's supervision is covered under all the following conditions.

a. The service falls within the CRNA's scope of practice and scope of license as defined by law.

b. The service is reasonable and medically necessary.

c. The service is supervised by a licensed health care provider who has prescriptive authority.

d. The service is provided under one of the following conditions:

i. in accordance with the clinical privileges individually granted by the hospital or other health care organization;

ii. the doctor performing the procedure requiring the service specifically requests the service of a CRNA;

iii. the patient requiring the service specifically requests the service of a CRNA;
iv. the services are provided by a CRNA in connection with a medical emergency; or
v. no anesthesiologist is on staff or an anesthesiologist is unable to provide the service.
e. Payment for covered anesthesia services provided by a CRNA will be limited to the lesser of the actual charge or 80 percent of the medical reimbursement guideline total anesthesia value. Use Modifier –QZ.
f. Where a single anesthesia procedure involves both a physician medical direction service and the service of the medically directed CRNA, the payment amount for the service of each is 50 percent of the allowance otherwise recognized had the service been furnished by the anesthesiologist alone.
i. Use Modifier –QX if medical direction by physician.
ii. Use Modifier –QY if medical direction for one CRNA by anesthesiologist.
iii. Reimbursement shall not be made to either the anesthesiologist or the CRNA until the insurer has received and reviewed the bill and the anesthesia report from both providers.
iv. Reimbursement shall never exceed 100 percent of the maximum amount an anesthesiologist would have been allowed under the Medical Fee Schedule Allowance had the anesthesiologist or physician alone performed the services.
v. Medical supervision, as opposed to medical direction, occurs when the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedures. No additional reimbursement shall be made for general supervisory services rendered by the anesthesiologist or other physician.
AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.
HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR 47:606 (May 2021).

§5117 Pathology and Laboratory Services

A. General Ground Rules - The amount payable for Professional Pathology and Laboratory services will be the lessor of the actual charge or the Maximum Allowable Reimbursement (MAR) as calculated using the factors defined in this section. For Facility billing and reimbursement, see Outpatient Facility Section 5123.

1. Global, Professional and Technical Components – Some pathology and laboratory services may require interpretation by a physician. In this case, there may be a separate bill for the technical and professional components of the procedure. The technical component is the use of the laboratory equipment and technician's services, and the professional component is the physician's interpretation and report. When billing for the professional or the technical component, use the appropriate modifier 26 (professional) or modifier TC (technical component). When billing for the global procedure, no modifier is required.

2. Panel Tests - The billing for panel tests must include documentation listing the tests in the panel. When billing for panel tests (80047–80081), use the code number corresponding to the appropriate panel test. These tests will not be reimbursed separately. The panel components do not preclude the performance of other tests not listed in the panel. If other laboratory tests are performed in conjunction with a particular panel, the additional tests may be reported separately in addition to the panel.

3. Handling and Collection Process

a. In collecting a specimen, the cost for collection is covered by the technical component when the lab test is conducted at that site. No separate collection or handling fee for this purpose will be reimbursed.

b. When a specimen must be sent to a reference laboratory, the cost of specimen collection is covered in a collection fee. This charge is only allowed when a reference laboratory is used, and modifier 90 must be used.

B. Drug Screening - Current coding for drug testing relies on a structure of "screening" (also known as "presumptive" testing), followed by quantitative or "definitive" testing that identifies the specific drug and quantity. Presumptive testing indicates the presence or absence of a drug or drug classes. Results are commonly reported as "positive" or "negative" and do not indicate the level of drug present. Definitive drug testing is most often used to evaluate presumptive drug test results and identify specific drugs and concentrations of drugs and their associated metabolites.

1. A definitive drug test is reimbursable if:

a. a definitive concentration of a drug must be identified to guide treatment, or

b. a specific drug in a large family of drugs (e.g., benzodiazepines, barbiturates, and opiates) must be identified to guide treatment, or

c. a false result must be ruled out for a presumptive drug test that is inconsistent with a member's self- report, presentation, medical history, or current prescriptions, or

d. a specific substance or metabolite that is inadequately detected by presumptive drug testing (direct-to-definitive testing) must be identified.

2. CPT codes 80305, 80306 and 80307 are used for reporting presumptive drug class screening. Each code represents all drugs and drug classes performed by the respective methodology per date of service. Each code also includes all sample validation procedures performed.

3. Definitive drug screening should be reported using HCPCS Level II codes G0480-G0483, which are distinguished by the number of drug classes being tested, and G0659 that distinguishes between structural isomers. The AMA has developed CPT codes 80320-80377 for definitive drug testing; however, these codes are not reimbursable under this fee schedule.

4. At maximum, only one code from each category (presumptive and definitive) is to be utilized per date of service or patient encounter resulting in no more than two billing codes per bill.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR 47:606 (May 2021), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR

~~Editor's Note: The following Sections apply to all the schedules mentioned in the beginning of Chapter 51: §§5119, 5121, 5123, 5145, 5147, 5149, and 5153.~~

~~§5119. Deposition/Witness Fee Limitation~~

~~A. Any health care provider who gives deposition shall be allowed a witness fee. Procedure Code 99075 must be used to bill for a deposition. Reimbursement for a deposition should be a specific amount mutually agreed upon and in writing, in advance of the event. Fees may be at an hourly rate or a flat rate. Disputes over these fees will be resolved in the same manner and subject to the same procedures as established for dispute resolution of claims for workers' compensation benefits.~~

~~AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.~~

~~HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).~~

§5119 General Medicine Services

A. Allergy and Clinical Immunology

1. Procedure codes 95004-95199 are used for allergy testing and allergy immunotherapy services.

2. Allergy skin testing is reimbursed on a per test basis.

3. Professional services including the preparation and provision of antigens is reimbursed on a per dose basis.

B. Biofeedback

1. Biofeedback training (CPT codes 90901, 90912 and 90913) may be reimbursed when it is medically necessary. A written plan of care which includes objectives, the estimated length of treatment and stated goals must be submitted to the payor for approval prior to the services being provided.

2. Reimbursement of biofeedback services is limited to providers currently licensed or certified to provide biofeedback services. Providers include:

a. Physicians currently licensed in Louisiana who are certified by or meet certification requirements of the Biofeedback Certification Institute of America.

b. Physical and Occupational therapists licensed through the license laws of Louisiana and biofeedback therapists certified by the Biofeedback Certification Institute of America, who are employed by physicians. Billing for biofeedback services provided by these therapists must be submitted by the supervising physician. The appropriate license and/or certification number must be provided on the billing form to receive reimbursement for biofeedback services.

3. Reimbursement for biofeedback training is limited to 12 visits unless additional visits are appropriately justified per the medical treatment guidelines. One or more procedures may be provided during a visit if medically necessary and included in the approved plan of care.

C. Injections

1. Subcutaneous, Intramuscular, and Intravenous

a. Any procedure codes from 90476-90749 which are listed as “By Report” in the fee schedule table require that the report include the name of the medication strength and volume injected.

b. When multiple drugs are administered from the same syringe, Modifier-51 must be added to the procedure codes for the second and subsequent drugs.

c. Reimbursement for multiple drugs administered from the same syringe must be at the provider's usual charge or the maximum allowable reimbursement, whichever is less for the first drug, and the provider's charge or 50 percent of the maximum allowable reimbursement, whichever is less for each additional drug.

d. Reimbursement for injections includes the cost of the drug, the charge for the administration of the drug and the cost of the supplies used to administer the drug.

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

2. Intra-Articular or Intrabursal Injections (Procedure codes 20550-20615)

a. Reimbursement for intra-articular or intrabursal injections includes the supplies usually required to perform the procedure, but not the medications.

b. An invoice documenting the cost of the injectable medications must be submitted with the claim form since reimbursement is limited to the provider's charge or up to 20 percent above the actual cost to the provider, whichever is less.

D. Neurology & Neuromuscular Services

1. Neurologic services are typically consultation services and any of the five levels of consultation (Procedure Codes 99241-99245) may be appropriate. However, when provided by the attending physician for all or partial care, the appropriate evaluation and management level of service must be billed.

2. Diagnostic studies (nerve conduction tests, electromyograms, electroencephalograms, etc.) are reimbursable in addition to the office visit or consultative service.

3. Diagnostic study includes both a technical (equipment, technical personnel, supplies, etc.) and professional (interpreting test results, written reports, etc.) components. Billing CPT neurological and neuromuscular procedure codes indicate that the complete service, both professional and technical components, are being billed. Reimbursement is the lesser of the provider's charge or the maximum allowable reimbursement for the procedure.

4. When a visit/consultation is made for the purpose of an assessment and evaluation of the patient, range of motion tests and measurements are not reimbursed as separate entities as these tests are an integral part of the visit/consultation. When the visit/consultation is made solely for the purpose of performing tests and measurements, the testing procedures may be reimbursed as separate entities however no additional reimbursement will be made for the visit. Reports showing these measurements must accompany the billing of these codes.

E. Psychological Services

1. Provision of Services

a. Psychiatric services may be billed by licensed physicians who are certified by or who have satisfactorily completed the specialized training requirements of the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry. These physicians must either perform the service directly or provide direct supervision of qualified mental health professionals performing the service as required under the applicable Louisiana statutes.

b. Psychiatric evaluations may be provided as independent medical examinations (IMEs) when requested by the payor.

c. Psychiatric evaluations may be provided as consultations when requested by a physician and when authorized by the payor.

d. Upon authorization by the payor, psychiatric treatment may be provided when documentation submitted by the physician to the payor substantiates the medical necessity of the treatment and includes the estimated length of treatment.

e. Psychiatric diagnostic, evaluative and therapeutic procedures must be billed under appropriate CPT procedure codes.

2. Reimbursement

a. A routine medical visit rendered by the same physician on the same day as psychiatric therapy is included in the reimbursement for the more comprehensive service.

b. Hypnosis may be reimbursed when it is an integral part of a plan for the treatment of post-traumatic stress disorders arising from on-the-job injuries.

c. Psychiatric Diagnostic Interview (Procedure Code 90791 and 90792) includes history and mental status determination, development of a treatment plan when treatment is necessary, and the preparation of a written report.

d. Psychological Testing Evaluation Services (Procedure Codes 96130-96133) includes the interpretation of results and preparation of a written report. Test administration and scoring services (Procedure Codes 96136-96139) provided by a physician or qualified health care professional may be reported in addition to the psychological testing evaluation services.

e. Individual Psychotherapy (Procedure Codes 90832-90838) must be billed under the procedure code most closely approximating the length of the session.

f. Group psychotherapy (Procedure Code 90853) generally requires 75 to 90 minutes per session. When a psychiatric treatment program includes group sessions routinely scheduled for more or less time than this, appropriate modifiers should be used.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR

~~**§5121. Missed Appointments**~~

~~A. The provider shall not receive payment for a missed appointment unless the appointment was arranged by the carrier or the employer. If the carrier or employer fails to cancel the appointment not less than 72 hours prior to the time of the appointment and the provider is unable to arrange for a substitute appointment for that time, the provider may bill the carrier for the missed appointment.~~

~~AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.~~

~~HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).~~

§5121 Physical Medicine Services

A. General Ground Rules

1. Practicing Physical and Occupational Therapists - To bill for physical therapist and/or occupational therapist services under workers' compensation, a practicing therapist must be:

a. currently licensed in the state of Louisiana as a physical therapist or as an occupational therapist;

b. if billing for physical or occupational therapy procedures, you must provide your physical therapist or occupational therapist license number. These procedures will not be reimbursed unless a current Louisiana license number is provided;

c. services must be billed using the appropriate CPT codes.

2. Physical and occupational therapy services billed by hospitals, other facility settings, or billed by therapists in a non-facility setting will be reimbursed based on the lesser of the amount charged or the MAR set forth in the Professional Services Rate Table, Section 5157.B. This represents the total reimbursement for the service. No additional reimbursement will be due to the facility.

3. The following criteria must be met for therapy to qualify for reimbursement:

a. the patient's condition must have the potential for restoration of function;

b. the therapy must be specific for the improvement of the patient's condition; and

c. the therapy must be provided under a current, written plan of care. The plan of care needs to be substantiated in the office notes and approved by a physician unless the therapy is performed by a physical therapist possessing a doctorate degree or five years of licensed clinical practice experience.

4. Upon request, physicians must submit to the payor documentation substantiating the medical necessity of the therapies ordered.

B. Plan of Care

1. On the initial visit, a therapist must evaluate the patient's therapy needs and develop a written plan of care based upon the assessment of the patient's level of function.

2. Plan of Care Content. At a minimum, the plan of care should contain:

a. the potential degree of restoration and measurable goals;

b. the specific therapies to be provided including the frequency of each treatment;

c. the estimated duration for the therapeutic regimen.

3. Plan of Care Review - The therapist must review each plan of care at least every 30 days and make necessary revisions. Physical and occupational therapy services required in excess of 45 days from onset of evaluation for treatment shall require evidence in writing as to the necessity for continued therapy. Thereafter, evidence in writing to the necessity for continued physical therapy shall be required every 30 days.

C. Assessment - Only one initial assessment per injury may be reimbursed. Reimbursement for the use of additional initial assessment time is not allowed. Reimbursement for reassessments shall be recommended only once in a seven-day period.

1. Physical Therapist - The initial, written assessment developed by a physical therapist must be reported to the payor using procedure code 97161-97163. Code 97164 is used for re-evaluation of a patient by the physical therapist.

2. Occupational Therapist - The initial, written assessment developed by an occupational therapist must be reported to the payor using procedure code 97165-97167. Code 97168 is used for re-evaluation of a patient by the physical therapist.

3. Assessment of the patient's status includes assessment of the neuromuscular system. Therefore, reimbursement must not be made for neuromuscular testing codes, extremity testing codes and/or range of motion codes.

D. Medical Supplies - Medical supplies used in the course of physical and occupational therapy including dressings, splinting and orthotic materials, educational materials, lumbar and cervical rolls, etc., may be billed and reimbursed using procedure code 99070.

E. Modalities and Procedures

1. Body Areas - Under workers' compensation, the following two body areas, or any portions thereof, are recognized for the provision of modalities and procedures:

a. the trunk—the entire body including the spine, excluding the head and limbs (syn: torso);

b. any two extremities:

i. an upper extremity is an upper limb, including the shoulder, upper arm, elbow, forearm, wrist and hand;

ii. a lower extremity is a lower limb, including the hip, thigh, knee, leg, ankle, and foot.

2. Reimbursement

a. No more than one visit per day for the purpose of therapy may be reimbursed.

b. The payor should compare the billing with the plan of care to ensure that only the services that are itemized in the plan of care are reimbursed.

c. Since the Hubbard Tank or Therapeutic Pool is designed for full body immersion, unless full body immersion is medically necessary and prescribed, procedure code 97036 must not be reimbursed.

d. Prior written authorization must be obtained when billing for more than eight modalities, procedures, or combination in one physical and occupational therapy session.

e. Therapeutic exercises and procedures codes 97150, 97110, 97530 are to be utilized by physical therapists when billing for therapeutic exercise and procedures such as, but not limited to, joint mobilization, gait training, muscle re-education, activities of daily living, patient education, etc.

F. Tests and Measurements

1. Test and measurements codes are included in the value of an evaluation and management service when performed on the same day (CPT codes 97750-97755)

2. Procedure code 97755 shall be used when testing is performed by means of mechanical equipment. This procedure code shall include a print out of test results with report.

3. Prior authorization is required to bill 97755 if testing exceeds 30 minutes for single joint, single plane; or, 45 minutes for single joint multiple plane; or, 45 minutes for multiple joint, multiple plane for noninvolved side.

4. Prior authorization if required to bill 97755 if re-testing exceeds 15 minutes for a single joint, single plane; or 30 minutes for single joint multiple plane; or, 30 minutes for multiple joints, multiple planes for noninvolved side.

G. Fabrication of Orthotics – Orthotics must be billed separately for professional fitting and supplies. CPT code 97760 should be used by a health care provider or therapist to fabricate orthotics. Supplies should be billed according to Section 5103.H.3. Supplies and Materials.

H. Transcutaneous Electrical Nerve Stimulation (TENS) – TENS may be provided by the therapist when ordered by the physician, itemized in the plan of care, and authorized by the payor.

1. Reimbursement for TENS testing and training is limited to four sessions per injury.

2. When the provider recommends TENS for long-term therapy, authorization must be obtained from the payor for rental or purchase of equipment prior to providing the equipment to the patient. For reimbursement and billing instructions, refer to the Durable Medical Equipment Manual, LAC40:I.Chapter 41.

I. Work Hardening and Work Conditioning – Use CPT code 97545 and 97546 to report Work Hardening and Work Conditioning services. A checklist for the billing and medical record requirements is provided in this section as an outline when performing billing for these services.

1. Operational Definitions

a. Direct Supervision - Direct supervision means supervision of personnel by a licensed provider who is physically available on site.

b. Work Conditioning - Work conditioning is a work-related, intensive, goal-oriented treatment program specifically designed to restore an individual's systemic, neuro-musculo-skeletal (strength, endurance, movement, flexibility, and motor control) and cardiopulmonary functions. The objective of the work conditioning program is to restore the claimant's physical capacity and function so the claimant can return to work.

c. Work Conditioning Assessment - Work conditioning assessment is defined as evaluation(s), test(s), and procedure(s) required to identify and quantify the claimant's individual work-related, systemic, neuro-musculo-skeletal restoration needs. The results of this assessment shall be used to identify eligibility, design a plan of care, monitor progress, and plan for discharge and return to work.

d. Work Conditioner Provider - A licensed physical therapist or a licensed occupational therapist.

e. Work Hardening - Work hardening is a highly structured, goal-oriented, individualized treatment program designed to return the claimant to work. Work hardening programs, which are interdisciplinary in nature, use real or simulated work activities designed to restore physical, behavioral, and vocational functions. Work hardening addresses the issues of productivity, safety, physical tolerances, and worker behaviors.

f. Work Hardening Assessment - Work hardening assessment is defined as interdisciplinary evaluation(s), test(s), and procedure(s) required to identify and quantify the claimant's individual restoration needs related to physical, functional, behavioral, and vocational status. The initial interdisciplinary assessment is used to identify claimant's eligibility, design a plan of care, monitor process, plan for discharge, and return to work.

g. Work Hardening Providers - Work hardening providers include the following professionals:

i. physical therapist;
ii. occupational therapist;
iii. psychologist;
iv. vocational specialist.

2. Program Comparison

Work Conditioning Program	**Work Hardening Program**
Addresses physical and functional needs which may be provided by one discipline (single discipline model).	Addresses physical, functional, behavioral vocational needs within an interdisciplinary model.
Requires work conditioning assessment.	Requires work hardening assessment.
Utilizes physical conditioning and functional activities related to work.	Utilizes real or simulated work activities.
Provided in multi-hour sessions up to: 2-4 hours/day, 5 days/week, up to 8 weeks (need additional approval after this length of stay)	Provided in multi-hour sessions up to: 4-8 hours/day, 2-5 visits/week, up to 8 weeks

3. Work Conditioning Guidelines

a. Eligibility – To be eligible for work conditioning, a claimant must have a job goal, have started, or demonstrated willingness to participate, have identified systemic neuro-musculo-skeletal physical and functional deficits that interfere with work and be at a point of resolution of the initial or principal injury that participation in the work conditioning program would not be prohibited. Work conditioning generally follows acute medical care or may begin when the claimant meets the eligibility criteria.

b. Provider Responsibility

i. Provider must seek authorization from the payor prior to initiation of the program.
ii. The need for a program shall be established by a work conditioning provider based on the results of a work conditioning assessment.
iii. The program shall be provided by or under the direct supervision of a work conditioning provider.
iv. The work conditioning provider shall document all evaluations, services provided, claimant progress, and discharge plans. Information shall be available to the claimant, payor, other providers, and any referral source.
v. The work conditioning provider shall develop and utilize an outcome assessment system designed to evaluate, at a minimum, patient care results, program effectiveness, and efficiency.

vi. The work conditioning provider should be appropriately familiar with job expectations, work environments, and skills required of the claimant through means such as site visitation, videotapes, and functional job descriptions.

c. Program Content:

i. development of program goals in relation to job skills and job requirements;

ii. techniques to improve strength, endurance, movement, flexibility, motor control and cardiopulmonary capacity related to the performance of work tasks;

iii. practice, modification, and instruction in work related activities;

iv. education related to safe job performance and injury prevention;
promotion of claimant responsibility and self management;

v. work conditioning programs are provided in multi-hour sessions available up to five days a week for a duration of up to eight weeks.

d. Program Termination – The claimant shall be discharged from the work conditioning program when the goals for the claimant have been met. Work conditioning shall be discontinued when any of the following occur:

i. The claimant has or develops behavioral or vocational problems which are not being addressed and which interfere with return to work.

ii. There are medical contraindications.

iii. The claimant fails to comply with the requirements of participation.

iv. The claimant's progress has reached a plateau prior to meeting goals.

v. Services are discontinued by the referral source.

When the claimant is discharged or discontinued from the work conditioning program, the work conditioning provider shall notify the payor and/or any referral source, including the reasons for program termination, the clinical and functional status, recommendations regarding return to work and recommendations for follow-up services.

e. Work Conditioning Billing Checklist

1.	No additional modality charge should be added to a work conditioning charge
2.	Services rendered by a licensed Physical Therapist or Occupational Therapist
3.	Maximum treatment program for work conditioning is eight weeks
4.	Claimant should not have frequent unexcused absences

f. Work Conditioning Medical Records Checklist

1.	Thorough initial evaluation to include history, musculo-skeletal assessment, functional testing and job description or job evaluation
2.	Treatment plan
4.	Claimant's progress documented in progress notes
5.	Discharge evaluation and discharge report
6.	Documentation of claimant education
7.	Documentation of work simulation tasks
8.	Documentation of therapeutic exercise task
9.	Documentation of aerobic conditioning tasks
10.	Documentation of two-to-four-hour daily program

4. Work Hardening Guidelines

a. Eligibility – To be eligible for work hardening, a claimant must have a have a job goal for return to work at the time of discharge, have stated or demonstrated willingness to participate, have identified physical (systemic neuro-muscular-skeletal), functional, behavioral, and vocational deficits that interfere with work and be at the point of resolution of the initial or principal injury that participation in the work hardening program would not be prohibited. Work hardening may begin only after the completion of the work hardening assessment.

b. Provider Responsibility

i. The payor should be notified prior to initiation of the program.

ii. The need for a program shall be based on the results from a work hardening assessment performed by all of the work hardening providers.

iii. The program components shall be provided by or under the direct supervision of the appropriate work hardening providers.

iv. The treating work hardening providers shall meet on a regular basis to discuss, coordinate and document program progress and outcome achievement.

v. The work hardening providers shall document all evaluations, services provided, claimant progress, and discharge plans. Information shall be available to the claimant, C/SIE, other professional providers, and any referral source.

vi. The work hardening providers shall develop and utilize an outcome assessment system designed to assess, at a minimum, patient care results, program effectiveness, and efficiency.

vii. The work hardening providers should be familiar with job expectations, work environments, and skills required of the claimant through means as site visitation, videotape, functional job descriptions, interview of claimant, or interview of employer

viii. There should be an area that is designed, arranged, and equipped for the specific purpose of providing work hardening programs

c. Program Content

i. development of program goals in relationship to specific job requirement or specific functional goals;

ii. techniques to develop strength, endurance, movement, flexibility, motor control and cardiopulmonary capacity related to the performance of work tasks;

iii. practice, modification, and instruction in simulated or real work activities;

iv. education related to safe job performance and injury prevention;

v. provision of behavioral and vocational services as determined by the respective work hardening provider;

vi. promotion of claimant responsibility and self-management;

vii. provision in multi-hour sessions with a minimum of four hours and up to eight hours, five days a week, for duration up to eight weeks;

viii. assist the claimant to obtain as appropriate:

(a). alcohol and other drug dependency counseling;

(b). engineering and ergonomic services;

(c). medical services;

(d). nutritional and weight control services;

(e). orthotic and prosthetic services;

(f). smoking cessation counseling.

d. Program Termination – The claimant shall be discharged from the work conditioning program when the goals for the claimant have been met. Work conditioning shall be discontinued when any of the following occur:

i. The claimant has or develops problems which cannot be addressed within the program.

ii. There are medical contraindications.

iii. The claimant demonstrates a lack of willingness to participate.

iv. The claimant fails to comply with the requirements of participation.

v. The claimant's progress has reached a plateau prior to meeting goals.

vi. Services are discontinued by the referring source.

When the claimant is discharged or discontinued from the work hardening program, the work hardening provider shall notify the payor and/or any referral source, including the reasons for program termination, clinical and functional status, recommendations regarding return to work and recommendations for follow-up services.

e. Work Hardening Billing Checklist

1.	No additional modality charge should be added to a work hardening charge
2.	Services rendered by licensed Work Hardening providers as defined in LAC Title 40
3.	Maximum treatment program for work hardening is eight weeks
4.	Program should be daily after first week of evaluation
5.	Claimant should not have frequent unexcused absences
6.	Preauthorization obtained

f. Work Hardening Medical Records Checklist

1.	Thorough initial evaluation to include history, musculo-skeletal assessment, functional testing and job description or job evaluation
2.	Treatment plan

3.	Documentation of claimant staffing
4.	Claimant's progress documented in progress notes
5.	Discharge evaluation and discharge report
6.	Documentation of claimant education
7.	Documentation of work simulation tasks
8.	Documentation of therapeutic exercise task
9.	Documentation of aerobic conditioning tasks
10.	Documentation of four-to-eight-hour daily program

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.
HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR

~~**§5123. Copies of Records and Reports**~~

~~A. Health care providers must submit copies of records and reports to carriers, employers, claimants or their attorney and the Office of Workers' Compensation Administration upon request. Providers can facilitate the timely processing of claims and payment for services by submitting appropriate documentation to the carrier/self-insured employer when requested.~~

~~B. Health care providers are entitled to recover a reasonable amount, not to exceed $1 per page, to cover the cost of copying documents which have been requested by the carrier.~~

~~1. Certain procedure code descriptors require the submission of records and/or reports with the claim form. There is no reimbursement of copy charges to the provider for these required records and reports.~~

~~2. Documentation which is submitted by the provider, but was not specifically requested by the carrier, is not allowed a copy charge.~~

~~C. Health care providers must furnish an injured employee copies of his records and reports at the same time as copies are being furnished to the employer or carrier, at no expense to the employee. If additional copies are requested by claimant or his attorney, the copy charge to the employee or his attorney may not exceed $0.50 per page.~~

~~D. Health care providers may charge the actual direct cost of copying X-rays, microfilm or other nonpaper records.~~

~~E. The OWCA may charge the actual cost of reproducing records which is established at $0.25 per page and must be paid in advance.~~

~~F. A health care provider may not charge a separate fee for medical reports that are required to substantiate the medical necessity of a service.~~

~~G. CPT Code 99080 is not to be used to complete required workers' compensation forms or to complete required documentation to substantiate medical necessity. CPT Code 99080 is not to be used for signing affidavits or certifying medical records forms. CPT Code 99080 is appropriate for billing of a special report such as independent medical examination report.~~

~~AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2., 1125, 1127 and 1310.12.~~
~~HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).~~

§5123 Outpatient Facility

A. General Ground Rules

1. Facility Services Reimbursement - All hospital-based, freestanding ambulatory surgery centers, rehabilitation, psychiatric and chemical dependency outpatient facilities will be reimbursed at covered charges less a ten percent discount. The formula for calculating the payment amount is as follows:

((Billed Charges) – (Noncovered Charges)) x 0.90 = Reimbursement Amount

2. For the purposes of this fee schedule, if a patient is admitted as an outpatient but stays in the hospital overnight, the patient will not be considered an "inpatient" until the patient remains in the hospital by midnight census of the second day.

3. The rate table provided in Section 5157 should not be referenced for the reimbursement of outpatient facility services. The formula referenced above is for all outpatient facility payments.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2., 1125, 1127 and 1310.12.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR

§5125. Special Instructions

A. Procedure Codes Not Listed in Rules

1. If a procedure is performed which is not listed in the maximum reimbursement allowance, the health care provider must use an appropriate CPT code descriptor. The provider must submit a narrative report to the carrier to explain why it was medically necessary to use a particular procedure code or descriptor not contained in the maximum reimbursement allowance. The codes used in this schedule are 1994 CPT codes.

2. The CPT contains codes for unlisted procedures which end in "99." These codes should only be used when there is no procedure code which accurately describes the service rendered. A special report is required as these services are reimbursed by report.

3. Services must be coded with valid five digit procedure codes.

B. Modifiers

1. Modifier codes must be used by providers to identify procedures or services that are modified due to specific circumstances.

2. Modifiers listed in the CPT must be added to the procedure code when the service or procedure has been altered from the basic procedure described by the descriptor.

3. When Modifier 22 is used to report an unusual service, a report explaining the medical necessity of the situation must be submitted with the claim to the carrier. It is not appropriate to use Modifier 22 for routine billing.

4. The use of modifiers does not imply or guarantee that a provider will receive reimbursement as billed. Reimbursement for modified services or procedures must be based on documentation of medical necessity and must be determined on a case by case basis.

5. The modifier 95 appended to a code indicates it was performed by telemedicine/telehealth methods. Services should be reimbursed the same amount as the exact same codes without the modifier as long as the Emergency Rule exist. If carrier requires a Place of Service (POS) code for telemedicine/telehealth, code 02 may be used.

C. By Report (BR)

1. BR refers to the method by which the reimbursement for a procedure is determined by the carrier when a service or procedure is performed by the provider that does not have an established maximum reimbursement allowance.

2. Reimbursement for procedure codes listed as BR must be determined by the carrier based on documentation which is submitted to the carrier by the provider in a special report attached to the claim form. Information in this report must include, as appropriate:

a. the pertinent history and physical findings;

b. diagnostic tests and interpretation;

c. therapeutic procedures;

d. treatment for concurrent medical conditions;

e. the final diagnosis/diagnoses;

f. identification of, or an estimate of the time required for follow-up care;

g. summary of treatment plan;

h. copies of operative reports, consultation reports, progress notes, office notes or other applicable documentation;

i. description of equipment necessary to provide the service.

3. Reimbursement by the carrier of BR procedures should be based upon the following:

a. review of the submitted documentation;

b. recommendation of the C/SIE's medical consultant;

c. the C/SIE's review of the prevailing charges for like procedures based upon data which is specific for Louisiana charges.

4. Bundled Code. These codes are marked BR, and are not payable because the service is included in the payment for other services.

D. Pathology. If no indication is given in the fee schedule to differentiate between professional and technical components for the MFA, the standard would be 15 percent of the total allocated for the technical component and 85 percent for the professional component.

~~E. Adjunct of Subsidiary Codes. Certain codes, by the nature of their description have already been reduced, as they are never to be billed as primary procedures. These codes should be reimbursed at the listed value when billed with other procedures.~~

~~F. Dispensing Physician Services~~

~~1. Reimbursement to a physician for dispensing medications, drugs or chemicals is limited to physicians who are licensed through the State Board of Medical Examiners for dispensing such.~~

~~2. Payments shall be made in accordance with the Pharmacy Reimbursement Schedule, Chapter 29.~~

~~AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.~~

~~HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Louisiana Workforce Commission, Office of Workers' Compensation Administration, LR 46:1400 (October 2020).~~

§5125 Inpatient Facility

A. Acute Inpatient Facilities

1. Pre-certification is required for all inpatient admissions. Refer to the Managed Care Program section of the Utilization Review Manual for definitions and requirements.

2. Reimbursement for inpatient hospital services is limited to the lesser of covered billed charges or the per diem amount as specified in the table below.

a. The per diem rate assigned will be applied to the inpatient days by type of service, either medical or surgical. The diagnosis/procedure code requiring the greatest resource consumption (severity) should be used to assign the correct type of service.

b. Charges for noncovered items and services should not be included in the total charges considered for reimbursement.

3. Reimbursement Calculation – Using the Per Diem Rate Table below, the formula for calculating the reimbursement amount is:

Per Diem Rate x LOS = Per Diem Amount

a. If the billed charges are greater than the calculated per diem amount, reimbursement will be the per diem amount less any noncovered charges.

b. If the billed charges are less than the calculated per diem amount, reimbursement will be the billed charges less any noncovered charges.

Per Diem Rate Schedule		
	Medical per Diem	**Surgical per Diem**
Louisiana State Rate	$1818	$3089

4. For the purposes of this fee schedule, if a patient is admitted as an outpatient but stays in the hospital overnight, the patient will not be considered an “inpatient” until the patient remains in the hospital by midnight census of the second day.

B. Skilled Nursing Facilities

1. Reimbursement for inpatient skilled nursing or intermediate care (swing bed) facility services is limited to the lesser of covered billed charges or the per diem amount as specified in the table below.

a. The uniform statewide per diem rate will be applied to all inpatient days by type of facility, either hospital-based or freestanding.

b. Charges for noncovered items and services should not be included in the total charges considered for reimbursement.

2. Reimbursement Calculation – Using the Per Diem Rate Table below, the formula for calculating the reimbursement amount is:

Applicable Per Diem Rate x LOS = Per Diem Amount

a. If the billed charges are greater than the calculated per diem amount, reimbursement will be the per diem amount less any noncovered charges.

b. If the billed charges are less than the calculated per diem amount, reimbursement will be the billed charges less any noncovered charges.

Per Diem Rate Schedules	Rates
Skilled Nursing Facility	
Hospital Based	$441
Freestanding	$104
Intermediate Care Facility	
Hospital Based	$336
Freestanding	$95

C. Rehabilitation Facilities

1. Reimbursement for inpatient rehabilitation facility services is limited to the lesser of covered billed charges or the per diem amount as specified in the table below.

a. The uniform statewide per diem rate will be applied to all inpatient days by type of facility, either hospital-based or freestanding.

b. Charges for noncovered items and services should not be included in the total charges considered for reimbursement.

2. Reimbursement Calculation – Using the Per Diem Rate Table below, the formula for calculating the reimbursement amount is:

Applicable Per Diem Rate x LOS = Per Diem Amount

a. If the billed charges are greater than the calculated per diem amount, reimbursement will be the per diem amount less any noncovered charges.

b. If the billed charges are less than the calculated per diem amount, reimbursement will be the billed charges less any noncovered charges.

Per Diem Rate Schedule	Rates
Hospital Based Rehabilitation Facility	$1056
Freestanding Rehabilitation Facility	$1838

D. Psychiatric & Chemical Dependency Facilities

1. Reimbursement for inpatient psychiatric and/or chemical dependency unit facility services is limited to the lesser of covered billed charges or the per diem amount as specified in the table below.

a. The uniform statewide per diem rate will be applied to all inpatient days by type of service, either psychiatric or chemical dependency.

b. Charges for noncovered items and services should not be included in the total charges considered for reimbursement.

2. Reimbursement Calculation – Using the Per Diem Rate Table below, the formula for calculating the reimbursement amount is:

Applicable Per Diem Rate x LOS = Per Diem Amount

a. If the billed charges are greater than the calculated per diem amount, reimbursement will be the per diem amount less any noncovered charges.

b. If the billed charges are less than the calculated per diem amount, reimbursement will be the billed charges less any noncovered charges.

Per Diem Rate Schedule	Rates
Psychiatric Services	$1199
Chemical Dependency Unit Services	$896

E. Outliers

1. Automatic Outliers – Inpatient stays for hospital acute care services falling within the classification of DRG 927, 928, 929, and 933 (severe burns) are considered automatic outliers and will be reimbursed outside of the normal per diem reimbursement method. These inpatient stays will be reimbursed at covered billed charges less a 15 percent discount. The reimbursement calculation formula for an automatic outlier is:

(Billed Charges – Noncovered Charges) x 0.85 = Reimbursement Amount

2. Special Reimbursement Appeals –

a. Special consideration will be given to cases that are atypical in nature due to a patient's case complexity causing unusually high expense when compared to the provider's usual case mix. The following criteria will be

applied to determine when an inpatient stay, originally paid according to the per diem methodology of this section, may be appealed for additional reimbursement consideration:

i. Total charges for an acute inpatient surgical stay are equal to or greater than $100,000;

ii. Total charges for an acute inpatient medical stay are equal to or greater than $75,000;

iii. Average charge per day for any inpatient stay (acute, rehab, SNF, etc.) equal to 1.75 times the applicable per diem rate for the inpatient facility type.

b. If a facility determines that an inpatient stay falls within the appealable criteria, a request for review may be submitted to the payor.

c. If the request for review is denied by the payor, the facility may then file a formal appeal with the Office of Workers' Compensation using the Special Reimbursement Consideration Appeal Form (LWC-WC-3000) (see LAC 40:II.5129). Forms are available upon request from the Office of Workers' Compensation at the address shown on the sample form. Procedures for filing the appeal and documentation required are provided on the form.

d. Final determination as to the acceptance of a case for special reimbursement rests solely with the state of Louisiana, Office of Workers' Compensation.

e. If the appeal is approved, the facility will be reimbursed covered billed charges less a 15 percent discount. The reimbursement calculation formula for an approved appeal is:

(Billed Charges – Noncovered Charges) x 0.85 = Reimbursement Amount

3. All workers' compensation inpatient claims paid outside of the per diem reimbursement method either as automatic outliers or as Special Reimbursement Appeals are subject to on-site bill audit. Bill audits are governed by the rules and procedures found in the Utilization Review Procedures Manual. Please refer to that manual for further details.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Louisiana Workforce Commission, Office of Workers' Compensation Administration, LR 46:1400 (October 2020), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR

~~**§5127. Physical Medicine**~~

~~A. Practicing Physical and Occupational Therapists~~

~~1. To bill for physical therapist and/or occupational therapist services under workers' compensation, a practicing therapist must be:~~

~~a. currently licensed in the state of Louisiana as a physical therapist or as an occupational therapist;~~

~~b. if billing for physical or occupational therapy procedures, you must provide your physical therapist or occupational therapist license number. These procedures will not be reimbursed unless a current Louisiana license number is provided;~~

~~c. services must be billed using the appropriate national CPT codes as listed in this manual.~~

~~2. The following criteria must be met for therapy to qualify for reimbursement:~~

~~a. the patient's condition must have the potential for restoration of function;~~

~~b. the therapy must be specific for the improvement of the patient's condition;~~

~~c. the therapy must be provided under a current, written plan of care which is approved by a physician and substantiated in the office notes.~~

~~3. Upon request, physicians must submit to carriers documentation substantiating the medical necessity of therapies ordered.~~

~~B. Plan of Care~~

~~1. On the initial visit, a therapist must evaluate the patient's therapy needs and develop a written plan of care based upon the assessment of the patient's level of function and the physician's orders.~~

~~2. Plan of Care Content. At a minimum, the plan of care should contain:~~

~~a. the potential degree of restoration and measurable goals;~~

~~b. the specific therapies to be provided including the frequency of each treatment;~~

~~c. the estimated duration for the therapeutic regimen.~~

~~3. Plan of Care Review~~

~~a. The therapist must review each plan of care at least every 30 days and make necessary revisions.~~

~~b. Physical and occupational therapy services required in excess of 45 days from onset of evaluation for treatment shall require evidence in writing as to the necessity for continued therapy. Thereafter, evidence in writing to the necessity for continued physical therapy shall be required every 30 days.~~

~~C. Assessment~~

1. Billing. The initial, written assessment developed by the therapist must be reported to the carrier using procedure code, 97001 or 97003.

2. Reimbursement

a. Only one initial assessment per injury may be reimbursed. Reimbursement for the use of additional initial assessment time is not allowed.

b. Reimbursement for reassessment shall be recommended only once in a seven day period. Reassessment for established patients shall be billed under 97002 or 97004.

c. Assessment of the patient's status includes assessment of the neuromuscular system. Therefore, reimbursement must not be made for neuromuscular testing codes, extremity testing codes and/or range of motion codes except for those testing procedures identified by the following code: 97535 or 97755.

D. Modalities and Procedures

1. Body Areas. Under workers' compensation, the following two body areas, or any portions thereof, are recognized for the provision of modalities and procedures:

a. the trunk—the entire body including the spine, excluding the head and limbs (syn: torso);

b. any two extremities:

i. an upper extremity is an upper limb, including the shoulder, upper arm, elbow, forearm, wrist and hand;

ii. a lower extremity is a lower limb, including the hip, thigh, knee, leg, ankle and foot.

2. Reimbursement

a. No more than one visit per day for the purpose of therapy may be reimbursed.

b. The carrier should compare the billing with the plan of care to ensure that only the services that are itemized in the plan of care are reimbursed.

c. Since the Hubbard Tank or Therapeutic Pool is designed for full body immersion, unless full body immersion is medically necessary and prescribed, Procedure Codes 97036 must not be reimbursed.

d. Prior written authorization must be obtained when billing for more than eight modalities, procedures or combination in one physical and occupational therapy session.

e. Therapeutic exercises and procedures codes 97150, 97110, 97530 are to utilized by physical therapists when billing for therapeutic exercise and procedures such as, but not limited to, joint mobilization, gait training, muscle re-education, activities of daily living, patient education, etc.

E. Transcutaneous Electrical Nerve Stimulation (TENS)

1. TENS may be provided by the therapist when ordered by the physician, itemized in the plan of care and authorized by the carrier.

2. Reimbursement for TENS testing and training is limited to four sessions per injury.

3. Billing for TENS Equipment. When the physician recommends TENS for long-term therapy, authorization must be obtained from the carrier for rental or purchase of equipment prior to providing the equipment to the patient. For reimbursement and billing instructions, please refer to the Durable Medical Equipment Manual.

F. Medical Supplies. Medical supplies used in the course of physical and occupational therapy including dressings, splinting and orthotic materials, educational materials, lumbar and cervical rolls, etc., may be billed and reimbursed using Procedure Code 99070.

G. Fabrications of Orthotics

1. Evaluation of orthotics shall be billed according to §5127.C.

2. Fabrication and fitting of orthotics shall be billed under 97530 or 97760 as a PT/OT procedure.

3. Supplies shall be billed according to §5127.F.

H. Test and Measurements

1. Reimbursement for extremity testing, muscle testing and range of motion measurements shall be billed according to §5127.C.

2. Procedure codes 97755 shall be used when testing is performed by means of mechanical equipment. These procedure codes shall include print out of test results with report.

a. Prior authorization is required to bill 97755 if testing exceeds 30 minutes for single joint, single plane; or, 45 minutes for single joint multiple plane; or, 45 minutes for multiple joint, multiple plane for noninvolved side.

b. Prior authorization is required to bill 97755 if re-testing exceeds 15 minutes for single joint, single plane; or 30 minutes for single joint multiple plane; or, 30 minutes for multiple joint, multiple plaine for noninvolved side.

I. Programs in Industrial Rehabilitation; Work Hardening and Work Conditioning

1. Operational Definitions

a. Work Conditioning. Work conditioning is a work-related, intensive, goal-oriented treatment program specifically designed to restore an individual's systemic, neuro-musculo-skeletal (strength, endurance, movement,

flexibility and motor control) and cardiopulmonary functions. The objective of the work conditioning program is to restore the claimant's physical capacity and function so the claimant can return to work.

b. Work Conditioning Assessment. Work conditioning assessment is defined as evaluation(s), test(s), and procedure(s) required to identify and quantify the claimant's individual work-related, systemic, neuro-musculo-skeletal restoration needs. The results of this assessment shall be used to identify eligibility, design a plan of care, monitor progress and plan for discharge and return to work.

c. Work Conditioner Provider. A licensed physical therapist, a licensed occupational therapist.

d. Work Hardening. Work hardening is a highly structured, goal-oriented, individualized treatment program designed to return the person to work. Work hardening programs, which are interdisciplinary in nature, use real or simulated work activities designed to restore physical, behavioral, and vocational functions. Work hardening addresses the issues of productivity, safety, physical tolerances, and worker behaviors.

e. Direct Supervision. Direct supervision means supervision of personnel by a licensed provider who is physically available on site.

f. Work Hardening Assessment. Work hardening assessment is defined as interdisciplinary evaluation(s), test(s), and procedure(s) required to identify and quantify the claimant's individual restoration needs related to physical, functional, behavioral, and vocational status. The initial interdisciplinary assessment is used to identify claimant's eligibility, design a plan of care, monitor process, plan for discharge and return to work.

g. Work Hardening Providers. Work hardening providers include the following professionals:

i. physical therapist;

ii. occupational therapist;

iii. psychologist;

iv. vocational specialist.

2. Program Comparison

Work Conditioning Program	Work Hardening Program
Addresses physical and functional needs which may be provided by one discipline (single discipline model).	Addresses physical, functional, behavioral vocational needs within an interdisciplinary model.
Requires work conditioning assessment.	Requires work hardening assessment.
Utilizes physical conditioning and functional activities related to work.	Utilizes real or simulated work activities.
Provided in multi-hour sessions up to: — 2-4 hours/day, — 5 days/week, — up to 6 weeks (need additional approval after this length of stay)	Provided in multi-hour sessions up to: — 4-8 hours/day, — 5 days/week, — up to 8 weeks

3. Work Conditioning Guidelines

a. Claimant Eligibility

i. To be eligible for work conditioning, a claimant must:

(a). have a job goal;

(b). have stated or demonstrated willingness to participate;

(c). have identified systemic neuro-musculo-skeletal physical and functional deficits that interfere with work;

(d). be at a point of resolution of the initial or principal injury that participation in the work conditioning program would not be prohibited.

ii. Work conditioning generally follows acute medical care or may begin when the claimant meets the eligibility criteria.

b. Provider Responsibility

i. The carrier/SIE should be notified prior to initiation of the program.

ii. The need for a program shall be established by a work conditioning provider based on the results of a work conditioning assessment.

iii. The program shall be provided by or under the direct supervision of a work conditioning provider.

iv. The work conditioning provider shall document all evaluations, services provided, claimant progress, and discharge plans. Information shall be available to the claimant, C/SIE, other providers, and any referral source.

v. The work conditioning provider shall develop and utilize an outcome assessment system designed to evaluate, at a minimum, patient care results, program effectiveness, and efficiency.

vi. The work conditioning providers should be appropriately familiar with job expectations, work environments, and skills required of the claimant through means such as site visitation, videotapes, and functional job descriptions.

c. Program Content:

i. development of program goals in relation to job skills and job requirements;

ii. techniques to improve strength, endurance, movement, flexibility, motor control and cardiopulmonary capacity related to the performance of work tasks;

iii. practice, modification, and instruction in work related activities;

iv. education related to safe job performance and injury prevention;

v. promotion of claimant responsibility and self management;

vi. work conditioning programs are provided in multi-hour sessions available up to five days a week for a duration of up to eight weeks.

d. Program Termination

i. The claimant shall be discharged from the work conditioning program when the goals for the claimant have been met.

ii. Work conditioning shall be discontinued when any of the following occur.

(a). The claimant has or develops behavioral or vocational problems which are not being addressed and which interfere with return to work.

(b). There are medical contraindications.

(c). The claimant fails to comply with the requirements of participation.

(d). The claimant's progress has reached a plateau prior to meeting goals.

(e). Services are discontinued by the referral source.

iii. When the claimant is discharged or discontinued for the work conditioning program, the work conditioning provider shall notify the C/SIE, and/or any referral source, and include the following information:

(a). reasons for program termination;

(b). clinical and functional status;

(c). recommendations regarding return to work;

(d). recommendations for follow-up services.

4. Work Hardening Guidelines

a. Client Eligibility

i. To be eligible for work hardening a claimant must:

(a). have a job goal for return to work at the time of discharge;

(b). have stated or demonstrated willingness to participate;

(c). have identified physical (systemic-neuro-muscular-skeletal), functional, behavioral and vocational deficits that interfere with work;

(d). be at the point of resolution of the initial or principal injury that participation in the work hardening program would not be prohibited.

ii. Work hardening may begin only after the completion of the work hardening assessment.

b. Provider Responsibility

i. The C/SIE should be notified prior to initiation of the program.

ii. The need for a program shall be based on the results from a work hardening assessment performed by all of the work hardening providers.

iii. The program components shall be provided by or under the direct supervision of the appropriate work hardening providers.

iv. The treating work hardening providers shall meet on a regular basis to discuss, coordinate and document program progress and outcome achievement.

v. The work hardening providers shall document all evaluations, services provided, claimant progress, and discharge plans. Information shall be available to the claimant, C/SIE, other professional providers, and any referral source.

vi. The work hardening providers shall develop and utilize an outcome assessment system designed to assess, at a minimum, patient care results, program effectiveness, and efficiency.

vii. The work hardening providers should be familiar with job expectations, work environments, and skills required of the claimant through means as site visitation, videotape, functional job descriptions, interview of claimant, or interview of employer.

viii. There should be an area that is designed, arranged and equipped for the specific purpose of providing work hardening programs.

c. Program Content:

i. development of program goals in relationship to specific job requirement or specific functional goals;

ii. techniques to develop strength, endurance, movement, flexibility, motor control and cardiopulmonary capacity related to the performance of work tasks;

iii. practice, modification, and instruction in simulated or real work activities;

iv. education related to safe job performance and injury prevention;

v. provision of behavioral and vocational services as determined by the respective work hardening provider;

vi. promotion of claimant responsibility and self-management;

vii. provision in multi-hour sessions with a minimum of four hours and up to eight hours, five days a week, for duration up to eight weeks;

viii. assist the claimant to obtain as appropriate:

(a). alcohol and other drug dependency counseling;

(b). engineering and ergonomic services;

(c). medical services;

(d). nutritional and weight control services;

(e). orthotic and prosthetic services;

(f). smoking cessation counseling.

d. Program Termination

i. The claimant shall be discharged from the work hardening program when the goals for the claimant have been met.

ii. Work hardening shall be discontinued when any of the following occur.

(a). The claimant has or develops problems which cannot be addressed within the program.

(b). There are medical contraindications.

(c). The claimant demonstrates a lack of willingness to participate.

(d). The claimant fails to comply with the requirements of participation.

(e). The claimant's progress has reached a plateau prior to meeting goals.

(f). Services are discontinued by the referring source.

iii. When the claimant is discharged or discontinued from the work hardening program, the work hardening provider(s) shall notify the C/SIE and/or any referral source, and include the following information:

(a). reasons for program termination;

(b). clinical and functional status;

(c). recommendations regarding return to work;

(d). recommendations for follow-up services.

e. Work Hardening/Work Conditioning Checklist

Work Hardening/Work Conditioning Checklist

This checklist is intended only to be used as an outline. Please refer to billing instructions in reference to Work Hardening/Work Conditioning Guidelines for details.

Checklist for Bill

Work Hardening

___ 1.	No additional modality charge should be added to a work hardening charge
___ 2.	Services rendered by a licensed Physical Therapist or Occupational Therapist
___ 3.	Maximum length of stay for work hardening is eight weeks
___ 4.	Program should be daily after first week of evaluation

Work Hardening/Work Conditioning Checklist

This checklist is intended only to be used as an outline. Please refer to billing instructions in reference to Work Hardening/Work Conditioning Guidelines for details.

Checklist for Bill

Work Hardening

___5. Claimant should not have frequent unexcused absences

___6. Preauthorization obtained

Work Conditioning

___1. No additional modality charge should be added to a work conditioning charge

___2. Services rendered by a licensed Physical Therapist or Occupational Therapist

___3. Maximum length of stay for work conditioning is six weeks

___4. Program should be three to five weeks

___5. Claimant should not have frequent unexcused absences

___6. Preauthorization obtained

Checklist for Medical Records

Work Hardening

___1. Thorough initial evaluation to include history, musculo-skeletal assessment, functional testing and job description or job evaluation

___2. Treatment plan

___3. Documentation of claimant staffings

___4. Claimant's progress documented in progress notes

___5. Discharge evaluation and discharge report

___6. Documentation of claimant education

___7. Documentation of work simulation tasks

___8. Documentation of therapeutic exercise task

___9. Documentation of aerobic conditioning tasks

___10. Documentation of four to eight hour daily program

Work Conditioning

___1. Thorough initial evaluation to include history, musculo-skeletal assessment, functional testing and job description or job evaluation

___2. Treatment plan

___3. Claimant's progress documented in progress notes

___4. Discharge evaluations and discharge reports

___5. Documentation of claimant education

___6. Documentation of work simulation tasks

~~**Checklist for Medical Records**~~

~~**Work Hardening**~~

~~___7.~~	~~Documentation of therapeutic exercise tasks~~
~~___8.~~	~~Documentation of aerobic conditioning tasks~~
~~___9.~~	~~Documentation of two to four hour daily program~~

~~AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.~~
~~HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Workforce Commission, Office of Workers' Compensation, LR 40:376 (February 2014).~~

§5127 Reporting Requirements

A. Data Reporting Requirements - As provided in R.S. 23:1034.2, OWCA may at any time request payors, administrators, and other entities with claims data to submit data to support workers' compensation fee schedule analysis, development, maintenance, and updates. Data submitters shall send data to OWCA's indicated vendor in the format based on the vendor's data specifications. The data parameters and formats will be defined by OWCA and provided in advance of the request for data.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.
HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Workforce Commission, Office of Workers' Compensation, LR 40:376 (February 2014). amended by the Workforce Commission, Office of Workers' Compensation Administration, LR

~~**§5129. Allergy and Clinical Immunology**~~

~~A. Procedure Codes 95004-95199 must be billed for allergy testing and allergy immunotherapy.~~
~~B. When billing for allergy tests, enter the appropriate CPT procedure code in Item 24-D of the HCFA-1500 Form.~~
~~1. Enter the total number of tests performed in Item 24-G.~~
~~2. Enter the total amount charged for the procedure code in Item 24-F.~~
~~3. Allergy skin testing is reimbursed on a per test basis.~~
~~C. When billing for test where antigens are specified in the descriptor, the appropriate procedure code must be entered in Item 24.~~
~~1. Enter the total number of antigens in Item 24-G.~~
~~2. Enter the provider's usual total charge in Item 24-F.~~
~~3. Reimbursement is based on a per antigen basis.~~
~~AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.~~
~~HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).~~

§5129 SPECIAL REIMBURSEMENT CONSIDERATION APPEAL

A. Form LWC-WC 3000

LOUISIANA WORKFORCE COMMISSION
OFFICE OF WORKERS' COMPENSATION ADMINISTRATION
POST OFFICE BOX 94040
BATON ROUGE, LA 70804-9094
(800) 201-2494/ (225) 342-7555

SPECIAL REIMBURSEMENT CONSIDERATION APPEAL

INSTRUCTIONS: Please provide the following information and return this form with the required medical records to the address shown below. It should be understood that an appeal is not a guarantee of additional reimbursement.

DATE	WORKERS' COMPENSATION CARRIER NAME AND ADDRESS

PROVIDER INFORMATION

PROVIDER NAME			
ADDRESS	CITY, STATE, ZIP		
CONTACT PERSON	TITLE	TELEPHONE	EXT
	EMAIL ADDRESS	FAX NUMBER	

PATIENT INFORMATION

PATIENT NAME	SOCIAL SECURITY NUMBER
EMPLOYER NAME AND ADDRESS	DATES OF SERVICE
PATIENT ADDRESS	CITY, STATE, ZIP
DIAGNOSIS AND SURGICAL PROCEDURES	
WAS ADMISSION PRE-CERTIFIED? ☐ YES ☐ NO	

MEDICAL INFORMATION

The following information must be submitted with an appeal for special reimbursement consideration:		
• Relevant medical records	• Cover letter identifying issue of dispute	• All Explanation of Benefits
• Itemization of charges	• Provider's written request for reconsideration	• All supporting information which could substantiate percentage of charge reimbursement

Do NOT send:	
• Consents	• Therapy notes
• PT Education documents	• Medication records

SEND THIS FORM TO:

Louisiana Workforce Commission
Office of Workers' Compensation Administration
Medical Services Section
Post Office Box 94040
Baton Rouge, LA 70804-9040

LWC-WC 3000 Revised 10/2021

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994), amended by the Workforce Commission, Office of Workers' Compensation Administration, LR

~~**§5131. Biofeedback**~~

~~A. Biofeedback training may be reimbursed when it is medically necessary. A written plan of care which includes objectives, the estimated length of treatment and stated goals must be submitted to the carrier/self-insured employer for approval prior to the services being provided.~~

~~B. The reimbursement of biofeedback is limited to providers currently licensed or certified to provide biofeedback services. Providers include:~~

~~1. physicians currently licensed in Louisiana who are certified by or meet certification requirements of the Biofeedback Certification Institute of America;~~

~~2. physical therapists and occupational therapists, licensed through the license laws of Louisiana, and biofeedback therapists, certified by the Biofeedback Certification Institute of America, who are employed by physicians. Billings for these biofeedback services provided by these therapists must be submitted by the employer (physician). The appropriate license or certification number must be placed in Item 24-K on the HCFA-1500 Billing Form to receive reimbursement for these procedures.~~

~~C. Biofeedback training procedures must be billed under the appropriate procedure codes listed in the CPT (90900-90915) or PT260, PT265 or OT260, OT265.~~

~~D. Reimbursement for biofeedback training is limited to 12 visits. One or more procedure may be provided during a visit if medically necessary and included in the approved plan of care.~~

~~AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.~~

~~HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).~~

~~**§5133. Injections**~~

~~A. Subcutaneous, Intramuscular and Intravenous~~

~~1. Procedure Codes 90700-90749 are reimbursed by report only. The report must include the name of the medication strength and volume injected.~~

~~2. When multiple drugs are administered from the same syringe, Modifier 51 must be added to the procedure codes for the second and subsequent drugs.~~

~~3. Reimbursement for multiple drugs administered from the same syringe must be at the provider's usual charge or the maximum reimbursement allowable, whichever is less for the first drug, and the provider's charge or 50 percent of the maximum reimbursement allowable, whichever is less for each additional drug.~~

~~4. Reimbursement for injections includes the cost of the drug, the charge for the administration of the drug and the cost of the supplies used to administer the drug.~~

~~5. Reimbursement for anesthetic agents, such as Xylocaine and Carbocaine, when used for infiltration, is included in the reimbursement for the basic procedure performed and must not be separately reimbursed.~~

~~B. Intra-Articular or Intrabursal Injections~~

~~1. CPT Procedure Codes 20550-20615 must be billed for intra-articular or intrabursal injections.~~

~~2. Reimbursement for these injection codes includes the supplies usually required to perform the procedure, but not the medications.~~

~~3. An invoice documenting the cost of the injectable medications must be submitted with the claim form since reimbursement is limited to the provider's charge or up to 20 percent above the actual cost to the provider, whichever is less.~~

~~AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.~~

~~HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).~~

~~**§5135. Evaluation and Management**~~

~~A. Examination, evaluations, treatments, conferences with or concerning patients, and similar medical services necessitate wide variations in the skill, effort, time, responsibility and medical knowledge required for the diagnosis and treatment of work-related illnesses and on the job injuries. The various types of physician visits have been categorized into different levels of service in the CPT.~~

~~B. Reimbursement may be made for only one visit per physician per patient per day at the highest level of care provided.~~

C. When billing for visit and consultations, providers must use the appropriate CPT procedure code that best describes the service rendered.
D. Consultation Services (Procedure Codes 99241-99275).
1. A consultation includes services rendered by a physician whose opinion or advice is requested by another physician or other appropriate source for the further evaluation and/or management of the patient.
a. A consultant may initiate diagnostic or therapeutic services at the request of the attending physician.
b. When the documentation supports a consultative service, reimbursement must be at the appropriate consultative level.
c. A copy of the consultation report must be submitted with the bill in order for reimbursement to be made.
d. The reimbursement for a consultation includes payment for the report. Separate reimbursement must not be made for the report.
e. When a physician performs consultative services and subsequently becomes the treating physician for either total or partial care, reimbursement for the consultative services should not be denied by the carrier. The subsequent services must be billed and reimbursed under the appropriate visit codes, not consultation codes.
E. Hospital Discharge Day Management (Procedure Code 99238). Reimbursement must not be made for this service in addition to another hospital visit billed by the same physician on the same day for the same patient.
AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.
HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).

§5137. Neurologic and Neuromuscular Services
A. General
1. Neurologic services are typically consultation services and any of the levels of consultation (Procedure Codes 99241-99263) may be appropriate. However, when one is the attending physician for or partial care, the appropriate evaluation and management level of service must be billed.
2. Diagnostic studies (nerve conduction tests, electromyograms, electroencephalograms, etc.) are reimbursable in addition to the office visit or consultative service.
3. Diagnostic study includes both a technical component (equipment, technical personnel, supplies, etc.) and a professional component (interpreting test results, written reports, etc.).
4. Billing of the five-digit CPT neurological and neuromuscular procedure codes indicate that the complete service (professional and technical components) is being billed. Reimbursement is the lesser of the provider's charge or the MRA for the procedure.
5. When the professional and technical components are performed by two different health care providers, the total reimbursement for both components must not exceed the listed MRA.
a. The physician bills for the test interpretation and written report by adding Modifier-26 to the five-digit procedure code. The reimbursement is the lesser of the provider's charge or the MRA listed for the five digit procedure code plus Modifier-26.
b. The health care provider who performs the technical component bills for the technical component by adding Modifier-90 to the five digit procedure code. The reimbursement for the technical component is the lesser if the provider's charge or the difference between the MRA for the total procedure and the MRA for the five-digit procedure code plus Modifier-90.
c. When a procedure coded does not list a separate amount for the professional component, reimbursement for the professional component must not exceed 85 percent of the total MRA. The reimbursement for the technical component must not exceed 15 percent of the total MRA.
6. When the diagnostic services are provided at a hospital or ambulatory surgical center, the hospital or ambulatory surgical center bills for the technical services and the physician bills for the professional component only, using Modifier-26.
B. Specific
1. Extremity Testing, Muscle Testing and Range of Motion (ROM) Measurements (Procedure Codes 95831-95852 and 97720-97752)
a. Visits/Consultations
i. When a visit/consultation is made for the purpose of an assessment and evaluation of the patient, the visit/consultation may be reimbursed at the appropriate level of service. Extremity, muscle and ROM tests and measurements performed during the visit must not be reimbursed as separate entities. As these tests are an integral part of the visit/consultation, reimbursement for these tests and measurements is included in the reimbursement for the visit/consultation.

ii. When an office visit/consultation is made solely for the purpose of performing tests and measurements, these testing procedures may be reimbursed as separate entities. Reimbursement must not be made for a visit in addition to the test.

b. When performed as separate procedures, muscle testing and range of motion measurements require objective measurements of the muscle and joint functions being tested. For reimbursement to be made, reports showing these measurements must accompany the billing of these codes.

c. Procedure Code 97752 must be used when testing is performed by means of mechanical equipment.

d. Reimbursement

i. Reimbursement for extremity testing, muscle testing and range of motion measurements may be made only one in a 30-day period for the same body area.

ii. When two or more procedures from 95831 through 95852 are performed for the same patient by the same physician on the same date of service, the total reimbursement allowance may not exceed the reimbursement for Procedure Code 95834 (total evaluation of body, including hands).

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).

§5139. Psychiatry

A. General

1. Psychiatric evaluations may be provided as independent medical examinations (IMEs) when requested by the carrier/self-insured employer.

2. Psychiatric evaluations may be provided as consultations when requested by a physician and when authorized by the carrier/self-insured employer.

3. Upon authorization by the carrier/self-insured employer psychiatric treatment may be provided when documentation submitted by the physician to the carrier/self-insured employer substantiates the medical necessity of the treatment and includes the estimated length of treatment.

4. Reimbursement for a routine medical visit rendered by the same physician on the same day as psychiatric therapy is included in the reimbursement for the more comprehensive service.

5. Hypnosis may be reimbursed when it is an integral part of a plan for the treatment of post-traumatic stress disorders arising from on-the-job injuries.

B. Reimbursement

1. Psychiatric Diagnostic Interview (Procedure Code 90801). Reimbursement for this service includes history and mental status determination, development of a treatment plan when treatment is necessary, and the preparation of a written report.

2. Psychological Testing (Procedure Codes 90830, 95880, 95881, 95882)

a. Reimbursement for these procedures includes the administration of the test, scoring interpretation of results and preparation of a written report.

b. In order for appropriate reimbursement to be made, each test must be specifically identified on the HCFA 1500 Form by the appropriate procedure code.

c. The total charge for the test must be entered in Item 24-F on the HCFA 1500 Form.

d. A single unit of service must be entered in Item 24-G for each test.

3. Medical Psychotherapy (Procedure Codes 90841-90853)

a. Individual psychotherapy must be billed under the procedure code most closely approximating the length of the session.

b. Group psychotherapy generally requires 75 to 90 minutes per session. When a psychiatric treatment program includes group sessions routinely scheduled for more or less time than this, appropriate modifiers should be used.

4. Psychiatric services may be reimbursed when billed by Louisiana licensed physicians who are certified by, or who have satisfactorily completed the specialized training requirements of, the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry. These physicians must either perform the service directly or provide direct supervision of qualified mental health professionals performing the service as required under the applicable Louisiana statutes.

5. Psychiatric diagnostic, evaluative and therapeutic procedures must be billed under appropriate CPT procedure codes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).

§5141. Soft Tissue Injury Care

A. Initial Visits

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

2. When a cast or strapping is applied during initial visit, supplies and materials used such as stockinette, plaster, fiberglass, ace bandages, etc., may be itemized and billed separately using Procedure Code 99070.

3. Replacement casting and strapping codes (29000-29799) must not be used for initial care.

B. Follow-Up Visits

1. Replacement casts or strapping, provided during follow-up visits, must be billed under the appropriate replacement Procedure Codes (29000-29799).

2. The reimbursement for replacement casts or strapping includes reimbursement for the service, supplies and materials usually required and the removal of casts, splints or strapping.

3. Special supplies, such as fiberglass casting materials, may be billed under Procedure Code 99070 and reimbursed separately.

4. Follow-up visit charges may be reimbursed in addition to replacement casting and strapping procedures only when significant, identifiable, further medical services are provided. The HCFA-1500 Form should indicate an additional diagnosis, when appropriate, and office notes should substantiate the medical necessity of the visit.

5. When replacement and strapping procedures are not performed during follow-up visits, the services should be billed under the appropriate established patient visit code in the evaluation and management section.

6. When an initial casting and strapping is applied for the first time during a follow-up visit, reimbursement may be made for the supplies and materials itemized under Procedure Code 99070 in addition to the appropriate established patient follow-up visit level.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).

§5143. Thermography

A. General Information

1. When medically necessary, thermographic testing may be used as an assistive device in the diagnosis of many different conditions.

2. When a request for authorization for thermography is received, carriers must ensure that a specially trained, qualified physician is to perform the test and that written documentation of medical necessity is obtained, when necessary, to substantiate the service.

3. As with all diagnostic tests, thermography should be ordered with discretion by the attending physician and authorized with discretion by the carrier.

B. Authorization

1. Prior to performing a thermographic test, thermography test, a physician must request authorization from the carrier.

2. Upon request, a physician must submit to the carrier written documentation of medical necessity for the thermographic testing.

3. Upon request by the carrier, a physician must submit documentation of certification or credentials supporting his/her qualifications for the provision of thermography.

4. Thermographic tests must not be authorized unless the date of service is at least 45 days after the date of accident unless it is medically necessary to provide the service at an earlier date and documentation of medical necessity is submitted to the carrier.

C. Body Areas

1. Major Body Areas (The following areas include all views):

a. head;

b. cervical spine and upper extremities;

c. lumbosacral spine and lower extremities.

2. Limited Body Areas (The following areas include all views):

a. thoracic spine;

b. any portion of a major area.

D. Billing

1. When performed to the entire head, Procedure Code 93760 must be used.

2. When performed to a portion of the head, e.g., temporomandibular joint, Modifier 52 must be added to 93760 to indicate a limited area. The exact site must be specified in Item 24-D on the HCFA-1500 Form.

3. When performed to a body area other than the head, Procedure Code 93762 must be used.

4. When performed to either the thoracic area or a portion of a major area, e.g., wrist or foot, Modifier 52 must be added to 93762 to indicate a limited area. The exact site must be specified in Item 24-D on the HCFA-1500 Form.

E. Reimbursement

1. Reimbursement is limited to one body area either major or limited, unless an additional area(s) is medically necessary and documentation of medical necessity is submitted to the carrier.

2. Reimbursement for thermography to a major body area must be at the provider's usual charge or the MRA, whichever is less.

3. Reimbursement for thermography to a limited body area must be at the provider's usual charge or 50 percent of the MRA, whichever is less.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).

§5145. Carrier Responsibilities for Reimbursement Determinations

A. Medical Consultant. Carriers must utilize the expertise of physicians or other health care professionals in making determinations pertaining to acceptable, safe medical care and treatment and appropriate reimbursement for services rendered. The consultants should have expertise in the areas for which medical or other treatment determinations are made.

B. Carriers must not change, alter, delete or obscure procedure codes.

1. When a carrier questions a procedure code reported by a provider, the carrier must contact the provider for clarification prior to reimbursing a claim. This may result in the carrier requesting additional documentation or a copy of the office or progress note to substantiate the service in question from the provider.

2. If after contacting the provider a carrier determines that available provider documentation does not support the level of service billed the carrier may reimburse the provider at the appropriate level but must ensure that an explanation of medical benefits specifically denotes the action taken and explains the reimbursement made for the service in question.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).

§5147. Explanation of Medical Benefits (EOMB)

A. Carriers must provide an explanation of medical benefits (EOMB) to health care providers whenever the carrier's reimbursement differs from the amount billed by the provider. The EOMB must be provided with the reimbursement check.

1. A carrier must use the listed EOMB codes and descriptors to explain why a provider's charge has been reduced or disallowed.

2. A carrier may develop additional EOMB codes, if necessary, to explain the adjustment of a claim, but must furnish to the provider a written explanation of each EOMB code used.

3. The EOMB must contain appropriate identifying information so the provider can relate a specific reimbursement to the applicable claimant, the procedure billed and the date of service.

B. Acceptable EOMBs may include:

1. copies of the bill on which reimbursements and EOMB codes are listed;

2. manually produced or computerized forms which contain the EOMB codes, written explanations and the appropriate identifying information.

C. The following EOMB codes must be used by the carrier to explain to the provider why a procedure or service is not reimbursed as billed.

001	These services are not reimbursable under the Workers' Compensation Program.
002	Charges exceed maximum allowance.

003	Charge is included in the basic surgical allowance.
004	Surgical assistant is not routinely allowed for this procedure. Documentation of medical necessity required.
005	This procedure is included in the basic allowance of another procedure.
006	This procedure is not appropriate to the diagnosis.
007	This procedure is not within the scope of the license of the billing provider.
008	Equipment of services are not prescribed by a physician.
009	Exceeds reimbursement limitations.
010	This service is not reimbursable unless billed by a physician.
011	Incorrect billing form.
012	Incorrect or incomplete license number of billing provider.
013	Medical report required for payment.
014	Documentation does not justify level of service billed.
015	Place of service is inconsistent with procedure billed.
016	Invalid procedure code.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.
HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).

§5149. Reconsideration of Disputed Reimbursements

A. When, after examination of the EOMB, a health care provider is dissatisfied with a carrier's payment of a bill for medical services, a reconsideration may be requested by the provider.

1. A provider must make a written request for reconsideration within 60 days from receipt of the EOMB, accompanied by a copy of the bill in question, the carrier's EOMB and any supporting documentation to substantiate the medical necessity of the service and the diagnosis provided.

2. The carrier must process a reconsideration within 60 days of receipt.

a. The carrier must review and re-evaluate the original bill and accompanying documentation using its own medical consultant if necessary.

b. The carrier must notify the provider within 60 days of the results of the reconsideration, explain the reason(s) for their decision and cite the specific policy upon which their final adjustment was made.

B. The provider may request the Office of Workers' Compensation Administration, Medical Services Section, to resolve the dispute if the result of the carrier's reconsideration remains unsatisfactory.

C. The Office of Workers' Compensation Administration's Medical Services Section will resolve disputes between a provider and carrier which involve the interpretation of the reimbursement policies and allowable reimbursement contained in the applicable reimbursement manual.

1. A written request for the resolution of a disputed reimbursement claim must be submitted to the Office of Workers' Compensation Administration within 60 days of the carrier's reconsideration or 90 days from the provider's requested date when no response is received.

2. Valid request for reconsideration must include copies of the following:

a. copies of the original and resubmitted bills;

b. EOMBs including the specific reimbursement;

c. supporting documentation and correspondence;

d. specific information regarding contact with the carrier.

3. The dispute will be reviewed by the Office of Workers' Compensation Administration, Medical Services Section, and both parties, the provider and the carrier, will be notified of the decision within 60 days after receipt of a valid request.

4. Request for resolving disputes may be sent to:

Office of Workers' Compensation
Medical Services Section
Attn: Medical Services Manager
Box 94040
Baton Rouge, LA 70804-9040

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).

§5151. Out-of-State, On-the-Job Injuries or Work-Related Illness Treated in Louisiana

A. A patient may receive medical services in Louisiana for injuries incurred in an out-of-state accident.

1. If the patient is receiving treatment under the Workers' Compensation Law of another state, this manual may not apply.

2. If the patient is receiving care and treatment in Louisiana pursuant to the Louisiana Act, the reimbursement is subject to the requirements and amount of this manual regardless of the site of injury.

B. Providers may contact carriers to determine whether or not claimant benefits are provided pursuant to Louisiana law or the law of another state or under the jurisdiction of other Workers' Compensation Laws.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1203 and 1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).

§5153. In State Medical Treatment

A.1. Each employer shall furnish all necessary drugs, supplies, hospital care and services, medical and surgical treatment, and any nonmedical treatment recognized by the laws of this state as legal. All such care, services, and treatment shall be performed at facilities within the state when available.

2. When billing for out of state services, supporting documentation is necessary to show that the service being provided cannot be performed within the state, or it is closer to patient's domicile to have services performed out of state.

B. The reimbursement allowances of this manual are not applicable to medical services rendered outside the state of Louisiana even though the services are provided under the Louisiana Workers' Compensation Statutes.

C. Health Care providers are required to report treatment to the carrier/self insured employer on the:

1. HCFA 1500 Form;

2. UB 92; or

3. ADA - Dental Claim Form.

D. Reimbursement for out of state services shall be based on one of the following:

1. the workers' compensation reimbursement schedule for the state in which services are rendered; or

2. the usual and customary fee for the geographic area in which the services are rendered.

AUTHORITY NOTE: Promulgated in accordance with R.S. 23.1203 and 1034.2.

HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).

Editor's Note: In addition, the following Sections of this Chapter are applicable and shall be used for the other Chapters in this Part governing reimbursement. These specific Chapters are: Chapter 31, Vision Care Services; Chapter 33, Hearing Aid Equipment and Services; Chapter 35, Nursing Attendant Care and Home Health Services; Chapter 39, Medical Transportation; Chapter 41, Durable Medical Equipment and Supplies; Chapter 43, Prosthetic and Orthopedic Equipment; Chapter 45, Respiratory Services; Chapter 47, Miscellaneous Claimant Expenses; and Chapter 49, Vocational Rehabilitation Consultant; and Chapter 51, Medical Reimbursement Schedule.

§5155. Maintenance of Schedule

A. Maintenance of the schedules requires that a database of applicable charges be accumulated by the carrier/self insured employer. This database will be utilized to profile the charges by each appropriate code.

B. Information Required. In order to update the schedule, each carrier/self insured employer shall submit the following information for claims incurred in the preceding period. This information shall be submitted to the OWCA upon request. Failure to do so may subject the payor to penalties. The information required for calculation of the reimbursement schedule will include:

Field Name	Length	Type
CPT/HCPCS	5	Alpha/Numeric
Modifier	2	Alpha/Numeric
Unit/Days	3	Numeric
Amount Charged	10	Numeric
Amount Paid	10	Numeric

~~C. Communication Format. The above information shall be submitted in the following format.~~

~~1. Magnetic tape:~~

~~a. tape 9 tract, 8.5 inch to 10.5 inch reels with silver mylar reflector (standard reels) with write ring removed;~~

~~b. recording density—1600 or 6250 bytes per inch;~~

~~c. recording code—Extended Binary Coded Decimal Interchange Code (EBCDIC);~~

~~d. header record must identify submitter and position of each field in the record;~~

~~e. tape must have a leading tape mark and an end of file mark;~~

~~f. the external label must identify the submitter, the date submitted, the tape number with identification of the total number of tapes submitted and a descriptive narrative of the information contained within the records.~~

~~D. Diskettes~~

~~1. A 5.25 inch diskette (floppy disk) that is IBM PC-DOS compatible with the following attributes:~~

~~a. double sided;~~

~~b. double density;~~

~~c. soft sectored;~~

~~d. 9 sectors per track; and~~

~~e. 40 tracks per diskette.~~

~~2. A 3.5 inch, 720K diskette, that is IBM PC-DOS compatible with the following attributes:~~

~~a. double sided;~~

~~b. double density.~~

~~3. The external label must identify the submitter, the date submitted, the diskette number with identification of the number of total number of diskettes submitted and the descriptive narrative of the information contained within the records.~~

~~AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.~~

~~HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:212 (February 1993), amended LR 20:1299 (November 1994).~~

§5157 Maximum Reimbursement Allowances

Editor's Note: December 2021- Table 1 removed columns for Modifiers and Global days as well as removing the redundant "+TM" verbiage on each row.

A. Table 1 Anesthesia Base Units Table

Maximum Fee Allowance Schedule Office of Workers' Compensation				
CPT Code	**~~Mod~~**	**Description**	**~~Global Days~~**	**~~Maximum Allowance~~ Base Units**
***		***		***
00142		Lens surgery		4 ~~6 + TM~~
***		***		***
00147		Iridectomy		4 ~~6 + TM~~
***		***		***
~~00452~~		~~Clavicle and scapula; radical surgery~~		~~6 + TM~~
***		***		***
00540		Thoracotomy procedures; nos		12 ~~13 + TM~~
***		***		***
00548		Repair trauma trachea/bronchi		17 ~~15 + TM~~
***		***		***
00561		Anesth, heart surg <1 yr		25 ~~+ TM~~
***		***		***
~~00622~~		~~Thoracolumbar sympathectomy~~		~~13 + TM~~
***		***		***
~~00634~~		~~Chemonucleolysis~~		~~10 + TM~~
***		***		***
00700		Upper anterior abdominal wall nos		4 ~~3 + TM~~
***		***		***
00731		Upper GI endoscopic procedures		5
00732		Upper GI ERCP		6
~~00740~~		~~Upper gi endoscopic procedures~~		~~5 + TM~~
***		***		***
00800		Lower anterior abdominal wall; nos		4 ~~3 + TM~~

Maximum Fee Allowance Schedule Office of Workers' Compensation				
CPT Code	~~Mod~~	Description	~~Global Days~~	~~Maximum Allowance~~ Base Units
***		***		***
~~00810~~		~~Intestinal endoscopic procedures~~		~~5 + TM~~
00811		Anes lwr intst ndsc nos		4
00812		Anes lwr intst scr colsc		3
00813		Anes upr lwr gi ndsc px		5
***		***		***
00902		Anorectal procedure		5 ~~4 + TM~~
***		***		***
01150		Rad proc tumor pelvis,		10 ~~8 + TM~~
***		***		***
~~01180~~		~~Obturator neurectomy; extrapelvic~~		~~3 + TM~~
~~01190~~		~~Intrapelvic~~		~~4 + TM~~
***		***		***
01440		Arteries knee and popliteal area nos		~~8~~ 5 ~~+ TM~~
***		***		***
~~01682~~		~~Shoulder spica~~		~~4 + TM~~
***		***		***
~~01964~~		~~Anesth, abortion pro~~		~~4 + TM~~
***		***		***
01996		~~Daily mgmt epidur/subarach~~ Hosp manage cont drug admin		~~$~~3
***		***		***

B. Table 2 Professional Services Rate Table

[Insert chart from file 2]

C. Table 3

Code	Mod	Description	Global Days	Maximum Allowance	Non-Facility Maximum	Facility Maximum
***		***		***		
G0480		Drug test def 1-7 classes	XXX	$171		
G0481		Drug test def 8-14 classes	XXX	$236		
G0482		Drug test def 15-21 classes	XXX	$299		
G0483		Drug test def 22+ classes	XXX	$371		
***		***		***		

AUTHORITY NOTE: Promulgated in accordance with R.S. 23:1034.2.
HISTORICAL NOTE: Promulgated by the Department of Labor, Office of Workers' Compensation, LR 19:54 (January 1993), repromulgated LR 19:21 2 (February 1993), amended LR 20:1299 (November 1994), LR 27:314 (March 2001), amended by the Workforce Commission, Office of Workers' Compensation, LR 39:1854 (July 2013), LR 40 379 (February 2014), amended by the Workforce Commission, Office of Workers' Compensation Administration LR 42:1696 (October 2016), LR 46:1401 (October 2020), amended by the Workforce Commission, Office of Workers' Compensation Administration LR

Family Impact Statement

This amendment to Title 40 should have no impact on families.

Poverty Impact Statement

This amendment to Title 40 should have no impact on poverty or family income.

Provider Impact Statement

1. This Rule should have no impact on the staffing level of the Office of Workers' Compensation as adequate staff already exists to handle the procedural changes.

2. This Rule should create no additional cost to providers or payers.

3. This Rule should have no impact on ability of the provider to provide the same level of service that it currently provides.

Small Business Statement

This amendment to Title 40 should have no direct impact on small or local businesses.

Public Comments

All interested persons are invited to submit written comments or hearing request on the proposed Rule. Such comments or request should be sent to Sheral Kellar, OWC-Administration, 1001 North 23rd Street, Baton Rouge, LA 70802. Such comments should be received by 5:00 pm on January 10, 2022.

Ava Cates
Secretary

Name of Person Responsible and Title

Sheral Kellar
Assistant Secretary
Office of Workers' Compensation
P.O. Box 94040
Baton Rouge, LA 70804-9040
Telephone: (225) 342-7555
Fax: (225) 342-5665
OWCA@lwc.la.gov