Summary of Revisions to the Workers' Compensation Schedule of Medical and Hospital Fees

December 22, 2011

Following is a summary of changes to the Workers' Compensation Court's January 1, 2010 Schedule of Medical and Hospital Fees. The changes are made pursuant to 85 O.S., §327.

Changes to the fee schedule include dollar value changes to the maximum allowable reimbursement (MAR) amount, anesthesia and follow-up changes in the surgery section; changes to the MS-DRG weights in the inpatient hospital section; and new sections on dental services, ambulance services and inpatient rehabilitation facility services.

Additional changes are described below.

I. Codes Added:

11045	24073	31627	37232	49411	65778	84145	90470	93460
11046	24079	31634	37233	49412	65779	84431	90644	93461
11047	25071	32552	37234	49418	66174	85598	90664	93462
14301	25073	32553	37235	51727	66175	86305	90666	93463
14302	25078	32561	37761	51728	74176	86352	90667	93464
21011	26111	32562	38900	51729	74177	86481	90668	93563
21012	26113	33620	43281	53855	74178	86780	90670	93564
21013	26118	33621	43282	53860	74261	86825	90867	93565
21014	27043	33622	43283	57156	74262	86826	90868	93566
21016	27045	33782	43327	57426	74263	86902	91013	93567
21552	27059	33783	43328	61781	75565	87150	91117	93568
21554	27337	33981	43332	61782	75571	87153	92132	93750
21558	27339	33982	43333	61783	75572	87493	92133	94011
21931	27364	33983	43334	63661	75573	87501	92134	94012
21932	27616	36147	43335	63662	75574	87502	92227	94013
21933	27632	36148	43336	63663	75791	87503	92228	95800
21936	27634	37220	43337	63664	76881	87906	92540	95801
22551	28039	37221	43338	64490	76882	88120	92550	95905
22552	28041	37222	43753	64491	77338	88121	92570	96446
22901	28047	37223	43754	64492	78451	88177	93451	99224
22902	29581	37224	43755	64493	78452	88363	93452	99225
22903	29914	37225	43756	64494	78453	88387	93453	99226
22904	29915	37226	43757	64495	78454	88388	93454	
22905	29916	37227	43775	64566	80104	88738	93455	
23071	31295	37228	45171	64568	82930	88749	93456	
23073	31296	37229	45172	64569	83861	89398	93457	
23078	31297	37230	46707	64570	83987	90460	93458	
24071	31626	37231	49327	64611	84112	90461	93459	

II. Codes Deleted:

01632	35459	36145	51795	75995	89100	91011	93237	93544
11040	35470	36834	61795	75996	89105	91012	93501	93545
11041	35473	39502	63660	76150	89130	91052	93508	93555
14300	35474	39520	64470	76350	89132	91055	93510	93556
20000	35480	39530	64472	76880	89135	91105	93511	96445
23221	35481	39531	64475	78460	89136	91123	93514	99185
23222	35482	43324	64476	78461	89140	92135	93524	99186
24151	35483	43326	64573	78464	89141	92569	93526	
24153	35484	43600	75558	78465	89225	93012	93527	
26255	35485	45170	75560	78478	89235	93014	93528	
26261	35490	46210	75562	78480	90379	93230	93529	
27079	35491	46211	75564	82307	90465	93231	93539	
29220	35492	46937	75790	82926	90466	93232	93540	
33861	35493	46938	75992	82928	90467	93233	93541	
35454	35494	49420	75993	86781	90468	93235	93542	
35456	35495	51772	75994	86903	91000	93236	93543	

III. MS-DRG Code Changes: Deletes **MS-DRG 009**. Adds **MS-DRG 014, MS-DRG 016, MS-DRG 017, MS-DRG 570, MS-DRG 571** and **MS-DRG 572**, and their associated description and weight, as reflected in the Centers for Medicare and Medicaid Services (CMS) FY12 MS-DRG coding and weights.

IV. Forward and Introduction: Provides that the schedule applies to healthcare services rendered after December 31, 2011, regardless of the date of injury. Updates the version and copyright date of CPT® and MS-DRG codes used in the schedule. Expands the fee schedule to include new sections on dental services, ambulance services and inpatient rehabilitation facility services. Specifies primary coding systems.

V. General Ground Rules: Conforms rules on reproduction of medical records, medical testimony, case management and treatment guidelines to statute. Excludes taxes as reimbursable costs for medical record copies. Amends rules on report preparation and reimbursement. Updates code values in a ground rule. Updates procedures for resolving disputed medical charges. Limits markups on implantable devices bought and sold by an entity to a hospital, ambulatory surgical center or physician. Provides rules on reimbursement for physician assistants and registered nurse first assistants. Establishes a no-show fee. Provides rules on disclosures required by law.

VI. Evaluation and Management: Updates the version and copyright date of CPT® codes used in the schedule. Adds a new code. Codes are valued as provided by law to a minimum of 150% of 2011 OK Medicare.

VII. Anesthesia: Deletes an old code.

XIII. Surgery: Adds new and deletes old codes. Strikes all ampersand ("&") procedures (i.e certain previous add-on codes). Updates "#" procedure designations, and anesthesia and follow-up day columns. Deletes the minimum assistant surgeon rule for reimbursement of physician assistants and registered nurse first assistants assisting in surgery from this section since moved and expanded in General Ground Rule 13.

IX. Radiology: Adds new and deletes old codes. Codes are valued by law at the lesser of 207% of 2011 OK Medicare or the 2010 OK FS level. Disallows reimbursement for an MRI unless the MRI unit produces a field strength of at least 1.0 Tesla, except if preauthorized or medically justified.

X. Pathology: Adds new and deletes old codes.

XI. Medicine: Adds new and deletes old codes. Updates administration codes for immune globulin and vaccines/toxoids per CPT®. Provides reimbursement for psychological services rendered by non-physician providers.

XII. Physical Medicine: Clarifies that treatment guidelines control if they conflict with the ground rules.

XIII. Dental Services: Provides for reimbursement of dental services.

XIV. Durable Medical Equipment, Supplies, Orthotics and Prostheses: Clarifies coding, billing and reimbursement rules. Caps reimbursement for DME, supplies, orthotics and prostheses. Defines "acquisition costs." Updates information about access to the CMS DMEPOS fee schedule. Excludes DME and supplies provided in an inpatient rehabilitation facility setting from covered services. Requires entities providing DME, supplies, orthotics or prostheses to be accredited by a Medicare approved accreditation organization, unless exempted from accreditation by CMS.

XV. Ambulance Services: Provides reimbursement rules for ground and air ambulance services.

XVI. Pharmaceutical Services: Defines "average wholesale price", "original labeler's National Drug Code", and "therapeutically equivalent drug". Caps reimbursement for repackaged medications dispensed by a pharmacy or provider, compound medications, and provider dispensed medication other than repackaged medication. Clarifies billing requirements. Authorizes reimbursement by a payer to an injured worker for certain medication expenses.

XVII. Ambulatory Surgical Center Services: Modifies the maximum allowable reimbursement formula for implantables. Requires a portion of the monetary value of adjustments to the implantable price be paid to the payer under certain circumstances.

XVIII. Inpatient Hospital: Adopts the FY12 Medicare MS-DRG coding and weights. Modifies the base rate. Modifies the maximum allowable reimbursement formula for implantables. Requires a portion of the monetary value of adjustments to the implantable price be paid to the payer under certain circumstances. Modifies the stop-loss reimbursement method. Defines "catastrophic injuries" for purposes of stop-loss.

XIX. Inpatient Rehabilitation Facility: Caps reimbursement for inpatient rehabilitation facility services using Medicare Case-Mix Groups (CMG) codes and various formulas. Adopts the October 1, 2011 Medicare CMG codes, descriptions, tier and average length of stay values.