Medical Fee Service eNews

2nd Quarter 2021

Virginia Workers' Compensation Commission
Office of Medical Fee Services

R. Ferrell Newman, Chairman
Wesley G. Marshall, Commissioner
Robert A. Rapaport, Commissioner
Evelyn V. McGill, Executive Director

Dr. Drema M. Thompson
MFS Manager

Email | p. 877-664-2566

From the MFS Desk

Provider and Payers: Your Concerns/Our Answers

1. American Medical Association Evaluation and Management Guidelines

Concern: Will the Virginia Workers' Compensation Commission elect to utilize the new American Medical Association 2021 Evaluation and Management Guidelines to select the appropriate Evaluation and Management CPT code billing selection? If so, when will this be effective?

- **Answer:** Virginia statute does not include treatment guidelines. The statute does define medical and surgical identifying codes using the Physicians' Current Procedural Terminology published by the American Medical Association. The Virginia statute required an initial review of the schedules following the implementation, and subsequent biennial reviews thereafter. The effective date of the next schedule will be 01/01/2022.

2. Codes not listed in the MFS

Concern: My code is not a new type of procedure or new type of technology and it is not listed in the fee schedule. Is it expected to follow the "BR" rule or just not reimbursable at all?

- **Answer:** The amount billed for a procedure for which the MFS does not provide a maximum fee shall be justified by a written report or BR. The health care provider may not charge a fee for the written report or BR. The employer's maximum liability shall not exceed 80 percent of the provider's charge for the service, based on the provider's billed charges. The absence of any particular code from the medical fee schedule does not mean that the medical services corresponding to that code are services outside of the scope of coverage provided by the Virginia Workers' Compensation Act.

3. Reimbursement of out-of-state providers

Concern: Our facility is a free-standing ambulatory surgery center located in Maryland, and we have an upcoming case with an injury that occurred in Virginia. How are out-of-state providers reimbursed?

- **Answer:** The applicable community for providers of medical services rendered outside of the Commonwealth shall be determined by the zip code of the principal place of business of the employer if located in the Commonwealth or, if no such location exists, the zip code of the location where the Commission hearing regarding a dispute concerning the services would be conducted.

4. Regulations for overpayment of a workers' compensation claim

Concern: What regulations are out there for workers' compensation when an overpayment is made to a Facility?

- **Answer:** Health care services for which voluntary payments in excess of the reimbursement levels of the MFS are made by a self-insured employer or an insurance carrier; are excluded from the MFS. The Commission does have jurisdiction over any disputes for recoveries.

Regulatory Focus

§ 65.2-605 (E) The maximum pecuniary liability of the employer for a fee scheduled medical service that is not included in a Virginia fee schedule when it is provided shall be determined by the Commission. The Commission's determination of the employer's maximum pecuniary liability for such fee scheduled medical service shall be effective until the Commission sets a maximum fee for the fee scheduled medical service and incorporates such maximum fee into an adjusted Virginia fee schedule adopted pursuant to subsection D. If the fee scheduled medical service is not included in a Virginia fee schedule, because it is:

1. A new type of technology, the employer's maximum pecuniary liability shall not exceed 130 percent of the provider's invoiced cost for such device, as evidenced by a copy of the invoice. If the new type of technology has not been cleared or approved by the FDA prior to such date, then the provider shall not be entitled to payment or reimbursement therefor unless the employer or its insurer agree; or

2. A new type of procedure that has not been assigned a billing code, the employer's maximum pecuniary liability shall not exceed 80 percent of the provider's charge for the service based on the provider's charge master or schedule of fees, provided the employer and the provider mutually agree to the provision of such procedure.

Did You Know?

- The MFS Biennial Review Timeline has been posted on the Commission's website.
- A summary of MFS changes is located on the Commission's website. Some general updates include:
  - Update for Medical Inflation
  - Removal of CPT/HCPCS Codes Retired
  - Addition of New Codes
  - Addition of New Crosswalked Codes

MFS Educating the Public

Dr. Drema Thompson, MFS Manager, will be presenting at the Virginia Association of Defense Attorneys virtual 2021 Spring Meeting on May 7, 2021.

The Commission's regulations for current schedules are effective on January 1st of the biennial review year. Prior MFS are applicable for medical treatment that occurs before the biennial review effective year.

MFS Ground Rules is intended to provide general information and instructions on how to interpret the MFS.

For inquiries related to the Medical Fee Schedule, Ground Rules, or Biennial Review, you may contact us by email.