Medical Fee Service eNews

4th Quarter 2021

Virginia Workers' Compensation Commission
Office of Medical Fee Services

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From the MFS Desk

Provider and Payers: Your Concerns/Our Answers

Q. Is there any payment method to account for codes, not in the fee schedule that has been recently added to CPT, for example, Covid Vaccine 0001A or Covid Diagnostic Test 'U0001' or any other COVID related treatments?

Answer: An employer's maximum pecuniary liability for a new type of procedure that has not been assigned a maximum fee on the MFS 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.

Q. Does the MFS include private payer codes?

Answer: HCPCS codes beginning with the letter "S" are private payer codes that represent a wide variety of items and services, and they are used in cases where existing CPT and HCPCS codes are deemed inadequate to describe an item or services. The CPT codes listed in Table AE represent payer codes that are subject to the MFS. The maximum fee for these codes shall be established as either a fixed amount per service or a fixed amount per unit. For those services with a maximum fee established as a fixed amount per unit, the applicable measure of units that shall be reported and upon which reimbursement shall be based are the units referenced in the description of each code. The maximum fees for these services for each region are also listed in Table AE of the MFS.

Q. Does Virginia have a specific form that EORs must be printed? If not, does the state require certain information to be on the EOR? Are there any disclaimers required on the EOR to providers?

Answer: VA code section: 65.2-605.1 provides some direction regarding the content for the notification of payment for health care services that the employer does not contest, notification of contested, denied, or considered incomplete itemizations of health care services.

Regulatory Focus

65.2-605(D) The Commission shall review Virginia fee schedules during the year that follows the transition date and biennially thereafter and, if necessary, adjust the Virginia fee schedules in order to address (i) inflation or deflation as reflected in the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) for the South as published by the Bureau of Labor Statistics of the U.S. Department of Labor; (ii)access to fee scheduled medical services; (iii) errors in calculations made in preparing the Virginia fee schedules; and (iv) incentives for providers.

Did You Know?

- Applicable coding conventions for “BR” codes Vs. Unlisted Services and Procedures codes:
  - "BY REPORT (BR)" means a service or procedure requiring additional justification in the form of a report that contains sufficient supportive information to permit proper identification. Pertinent information should be furnished concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary to provide the service, etc. and;
  - "UNLISTED SERVICES OR PROCEDURES" means services and procedures too unusual or variable in the nature of their performance, too new, or too infrequently performed to permit the assignment of a maximum fee. Unlisted services and procedures are typically billed with CPT or HCPCS codes ending in ’99’ and are identified as those with ‘BR’ listed as the maximum fee in the MFS.
- Implantable Medical Devices have multiple applications, as referenced in the Ground Rules Document:
  - The maximum fee for a new type of technology, including an implantable medical device or item of medical equipment, that is supplied by a third party shall not exceed 130 percent of the provider's invoiced cost for such device, as evidenced by a copy of the invoice. The “invoice” means the document from the manufacturer or purchase order that itemizes the implant(s) and the “provider’s invoiced cost” means a value equal to the actual manufacturer’s wholesale or purchase invoice cost at the time of billing, inclusive of applicable sales tax, shipping, and handling fees, and;
  - To be eligible for reimbursement, implantable devices and injectable drugs must be billed with the appropriate CPT/HCPCS code in addition to the appropriate Revenue Code. For implantable devices that do not yet have a code assigned, use HCPCS code L8699. When services for implantable medical devices are subject to a maximum fee established as a percentage of billed charges, no documents relating to the cost of the device, such as the invoice from the device manufacturer, shall be required.

MFS Educating the Public

- The approved 2022 Medical Fee Schedule Update has been uploaded to the Commission’s website and a summary of all applicable changes.
- The Virginia Workers’ Compensation Commission engaged Oliver Wyman Actuarial Consulting, Inc. to assist the Commission in the development of a set of medical fee schedules as outlined in Title 65.2, Section 605 of the Code of Virginia. More information on the methodology of the creation and application of the MFS can be located on the Medical Fee Schedule Overview and Methodology page on the Commission’s website.

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