Fee Schedule FAQs – Connecticut Workers' Compensation

REV 8.18.2022

TABLE OF CONTENTS

What is the most recent effective date?

The Connecticut Workers' Compensation Commission has revised the Fee Schedule as follows:

Fee Schedule	Effective
Official Connecticut Practitioner Fee Schedule	07/15/2022
Outpatient Hospital & ASC	04/01/2022
Inpatient Hospital	04/01/2022
Ambulance	01/01/2022

What is the fee schedule based on?

The practitioner fee schedule incorporates the following:

- Current Procedural Terminology (CPT)
- American Society of Anesthesiologists (ASA) Relative Value Guide
- HCPCS Level II
- International Classification of Diseases, Tenth Revision (ICD-10-CM)

The Hospital and ASC fee schedule are based on the CMS DRG and APC methodologies.

Where can the fee schedule rates be found?

The Official Connecticut Practitioner Fee Schedule and the Official Connecticut Fee Schedule for Hospitals and Ambulatory Surgical Centers are published by OptumInsight and may be purchased by calling 1.800.464.3649, option 1; or online at www.optum360coding.com.

Updates and changes posted before the periodic update may be found by checking the State of Connecticut Workers' Compensation Commission website at https://wcc.state.ct.us.

Does the state adopt NCCI?

Yes, the Commission adopts the National Correct Coding Initiative and Medically Unlikely Edits (MUEs) for both practitioners and facilities.

Does the state allow payment greater than billed charge?

For practitioners, the fee schedule payment is the lesser of the provider's billed amount and the fee schedule allowance.

For facilities, the fee schedule requires that reimbursement be in accordance with the fee schedule unless a different rate is negotiated between the parties. This method allows the reimbursement to exceed the billed line charge in cases where the service was billed less than the fee schedule amount, not to exceed the total billed amount.

Is balance billing allowed?

No, Rule 31-279-9 (e) states: "All charges for medical, surgical, hospital and nursing services, except those for expert testimony, shall be solely the responsibility of the employer or carrier, and no claim will be made against the injured employee for all or part of a fee."

Does the state have any state-reporting requirements?

The state of Connecticut has no specific state-reporting requirements.

Does the state have any EOR requirements?

The state of Connecticut has no specific explanation of review (EOR) form or format requirements.

Does the state have any bill certification requirements?

The Workers' Compensation Commission (WCC) does not have any bill certification requirements.

Does the state have any statute of limitations for submitting a medical bill?

Yes, under General Guidelines for Providers, claims for services must be submitted within 180 days after the date of service.

Does the state have any payment time limits?

Yes, payment is to be made within 60 days of receipt.

How are unlisted codes and/or By Report codes to be paid?

When a practitioner bills unlisted codes, a report must be included that adequately describes the procedure/service and the necessity of the treatment. Claims administrators/payers shall pay "By Report" services based on comparable procedures or analogous codes.

What should be done if the provider bills an incorrect code?

The state of Connecticut does not provide guidance for incorrect codes.

Does the state guidelines allow down coding?

Reviewers making coding adjustment are required to provide supporting documentation of the rationale to the provider at the time payment is made on the reduced service/procedure or amount. The explanation should include both the billed code and the code on which payment is made.

Does the state accept/recommend any usual and customary databases?

The state of Connecticut does not regulate or recommend any specific usual and customary database.

What are the rules for out-of-state provider reimbursement?

Out-of-state providers are subject to Connecticut payment rates and all Connecticut jurisdictional and procedural guidelines.

Has the state adopted a medical treatment guideline?

The State of Connecticut Workers' Compensation Commission has posted Guidelines for Use of Medical Protocols. They are available for review at: http://wcc.state.ct.us/download/acrobat/protocols.pdf.

ANESTHESIA

Reimbursement for anesthesia services is calculated as:

[Base Unit + Time Unit + Modifying units*] * CF = Reimbursement

*Modifying units = physical status and qualifying circumstances

Anesthesia modifiers:

Modifier	Description	Payment
22	Increased Procedural Services	150%
23	Unusual Anesthesia	Informational Only
46	Anesthesia by CRNA (Connecticut Modifier)	70%
AA	Anesthesia Services performed personally by the anesthesiologist	100%
AD	Medical Supervision by a physician; more than 4 concurrent anesthesia procedures	Informational Only
G8	Monitored anesthesia care for deep complex complicated, or markedly invasive surgical procedures	Informational only
G9	Monitored anesthesia care for patient who has a history of severe cardio-pulmonary condition	Informational only
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	Informational Only
QS	Monitored anesthesia care service	Informational only
QX*	CRNA service; with medical direction by a physician	Informational Only
QY*	Medical direction of one certified registered nurse anesthetist by an anesthesiologist	Informational Only
QZ	CRNA service: without medical direction by a physician	70%

*When an anesthesiologist ***directs*** a CRNA, the total reimbursed amount for anesthesia procedure will not exceed the amount allowed for that procedure. Only 100% of the fee schedule amount will be paid. How it is divided between providers is not addressed within the fee schedule.

The application is automated to calculate reimbursement for anesthesia services when the anesthesia code and modifier are entered into the system. In CORE, anesthesia time is entered as minutes in the **Time** field. Time units are computed by dividing the reported anesthesia time by 15 minutes. Five minutes or greater is considered a significant portion of a time unit.

Physical Status Modifiers

Modifier	Description	Unit Value
P1	A normal healthy person	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 declared brain-dead patient whose organs are removed for donor purposes	0

Qualifying Circumstances

Code	Description	Unit Value
99100	Anesthesia for patient of extreme age: under one year and over seventy	1
99116	Anesthesia complicated by utilization of total body hypothermia	5
99135	A patient with severe systemic disease	5
99140	A patient with severe systemic disease that is a constant threat to life	2

SURGERY

Multiple Procedure Reductions

Multiple surgical procedures performed on the same day, by the same practitioners may be subject to multiple surgery reductions and are based on the **Multiple Surgeries Guidelines**:

Effective 7/15/2017

Description	Reimbursement
Discount	Primary procedure = 100% Second through fifth procedure(s) = 50% Sixth or more procedures = By Report
Modifier 51 exempt and Add-on codes	100%

Dates of service prior to 7/15/2017

Description	Reimbursement
Discount	Primary procedure = 100% Secondary procedure = 50% Third through fifth procedure(s) = 25% Sixth or more procedures = By Report
Modifier 51 exempt and Add-on codes	100%

Multiple Endoscopic Procedures

Not addressed within the medical fee schedule.

Assistant Surgery

Assistant surgery ***by a physician***:

- Shall be billed with modifiers 80, 81 or 82.
- If payable, reimbursement is 20% of the fee schedule amount.

Assistant surgery ***by a non-physician practitioner*** (physician assistant, nurse practitioner or clinical nurse specialist):

- Shall be billed with modifier AS.
- If payable, reimbursement is 14% (70% of 20%) of the fee schedule amount.

Eligibility for payment is determined by the **Asst** identifier:

Asst Surg	Description	CORE Processing
0	Documentation of Medical Necessity required	Deny with **RC 2M** (Documentation required)
1	Assist-at-surgery services are not payable	Deny with **RC 91** (Service Not Allowed)
2	Assist-at-surgery services may be paid	Recommends Assistant Surgery Payment
9	Concept does not apply	Deny with **RC 91** (Service Not Allowed)

Bilateral Procedures

Bilateral procedures may be reported as a single code with modifier 50 or reported twice on the same date with modifiers LT and RT.

System is automated to calculate reimbursement at the lesser of the billed amount and 100% of the fee schedule value for the primary procedure and 80% for the secondary procedure.

Co-Surgery

When two surgeons work together to perform a specific procedure, each surgeon will report the surgical procedure with modifier 62 to indicate co-surgery. Each surgeon is reimbursed 75% of fee schedule amount for the surgical procedure.

Team Surgery

Reimbursement for team surgery (modifier 66) is not addressed within the medical fee schedule.

Follow Up Days

The fee schedule reflects the following guidelines for **Global Days**:

Glob Days	Surgical Package
000	E/M services on the day of surgery are generally not payable
010	E/M services on the day of surgery and during the 10-day post-operative are generally not payable
090	E/M services 1-day preoperative and within the 90-days post-operative are generally not payable
ZZZ	Add-on code. Global days are based on the primary procedure
YYY	Not used for workers' compensation

RADIOLOGY

Where applicable, the fee schedule has separate rates for the global component, technical component and professional component of radiology procedures.

LABORATORY AND PATHOLOGY

Where applicable, the fee schedule has separate rates for the global component, technical component and professional component of pathology procedures.

MEDICINE

Physical Medicine

Effective 7/15/2017, the following treatment limitations should be followed per visit, unless prior authorization has been obtained:

- The maximum payment amount will not exceed $125.00 per date of service, per provider, except in instances where more than one body region is treated.
- The maximum payment amount will not exceed $200.00 per date of service, per provider when more than one body region is treated.
- The initial evaluation is not included within the $125.00 daily cap.

Chiropractors may bill for an E/M service in addition to any manipulation service. The charge for an E/M service is allowed in addition to the $125.00 daily cap.

EVALUATION AND MANAGEMENT

The fee schedule has specific non-facility and facility values for outpatient and inpatient consultations. Please refer to the fee schedule for these specific rates.

NON-PHYSICIAN PRACTITIONERS (NPPS)

Physician assistants and advanced registered nurse practitioners (ARNP) are reimbursed at 70% of the fee schedule amount for their services.

Please reference the **Surgery section** for assist-at-surgery services by non-physician practitioners.

AMBULANCE

Reimbursement for ground service rates is published by the Department of Public Health. CORE is automated to calculate reimbursement at the lesser of the billed amount and the published rate.

Air transport rates are no longer set by the Department of Public Health.

DENTAL

The state does not provide fee schedule rates for dental services. Dental services are payable "By Report."

DURABLE MEDICAL EQUIPMENT/PROSTHETICS, ORTHOTICS, SUPPLIES (DMEPOS)

Durable medical equipment is payable at the acquisition price, including sales tax, plus 30%.

Rental equipment must be identified with modifier RR and is payable for short-term use (60 days or less with payer authorization).

J-CODES

Injection codes are payable at the acquisition cost, including sales tax, plus 30%.

INPATIENT HOSPITAL (ACUTE-CARE)

Inpatient admissions in an acute-care hospital are reimbursed using the Centers for Medicare & Medicaid Services (CMS) DRG methodology. There is a 174% markup applied to the amount that Medicare allows for each acute care admission. For discharges prior to 10/01/2020 the fee schedule references using the Medicare PC PRICER tools to determine the Medicare DRG allowance. For discharges on or after 10/01/2020 the fee schedule references using the Medicare IPPS Web Pricer tool to determine the Medicare DRG allowance. The PC PRICER versions along with the instructional IPPS Users Manual can be found through the following link:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PCPricer/inpatient.html.

The workers' compensation commission has provided instructions to Medata on using the exact version of the PC PRICER that is available from the CMS website as of the April 1st fee schedule effective date. For 2019 this is the version named INPC19B. That version of the PC PRICER should be used for all discharges after 4/1/2019 up until the new facility fee schedule updates the following year. This policy remains in effect even if CMS releases newer versions of the PC PRICER prior to the new fee schedule update in April of 2020. This is automated in CORE.

The Medicare IPPS Web Pricer web-based application is available at:
https://webpricer.cms.gov/ - /pricer/ipps

Outliers

The bill may qualify for an additional outlier payment if the hospital's costs exceed the outlier threshold.

Implants

There is a conditional separate payment that may be allowed for implantable hardware or devices provided during an inpatient stay. The invoice amount of the device must exceed the DRG's calculated device allocated amount in order for the implant to be eligible for separate reimbursement. When eligible, the implant is paid at 30% above invoice and the normal DRG allowance is reduced by the device allocated percentage. Please reference the fee schedule for further details.

Trauma

The Commission does not have special payment provisions for trauma admissions or trauma facilities.

Critical Access Hospitals

The state of Connecticut does not have any Critical Access Hospitals.

Out-of-State Inpatient Stays

Hospitals outside the state of Connecticut will be reimbursed for inpatient stays based on the "Review As" field setting in CORE's State Options screen. When this option is set to review to the carrier state, CORE applies CTWC's 174% markup to the Medicare allowance for the other state. When the "Review As" field is set to review to the provider's state, CORE applies reimbursement for the out-of-state facility as if the claimant were injured on the job in the other state.

Veteran Administration (VA) Hospitals

Services provided in a VA hospital are exempt from the fee schedule. If the Medicare ID ends with "F", CORE allows at the facility's billed charges.

Data Entry Requirements

The following guidelines identify the key fields required for accurate inpatient pricing in CORE.

On the **Provider Record** screen:

- **Prov Type** = 10

On the **Data Entry** screen:

- **UB04** = Y

On the **Additional Info** screen:

- **Date Admit** - Enter the Admission Date (FL12 on the UB-04)
- **Bill Type** - Enter the Type of Bill (FL4 on the UB-04)
- **B.O.S. Date** - Enter the Beginning date (FL6 on the UB-04)
- **E.O.S. Date** - Enter the Ending date (FL6 on the UB-04)
- **Facility Type** = A (Acute Care Facility) or O (use for all other facility types)
- **Billed DRG** - Enter the DRG (FL71 on the UB-04)

On the **MCMU Facility Header Input** screen:

- **DRG Y/N** = Y (Acute Care Facility) or N (use for Rehab, Psych, LTCH)
- **Pat Status** - Enter the Discharge Status (FL17 on the UB-04)
- **Medicare ID** - Enter the facility's Medicare Provider Number (MPN)
- **DRG Code** - Auto-populates per the DRG Grouper output. User may manually override.

When entering the revenue codes and charges:

- Key all lines presented on the bill
- **POS** = 21

CORE will calculate payment according to the fee schedule and RC ZE is applied to the lines.

DRG Grouper Requirements

CORE contains an MS-DRG Grouper program. The grouper program requires the following data elements in order to accurately compute a MS-DRG in the **DRG Code** field on the **MCMU Facility Header Input** screen:

1) Patient **Date of Birth** (in Claim Record)
2) Patient **Gender** (in Claim Record and in MCMU Facility Header Header Input screen)
3) Patient **Discharge Status** (in the MCMU Facility Header Input screen)
4) ICD **Diagnosis Codes** and POA Indicators (from FL67 A-Q on the UB-04)
5) ICD **Procedure Codes** (from FL 74 A-E on the UB-04)

NOTE: If any of these requirements are not met, the grouper will apply DRG 999. User may manually override.

OUTPATIENT HOSPITAL & AMBULATORY SURGERY CENTER

Outpatient hospital and ASC services are reimbursed based on the CMS Ambulatory Payment Classification (APC) method.

Outpatient Hospital

Generally, emergency room visits, surgical procedures and other outpatient services are reimbursed at 210% of the Medicare APC amount. Please refer to the fee schedule for Hospitals and Ambulatory Surgical Centers for specific details. The fee schedule lists the facilities' wage index groups and corresponding allowances for payable services.

Separately payable outpatient services that do not have APC amounts may be reimbursed according to the practitioner's medical fee schedule (Clinical Laboratory, DMEPOS, etc).

Ambulatory Surgery Center

Generally, surgical procedures performed in an ASC setting are reimbursed at 195% of the Medicare ASC allowance. The fee schedule lists the facilities' wage index groups and corresponding allowances for payable services.

Separately payable services that do not have APC amounts may be reimbursed according to the practitioner's medical fee schedule (Clinical Laboratory, DMEPOS, etc).

Implants

The APC allowances for surgical procedures done on an outpatient basis are developed to include the cost of associated implant devices and hardware. However, there are exceptions to this method that will allow separate payment under certain conditions. In order to qualify for separate payment, the invoice amount for the items must exceed the device allocated portion of the procedure. When this occurs, there will be a separate payment made for the qualifying item based on 130% of the invoice amount. This will be accompanied by a decrease in the normal allowance for the procedure equal to the device allocated portion.

SPECIALTY FACILITY/SERVICES

Rehabilitation, Psychiatric, Long Term Care Hospitals

Reimbursement for these facility types is not regulated by the Workers' Compensation Commission.

Skilled Nursing Facility (SNF)

Reimbursement for this facility type is not regulated by the Workers' Compensation Commission.

Home Health Agency

Reimbursement for this facility type is not regulated by the Workers' Compensation Commission.

Prescriptions are reimbursed as follows:

Brand name medications = **AWP + $5.00** dispensing fee

Generic medications = **AWP** + **$8.00** dispensing fee

Repackaged Drugs

Repackaged drugs are reimbursed based on the NDC of the original drug product used by the repackager in producing the repackaged product.

Compound Drugs

The fee schedule does not provide specific instructions regarding reimbursement for these services.

RESPONDENT'S MEDICAL EXAMINATIONS (FORMERLY IME)

Examinations directed by the insurer, employer or Commissioner, for purposes of independently reviewing the management and treatment plan of the attending physician, are often referred to as "RMEs." Unless directed by the Commissioner, the payer must approve them for need and payment. RME's were formerly known as independent medical examinations (IMEs).

REPORTS

Practitioners must use CPT 99080 when billing for reports. The fee is to be negotiated between the payer and the provider.

COPY SERVICE FEE SCHEDULE

The fee schedule does not provide specific instructions regarding reimbursement for these services.