ALABAMA DEPARTMENT OF WORKFORCE
WORKERS' COMPENSATION
ADMINISTRATIVE CODE

CHAPTER 480-5-5
UTILIZATION MANAGEMENT AND BILL SCREENING

TABLE OF CONTENTS

480-5-5-.01	Scope
480-5-5-.02	Definitions
480-5-5-.03	Timely Payment Of Undisputed Medical Claims
480-5-5-.04	Statement Of Services
480-5-5-.05	Entity Qualified To Perform Bill Screening
480-5-5-.06	Utilization Review Entity Qualified To Perform Utilization Review
480-5-5-.07	Utilization Review Process
480-5-5-.08	Pre-Certification Required
480-5-5-.09	Procedure For Pre-Certification
480-5-5-.10	Continued Stay Review Procedures
480-5-5-.11	Technical Considerations For Review (Bill Screening) Of Claims
480-5-5-.12	Physician Of Record
480-5-5-.13	Emergency Care
480-5-5-.14	Second Or Opposing Surgical Opinion
480-5-5-.15	Bill Screening
480-5-5-.16	Conflict Of Interest: Health Facility Owner-Ship By A Provider
480-5-5-.17	Optometric Services
480-5-5-.18	Chiropractic Services
480-5-5-.19	Physical Therapy/Occupational Therapy/ Speech Therapy Services
480-5-5-.20	Hospital Services
480-5-5-.21	Prescribed Medications
480-5-5-.22	Approved Standardized Medical Reimbursement Forms
480-5-5-.23	Appeals Process For Utilization Review Bill Screening, Peer Clinical Review And Denial Or Revocation Of Utilization Review Certificate
480-5-5-.24	Discharge Planning Procedures
480-5-5-.25	On Site Audit
480-5-5-.26	Ambulatory Surgery Centers
480-5-5-.27	Admission Review Procedures
480-5-5-.28	Dental Services
480-5-5-.29	Medical Case Management
480-5-5-.30	Home Health Care Service
480-5-5-.31	Pain Management Program

480-5-5-.32 Durable Medical Equipment
480-5-5-.33 Time Limits For Claims Payments
480-5-5-.34 Ambulance Services
480-5-5-.35 Impairment Rating Guide
480-5-5-.36 Time Limits For Employee Filing Incurred Expense Claims
480-5-5-.37 Out-Of-State Medical Providers

480-5-5-.01 Scope.

(1) These rules are designed to cover permissive bill screening and permissive utilization review undertaken on behalf of an employer by a person or entity other than an employee of the employer and following a determination that an employee has suffered an injury by accident arising out of and in the course of the employee's employment. These rules are not to be interpreted as limiting the employer's on prerogative.

(a) Nothing in Rule 480-5-5-.06 shall be construed to restrict or deny the employer's prerogative to authorize medical care pursuant to the Workers' Compensation Law.

(b) These Rules shall address medical services provided to compensable workers' compensation cases (claims) approved and authorized by the employer.

(c) These Rules shall not apply to medical services provided to an injured employee during the period of investigation to determine if the injury was the result of an accident arising out of and in the course of the employee's employment, but the employer/agent may apply these Rules retrospectively if compensability is accepted by the employer.

(2) These Rules do not and shall not mandate the -contracting of any outside vendor to perform utilization review and/or bill screening services for an employer or carrier.

(3) These Rules shall not take precedence over any arrangement between any employer, workers' compensation insurance carrier, self-insured employer, group fund or agent and provider of medical services regarding any rate, fees, or level of reimbursement which does not exceed that which is set by law or bill screening and/or utilization management agreements.

(4) Nothing in these Rules, including an employer's contracting with an outside vendor for bill screening and/or utilization review, is intended to alter the employer's rights, immunities and remedies under the Alabama Workers' Compensation Law. Nothing in these Rules shall be construed as to create any cause of action.

(5) In the event that Utilization Review and Bill Screening is mandated by Law, these Rules shall be reviewed in accordance with the change.

(6) These Rules shall be reviewed at least annually for continued appropriateness.

(7) Utilization review and bill screening services may be performed at the option of the employer.
Author: Workers' Compensation Division
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: **New Rule:** Filed August 9 1996; effective September 13, 1996.

480-5-5-.02 Definitions.

When used in these rules, the following words and phrases shall have the following meanings:

(1) **Accident** - The term, as used in the phrases "personal injuries due to accident" or "injuries or death caused by accident," shall be construed to mean an unexpected or unforeseen event, happening suddenly and violently, with or without human fault, and producing at the time, injury to the physical structure of the body or damage to an artificial member of the body by accidental means.

(2) **Adjudication** - The review of claims to apply prevailing rules that adjust reimbursements for the amount of work required when multiple procedures are performed at the same time; when assisting surgeons are present, to eliminate duplicate billing from the unbending of global fees; and to adjust for the most commonly occurring method adopted for total reimbursement.

(3) **Adjudicator** - An individual, entity or agent that is responsible for adjudication.

(4) Admission Review - The initial review after hospitalization of the medical necessity and appropriateness of hospital admission.

(5) **Advanced Life Support (ALS)** - The treatment of potentially life-threatening medical emergencies through the use of invasive medical techniques specified as advanced life support techniques in the applicable rules, which ordinarily would be performed or provided by physicians, but which may be performed by emergency medical technicians pursuant to these rules.

(6) **Agent** - An individual responsible for the administration of a workers' compensation claim for an employer.

(7) **Ambulance** - A vehicle specifically designed and equipped for transporting the wounded, injured, ill, or sick. Workers' Compensation recognizes three levels of ambulance services: Basic Life Support (BLS), Advanced Life Support (ALS), and Non-emergency Ambulance Transportation.

(8) **Ambulatory Review** - The review of the medical necessity and appropriateness of medical services rendered in a non-inpatient setting.

(9) **Ambulatory Surgical Center** - A facility licensed as an ambulatory surgical center that has as its primary purpose the provision of elective surgical care.

(10) **Appeals Process** - A system or systems providing for any aggrieved party to contest an adverse decision relative to utilization review and bill screening by an adjudicator, employer, carrier or agent.

(11) **Average Wholesale Price (AWP)** - The AWP is the amount, which includes cost, tax, shipping, and handling.

(12) **Basic Life Support (BLS)** - A level of pre-hospital care involving non-invasive life support measures.

(13) **Bill Screening** - The evaluation and adjudication of provider bills for appropriateness of reimbursement relative to medical necessity and prevailing rates of reimbursement, duplicate charges, unbundling of charges, relativeness of services to injury or illness, necessity of assistant surgeons, adjudication of multiple procedures, number of modalities, global procedures, and any other prevailing adjudication issues that may apply.

(14) **Clinical Criteria** - Any prevailing and generally accepted medical policies, rules, medical protocols, guides and standards which may include, but are not limited to, criteria set out in the Intensity/Severity/Discharge Manual; the nomenclature and rules set out in the latest edition of Physicians' Current Procedural Terminology (CPT-4) publication; the nomenclature and rules set out in the latest edition of International Classification of Diseases; the nomenclature and rules set out in the latest edition of the American Society of Anesthesiologist Relative Value Guide; rules and nomenclature set out in the latest edition of Global Service Data for Orthopedic Surgery published by the American Academy of Orthopedic Surgeons; criteria established by the Commission on Accreditation of Rehabilitation Facilities (CARF); rules, nomenclature and standards established by the International Association of Rehabilitation Professionals

(IARP); rules, nomenclature and standards established by the latest edition of the Health Care Finance Administration Common Procedure Coding Systems (HCPCS); rules and criteria as described in the Professional Activity Study; and prevailing rules, nomenclature and standards established by peer review committees established by medical provider associations used by the utilization review entity to determine certification of medical services; or any other professional groups as recognized by the Alabama Workers' Compensation Medical Services Board.

(15) **Clinical Review** - An objective, analytical review of the medical findings and records.

(16) **Commission on Accreditation of Rehabilitation Facilities (CARF)** - A national, private, nonprofit organization that sets standards of quality and provides accreditation for each specific rehabilitation program for organizations serving persons with disabilities.

(17) **Compensation** - The money benefits to be paid on account of injury or death, as provided in [Articles 3 and 4 of the Alabama Workers' Compensation Law], Code of Ala. 1975, §§25-5-50 to 25-5-123. The recovery which an employee may receive by action at law under [Article 2 of the Alabama Workers' Compensation Law] Code of Ala. 1975, §§25-5-30 to 25-5-36 is termed "recovery of civil damages," as provided for in Code of Ala. 1975, §§25-5-31 and 25-5-34. "Compensation" does not include medical and surgical treatment and attention, medicine, medical and surgical supplies, and crutches and apparatus furnished an employee on account of an injury.

(18) **Continued Stay Review** - The review of an ongoing inpatient hospitalization to assure the most appropriate setting for the care being rendered, sometimes called concurrent review.

(19) **Core Team** - A group of professionals providing interdisciplinary coordination of services for a specific program within a facility. The members are expected to provide therapeutic, educational and training services consistent with the requirements of CARF standards and the individualized needs of the clients served.

(20) **Current Dental Terminology (CDT-2) or the most current revision** - A listing of descriptive terms and identifying codes published by the American Dental Association for reporting dental services and procedures.

(21) **Department** - The Alabama Department of Labor.

(22) **Dictionary of Occupational Titles (DOT)** - Publication by the U.S. Department of Labor that sets out job descriptions and other related information pertaining to specific jobs.

(23) **Discharge Planning** - The process of assessing and facilitating the need for medically appropriate services and resources as related to the compensable injury after hospitalization to allow for an appropriate and timely discharge.

(24) **Elective Surgery** - Approved surgery which is medically necessary, yet non-emergency in nature, but which may be performed at a later date.

(25) **Emergency Hospitalization** - Inpatient services provided after the sudden onset of a medical condition manifested by symptoms of sufficient severity (which may include, but not be limited to, severe pain), which, in the absence of continued inpatient medical attention, could reasonably be expected by an appropriate health care professional to result in placing the claimant's life in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

(26) **Emergency Services** - Medical services provided after the onset of a medical condition manifested by symptoms of sufficient severity (which may include, but not be limited to, severe pain), which, in the absence of immediate medical attention, could be expected by an ordinary reasonable person to result in placing the claimant's life in jeopardy, impairment to bodily functions, or dysfunction of any bodily organ or part.

(27) **Employer** - Every person who employs another to perform a service for hire and pays wages directly to the person. The term shall include a service company for a self-insurer or any person, corporation, copartnership, or association, or group thereof, and shall, if the employer is insured, include his or her insurer, the insurer being entitled to the employer's rights, immunities, and remedies under the Alabama Workers' Compensation Law, as far as applicable. The inclusion of an employer's insurer within the term shall not provide the insurer with immunity from liability to an injured employee, or his or her dependent in the case of death to whom the insurer would otherwise be subject to liability under Code of Ala. 1975, §25-5-11. Notwithstanding the provisions of the Alabama Workers' Compensation Law, in no event shall a common carrier by motor vehicle operating pursuant to a certificate of public convenience and necessity be deemed the "employer" of a leased-operator or owner-operator of a motor vehicle or vehicles under contract to the common carrier.

(28) **Employee or Worker** - The terms are used interchangeably, have the same meaning throughout the Alabama Workers' Compensation Law, and shall be construed to mean the same. The terms include the plural and all ages and both sexes. The terms include every person in the service of another under any contract of hire, express or implied, oral or written, including aliens and also including minors who are legally permitted to work under the laws of this state, and also including all employees of Tannehill Furnace and Foundry Commission.

(29) **Functional Capacity Evaluation (FCE)** - Process to evaluate the injured worker's functional and/or vocational status.

(30) **Generally Accepted Criteria** - Written criteria used by clinical reviewers, which may include but are not limited to, ICD10, ISD, PAS, Milliam and Robertson (M&R) and Health Care Insurance Association (HCIA) Publications.

(31) **Global Charge Concept** - One charge covering the professional services and usual associated services necessary to perform the basic approved program or procedure.

(32) **Global Service Data for Orthopedic Surgery (GSDOS) or most current revision** - Publication by the American Academy of Orthopedic Surgeons which outlines services that are appropriate for inclusion and/or exclusion from the intraoperative component of the global service package.

(33) **Global Surgery Procedure** - A global service is a primary procedure that has specific related components that are identified as being inclusive within the already established primary procedure. Fee unbundling occurs when the charge for a specific procedure remains the same, but one or more components of the procedure are separated from the global service package and given a separate additional fee.

(34) **Healthcare Finance Administration Common Procedure Coding System (HCPCS) or most current revision** - Includes CPT-4 descriptive terms and numeric identifying codes and modifiers for reporting medical services and procedures and other materials contained in the CPT-4. HCPCS is designed to promote uniform medical services reporting and statistical data collection.

(35) **Hospital** - A hospital, ambulatory surgical center, outpatient rehabilitation center licensed by the State of Alabama, and diagnostic facilities accredited by the Commission on Accreditation of Rehabilitation Facilities. Rule 480-5-5-.19 addresses outpatient rehabilitation centers, Rule 480-5-5-.20 applies to hospitals, and Rule 480-5-5-.26 applies to free standing ambulatory surgery centers.

(36) **Independent Medical Examination (IME)** - An independent assessment of an injured workers' physical condition and/or bodily functions that is performed by a non-treating physician at the request of the employer/agent or employee. The non-treating physician shall not be the individual's family physician or a physician who is currently or has previously treated the individual for the same complaint. The IME differs from an impairment rating in that no impairment rating is given. The IME differs from a second opinion in that this examination is not a confirmatory evaluation. The party requesting the IME shall be the responsible party for payment of this service.

(37) **Injury** - "Injury and personal injury" shall mean only injury by accident arising out of and in the course of the employment, and shall not include a disease in any form, except for an occupational disease or where it results naturally and unavoidably from the accident. Injury shall include physical injury caused either by carpal tunnel syndrome disorder or by other cumulative trauma disorder if either disorder arises out of and in the course of the employment, and breakage or damage to eyeglasses, hearing aids, dentures, or other prosthetic devices which function as part of the body, when injury to them is incidental to an on-the-job injury to the body. Injury does not include an injury caused by reasons personal to him or her and not directed against him or her as an employee or because of his or her employment. Injury does not include a mental disorder or mental injury that has neither been produced nor been proximately caused by some physical injury to the body.

(38) **Injuries By An Accident Arising Out Of And In The Course Of The Employment** - Without otherwise affecting either the meaning or interpretation of the clause, the clause does not cover workers except while engaged in or about the premises where their services are being performed or where their service requires their presence as a part of service at the time of the accident and during the hours of service as workers.

(39) **Inpatient Admissions** - Medically necessary services provided to a registered bed patient in a hospital for more than 23 hours.

(40) **Intensity/Severity/Discharge Manual (ISD Manual) or most current revision** - Published by Internal, this manual provides the criteria for inpatient admission to hospitals.

(41) **Interdisciplinary** - An approach to client management which requires the integration of a core team from multiple disciplines which, on an ongoing basis, assesses, plans and implements a complex rehabilitation program for functional restoration. It does not mean an approach wherein multiple

disciplines are available as needed but function independently of one another to address isolated, clearly defined problems.

(42) **International Association of Rehabilitation Professionals (IARP)** – An international association dedicated to enhancing the competency of private rehabilitation professionals, advancing the professional field, improving the effectiveness of state level affiliates, and leading in the resolution of public policy issued that affect private sector rehabilitation.

(43) **International Classification of Diseases 9th Edition (ICD-10CM) or most current revisions** - A system of diagnostic coding which identifies and precisely delineates the clinical condition of patients.

(44) **Maximum Fee Schedule (MFS) or most current revision** - The prevailing reimbursement as published in the current Alabama Workers' Compensation Maximum Fee Schedule according to provider type.

(45) **Medical Case Management** - The process of assessing, planning, implementing, coordinating, monitoring and evaluating the services required to respond to an employee's health care needs to attain the goals of quality and cost effective care. Case Management is not intended as a substitute for utilization review and medical necessity determinations under these rules and case managers are not permitted to deviate from or alter a medical regimen ordered by a treating physician.

(46) **Medical Dispute Resolution** - Review by an Ombudsman of medical services that are provided or for which authorization of payment is sought, as defined in Code of Ala. 1975, §25-5-77(i).

(47) **Medical Necessity** - Services or supplies which are medically necessary to treat the work related illness or injury. To be medically necessary, services and supplies shall meet the following criteria: be consistent with the diagnosis and treatment of the work related illness or injury; be consistent with the standard of care for good medical practice; not be solely for the convenience of the patient, family, hospital, physician or other provider; be in the most appropriate and cost effective medical care setting as determined by the patient's condition; and have scientifically established medical value.

(48) **Medical Services** - All medical services, treatments, surgeries, procedures, equipment, or supplies provided by a provider to an authorized compensable workers' compensation injured worker.

(49) **Modifier** - A modifier provides the means by which the reporting provider can indicate that a service or procedure that has been performed has been altered by some specific circumstance but without changes in its definition or code. The judicious application of modifiers obviates the necessity for separate procedure listings that may describe the modifying circumstance. Modifiers may be used to indicate to the recipient of a report that: a service or procedure has both a professional and technical component; a service or procedure was performed by more than one provider and/or in more than one location; a service or procedure has been increased or reduced; only part of a service was performed; an adjunctive service was performed; a bilateral procedure was performed; a service or procedure was provided more than once; or unusual events occurred.

(50) **National Council for Prescription Drug Programs (NCPDP)** - An association of pharmacists and third-party administrators whose purpose is to standardize electronic claim filing and adjudication.

(51) **Non-emergency Ambulance Transportation** - Non-emergency transport of patients in a recumbent position who require transportation to or from a physician's office, hospital, other health care facility, or residence. This shall not include a hospital operated vehicle used exclusively for intra-hospital facility transfers.

(52) **Ombudsman** - An individual who assists injured or disabled employees, persons claiming death benefits, employers, and other persons in protecting their rights and obtaining information available under the workers' compensation law.

(53) **Outpatient Procedures and Services** - Medically necessary services provided to a patient who is not a registered bed patient and who does not remain in a hospital setting for more than 23 hours.

(54) **Pain Management Program** - A program to reduce pain, improve function and decrease the dependence on the health care system by persons with chronic pain that interferes with physical, psychosocial and vocational functioning through the provision of coordinated, goal oriented, interdisciplinary team services.

(55) **Participating and Nonparticipating Hospitals** - Participating hospitals are those hospitals that have a negotiated rate of reimbursement or payment with the Department of Labor. "Nonparticipating hospitals" means those hospitals that have not negotiated a rate of reimbursement or payment with the Department of Labor.

(56) **Payer** - The employer, carrier, self-insured employer, group self-insured fund, or agent responsible for determining compensability and making payment for medical services provided injured workers.

(57) **Peer** - A provider who is board certified in the same or similar specialty approved by the American Board of Medical Specialists for Physicians or the Advisory Board of Osteopathic Specialists for Osteopaths from the major areas of clinical services or a physician who normally treats that type of case as the ordering provider whose medical services are being reviewed, or for non-physician clinical peers, the recognized professional board for their specialty.

(58) **Physician** - For the purposes of providing services and treatment under the Alabama Workers' Compensation Law, Code of Ala. 1975, §25-5-77, physician shall mean medical doctor, surgeon, and chiropractor. For the purposes of oversight for services rendered pursuant to the Alabama Workers' Compensation Law set forth in and other functions required by Article 12 of the Alabama Workers' Compensation Law found in Code of Ala. 1975, §§25-5-310 through 25-5-315, physician shall mean a doctor of medicine or doctor of osteopathy licensed to practice medicine.

(59) **Physicians' Current Procedural Terminology 4th Edition (CPT-4) or most current revision** - A listing of descriptive terms and identifying codes published by the American Medical Association for reporting medical services and procedures.

(60) **Pre-certification Review** - The review and assessment of the medical necessity and appropriateness of services before they occur. The appropriateness of the site or level of care is assessed along with the timing, duration and cost effectiveness of the proposed services.

(61) **Prevailing** - The most commonly occurring reimbursements for medical services other than those provided by federal and state programs for the elderly (Medicare) and economically disadvantaged (Medicaid). "Prevailing" shall include not only amounts per procedure code, but also commonly used adjudication rules as applied to multiple procedures, global procedures, use of assistant surgeons, and others as appropriate. For hospitals, "prevailing" rate of reimbursement or payment shall be established by the method contained in Code of Ala. 1975, §25-5-77.

(62) **Providers** - A medical clinic, pharmacist, dentist, chiropractor, psychologist, podiatrist, physical therapist, pharmaceutical supply company, rehabilitation service, other person or entity providing treatment, service, or equipment, or person or entity of providing facilities at which the employee receives treatment.

(63) **Retrospective Review** - A utilization review conducted after services have been provided to a patient.

(64) **Rule** - Alabama Department of Labor Administrative Code as adopted under the Alabama Administrative Procedure Act.

(65) **Singular and Plural** - Wherever the singular is used, the plural shall be included.

(66) **The Court** - The circuit court that would have jurisdiction in an ordinary civil action involving a claim for the injuries or death in question and "the judge" means a judge of that court.

(67) **Utilization Management** - A comprehensive set of integrated components including: pre-certification review, admission review, continued stay review, retrospective review, discharge planning, bill screening and individual medical case management as required.

(68) **Utilization Review (UR)** - The determination of medical necessity for medical and surgical in-hospital, outpatient, and alternative setting treatments for acute and rehabilitation care. It includes pre-certification for elective treatments. Concurrent review and, if necessary, retrospective review are required for emergency cases.

(69) **Utilization Review Accreditation Commission (URAC)** - A national, nonprofit, organization established to encourage efficient and effective utilization review processes and to provide a method of evaluation and accreditation for utilization review programs.

(70) **Utilization Review Entity (URE)** - A private utilization review vendor, a carrier or its affiliate, a self-insured employer, a third-party administrator, or a group fund that provides utilization review.

(71) **Work Conditioning** - 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 client's physical capacity and function so the client can return to work.

(72) **Work Hardening Program** - A highly structured, goal oriented and individualized program that provides transition between acute care and return to work while addressing the issues of productivity, safety, physical tolerance and worker behavior.

(73) **Working Days** - Shall mean Monday through Friday; however, not including legal holidays. In computing any period of time prescribed or allowed by these Rules, the day of the act or event from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a legal holiday. As used in these Rules, "legal holiday" includes New Year's Day, President's Day, Memorial Day, Independence Day, Labor Day, Veterans' Day, Thanksgiving Day, Christmas Day, and any other day appointed as a holiday by the President or the Congress of the United States, or as prescribed in Code of Ala. 1975, §1-3-8.

Author: Workers Compensation Medical Services Board
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: New Rule: Filed August 9, 1996; effective September 13, 1996. **Amended:** Filed July 14, 1997; effective August 18, 1997. **Amended:** Filed August 31, 1998; effective October 5, 1998. **Amended:** Filed March 8, 2001; effective April 12, 2001. **Amended:** Filed April 26, 2016; effective June 10, 2016. **Amended:** Published July 29, 2022; effective September 12, 2022.

480-5-5-.03 Timely Payment Of Undisputed Medical Claims.

(1) 10 Percent (10%) Penalty:

(a) Appropriate reimbursement pursuant to Rule 480-5-5-.04 for undisputed medical services reasonably performed and billed in accordance with Code of Ala. 1975, §25-5-3 shall be paid to the provider within 25 working days of receipt of an approved service claim form pursuant to Rule 480-5-5-.22. A request for any additional documentation by a payer or agent shall be made by the payer or agent to the provider within fourteen (14) working days of receipt of the approved service claim form by the payer or agent. A request for documentation shall be made by the payer or agent to the provider via phone with written follow up or facsimile. If the documentation has not been provided to the requesting party within 14 working days of the receipt of the phoned request, the 25 working day deadline for payment shall not begin to run until the requested documentation is provided to the requesting party. If the requested documentation has been provided to the requesting within 14 working days of the receipt of the phoned request, the 25 working day deadline for payment shall begin to run upon receipt of the requested documentation by the requesting party.

(b) There shall be added to any undisputed service claim form which is not paid within 25 working days an amount equal to 10 percent (10%)of the unpaid balance pursuant to Code of Ala. 1975, §25-5-77(h).

(c) Failure to make timely reimbursement to any provider may subject the payer to an administrative fine of up to $500.00 (five hundred dollars), payable within 30 (thirty) days of assessment by the Director of the Department, pursuant to Code of Ala. 1975, §25-5-77(h).

Author: Workers' Compensation Medical Services Board
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: New Rule: Filed August 9, 1996; effective September 13, 1996. **Amended:** Filed May 31, 2002; effective July 5, 2002.

480-5-5-.04 Statement Of Services.

(1) A statement of medical services shall be made in accordance with standard coding methodology as established by the ICD-10-CM, HCPCS, and CPT-4 coding manuals and prevailing adjudication rules in Code of Ala. 1975, §25-5-1(15). Unbundling, fragmenting charges, duplicating, over-itemizing coding, upcoding, unrelated charges, or engaging in any other practice for the purpose of inflating bills for reimbursement shall be prohibited.

(2) Any reference in these Rules to any specific CPT-4 code, HCPCS code, or ICD-10-CM code is not intended to restrict or limit any provider's scope of practice, but is used for clarification only within the context of the specific section in which it appears. When specific codes are used in these Rules, the code reference shall refer to the most current description of the specific code or successor to such code as referenced in the most current edition of the coding manuals described in Rule 480-5-5-04(i).

(3) Medical services shall be billed by the provider using the provider's usual, customary and reasonable charges, although appropriate reimbursement shall be limited to the prevailing reimbursement as ascertained by the Department and published in the most current appropriate provider Maximum Fee Schedule; or as established through negotiated agreements between the Department and participating hospitals; or as established by statutory committee for nonparticipating hospitals; or according to any mutually agreed upon reimbursement in accordance with Code of Ala. 1975, §25-5-314.

(4) All bills may be subject to audit for verifying services rendered.

(5) Billing for subsequent medical services shall not include repeat billing for medical services previously performed and billed.

Author: Workers' Compensation Medical Services Board
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: New Rule: Filed August 9, 1996; effective September 13, 1996. **Amended:** Filed April 26, 2016; effective June 10, 2016.

480-5-5-.05 Entity Qualified To Perform Bill Screening.

(1) The following criteria shall be used by the Department of Industrial Relations to qualify an employer/agent who may perform the bill screening of medical services for workers' compensation claims. This entity shall be qualified by the Department as required in Rule 480-5-5-.05 and/or 480-5-5-.06, as applicable, of these rules. This entity shall:

(a) Be familiar with medical terms;

(b) Be familiar with the ICD-10-CM, CPT-4, and HCPCS Coding Manuals and Alabama Department of Industrial Relations Administrative Code Utilization Management and Bill Screening Chapter, and reimbursement as published in the most current Alabama Workers' Compensation Maximum Fee Schedule according to provider type;

(c) Be familiar with prevailing adjudication rules;

(d) Protect the confidentiality of medical records; and

(e) Provide a name and telephone number of a person for the Department to contact Monday through Friday during normal business hours, except legal holidays.

(2) It is the express intent of these rules that bill screening may be performed by the insurance carrier, employer/agent, self-insured employer, or group self-insurance fund including designated employees of the respective entity. There is no requirement that outside utilization review entity vendors be hired to perform bill screening activities in accordance with these rules.
Author: Workers' Compensation Medical Services Board
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: New Rule: Filed August 9, 1996; effective September 13, 1996. **Amended:** Filed July 14, 1997; effective August 18, 1997. **Amended:** Filed June 15, 2011; effective July 20, 2011. **Amended:** Filed April 26, 2016; effective June 10, 2016.

480-5-5-.06 Utilization Review Entity Qualified To Perform Utilization Review.

(1) **Technical Reviewer:**

(a) It is the express intent of these rules that approval of medical services may be performed by the employer/agent or its designated employee who meets the requirements of Rule

480-5-5-.05. The technical reviewer shall not deny a medical service related to an accepted compensable claim but shall refer any medical services which may not be approved to the first level of clinical review.

(2) **First Level Clinical Reviewer:**

(a) Nurses and other licensed or similarly certified medical professionals conducting first level clinical review of medical and surgical services and other clinical reviewers conducting reviews shall, in addition to qualifications of Rule 480-5-5-.05:

1. Possess current and valid license or certificate of registration from an appropriate licensure agency;

2. Be familiar with the principles and procedures of utilization review and these rules; and

3. Be clinically supported by an available physician, who has a nonrestricted license to practice medicine.

(3) **Second Level Clinical Reviewer:**

(a) Physicians or medical directors who directly support the utilization review activity of and employer/agent or RUE shall perform second level clinical review. In addition to the qualifications of Rule 480-5-5-.05, physicians or medical directors performing second level review shall:

1. Hold a current nonrestricted license to practice medicine or a health profession in the United States;

2. Be oriented to the principles and procedures of Utilization review, peer review and these rules;

3. Review cases in which a clinical determination to certify cannot be made by the first level clinical reviewer; and

4. Review all cases in which the utilization review process has concluded that a determination not to certify for clinical reasons is appropriate.

(4) **Third Level Clinical Reviewer:**

(l) Third level clinical reviewers shall be providers who serve as peer consultants or peer advisors and render Peer Clinical Review (Third Level Clinical Review) determinations for an expedited or standard appeal and shall, in addition to the qualification of Rule 480-5-5-.06(3), demonstrate their competency and currency by:

1. Being in active practice for standard appeal; or

2. Holding a current nonrestricted license to practice medicine or a health profession in the United States for a expedited appeal; and

3. Being board certified in the same or similar specialty approved by the American Board of Medical specialists for Physicians or the Advisory Board of Osteopathic Specialists for Osteopaths from the major areas of clinical services or a physician who normally treats that type of case as the ordering provider, whose medical services are being non-certified or denied, or for nonphysical clinical peers, the recognized professional board for their specialty; and

4. Being familiar with the principles and procedures of utilization review, peer review and these rules.

(5) An entity seeking to become qualified under this Rule shall submit an application in the form approved by the Director of the Department to the Workers' Compensation Division.

(6) **Qualified Utilization Review Entity (RUE):** A utilization review entity performing utilization review shall have a review staff properly qualified pursuant to the Rule and trained, supervised and supported by written clinical review criteria and review procedures.

(7) **Qualifications for a Qualified Utilization Review Entity Certificate:**

(a) An applicant for certification shall submit an application to the Workers' Compensation Division and meet the Department's minimal requirements as established by this Rule.

(b) The application shall be WC Form 50, or most current revision.

(c) The Department shall issue a certificate to an applicant that has met all the requirements of this Rule.

(d) Any utilization review entity who is accredited by URIC or the Alabama Department of Public Health shall be deemed to be qualified and shall be issued a certificate by the Department upon receipt of a copy of the entity's URIC or Department of Public Health certification.

(e) A certificate issued to the RUE under this Rule is nontransferable.

(f) A certificate initially issued pursuant to this Rule shall expire two years following its effective date unless renewed

for a two-year term pursuant to the Department's requirements for such renewal.

(g) The Department may deny a certificate to any applicant if, upon review of the application the Department determines that the applicant proposing to conduct utilization review, does not at all times comply with the following requirements:

1. Have available the services of a physician licensed to practice medicine who can administer its utilization review activities;

2. Protect the confidentiality of medical records, and be reasonably accessible to injured workers and providers Monday through Friday, except legal holidays, during normal business hours;

3. Make available to providers updated information regarding addresses, telephone numbers, business hours and contact persons for utilization review activities;

4. Provide the statistical data elements as reasonably required by the Department;

5. Maintain policies and procedures to comply with URIC standards and prevailing adjudication rules used in Alabama for situations not specifically addressed in these RULES;

6. Maintain policies and procedures assuring the timely review of appealed or denied services by a physician or other provider board certified in the same or similar specialty of the provider whose services are being denied or (a physician who normally treats the same type of case that is being denied;

7. Maintain policies and procedures assuring a system to properly and promptly review claims. The documentation shall be retrievable on a claim-by-claim basis for completion and classification on activity performance; and

8. Provide a name and telephone number of a person for the Department to contact.

(8) The Department shall notify the RUE in writing of any alleged violation of these Rules.

(a) Delivery of the notice shall be by either certified or registered mail.

(b) The qualified entity shall respond in writing to the notice not later than 30 days after the notice is received.

(c) Before denying or revoking a certificate under this Rule, the Department shall provide the applicant certificate holder with the opportunity to file an administrative appeal pursuant to the Rule 480-5-5-.23(2) and the successive levels of appeal.

Author: Workers' Compensation Medical Services Board
Statutory Authority: Code of Ala. 1975, §25-5-293 and 1994 Alabama Act 786.
History: **New Rule:** Filed August 9, 1996; effective September 13, 1996.

480-5-5-.07 Utilization Review Process.

(1) It is the express intent of these Rules that Utilization review may be performed by the insurance carrier, employer/agent, self-insured employer, or group self-insurance fund. There is no requirement that outside utilization review entity vendors be hired to perform utilization review activated in accordance with these Rules. Entities qualified by the Department may perform certain functions as herein described and permitted by these Rules.

(2) **Technical Reviewer** - It is the express intent of these Rules that approval of medical services may be performed by the employer/agent, or its designated employee which may include, but is not limited to, the Technical Reviewer. The employer/agent or designated employee shall not deny a medical service but shall refer any medical services which may not be approved to the first level of clinical review.

(3) **First Level Clinical Review** - Medical services that do not meet the criteria for first level clinical review shall be referred to the second level of review prior to a non-certification or denial determination.

(4) **Second Level Clinical Review:**

(a) If the physician performing the second level clinical review is not a peer to the ordering physician and a decision to approve the request cannot be rendered, the second level clinical reviewer shall:

1. Notify the requesting provider that up to 48 hours will be allowed for the purpose of a review by the requesting provider's peer, and

2. Refer the request for a review by the requesting provider's peer.

(b) The physician or medical director performing second level clinical review shall be reasonably available (within one

business day) by telephone or in person to discuss the determination with the attending physician and/or other ordering providers.

(c) Upon request by the attending physician or other ordering provider, a non-certification or denial of payment for medical services pursuant to the Second level Clinical Review process shall be reviewed pursuant to the Peer Clinical Review (Third Level Clinical Review) process.

(5) **Peer Clinical Review (Third Level Clinical Review):**

(a) Expedited Appeal - When a determination not to certify a medical service is made prior to or during an ongoing service requiring review, and the provider believes that the determination warrants immediate appeal, the provider shall have an opportunity to appeal that determination over the telephone on an expedited basis. Each qualified utilization review entity shall provide for reasonable access to its consulting Peer Clinical Review providers for such appeals. Both the provider and qualified utilization review entity shall share the maximum information by phone, facsimile or otherwise to resolve the expedited appeal (sometimes called a reconsideration request) satisfactorily. Expedited appeals that do not resolve a difference of opinion between the provider and the RUE may be resubmitted through the standard appeal process. The expedited appeal process applies only when the provider and the RUE mutually agree that an expedited appeal is necessary to resolve a dispute involving a denial of proposed treatment.

(b) Standard Appeal - The qualified utilization review entity shall establish procedures for appeals to be made in writing and/or by telephone.

1. Each qualified utilization review entity shall notify in writing the attending physician and claims administrator of its determination on the appeal as soon as practical, but in no case later than 30 days after receiving the required documentation on the appeal.

2. The documentation required by the qualified utilization review entity may include copies of part or all of the medical records and/or a written statement from the provider.

3. Prior to upholding the original decision not to certify for clinical reasons, the qualified utilization review entity shall obtain a review of such documentation by a Peer Clinical Review (Third Level Clinical Review) provider who was not involved in the original determination.

4. The process established by a qualified utilization review entity may include a time period within which an appeal shall be filed to be considered.

5. An attending physician or other ordering provider who has been unsuccessful in an attempt to reverse the appealed determination shall be provided the clinical basis for the upheld determination upon request.

6. The claimant may request through the ordering provider that a Third Level Clinical Review be conducted, if a denial or adverse determination is received at the Second Level Clinical Review.

(6) Notification of Adverse Determination Due to the Utilization Review Process - Not withstanding any other provision of the Alabama Department of Industrial Relations Administrative Code, Utilization Management and Bill Screening Chapter, a response shall be generated in writing (letter or facsimile) if the treatment or admission is denied. Copies of the written response, if required, shall be sent to the provider and shall notify the party of the right to appeal and the appeal process. The denial letter shall contain the following elements: claimant's name, the claimant's identifying number and address; date of accident; treatment or service denied; effective date of the denial; name of provider or facility; reason for denial; and the appeals process. The claimant shall be copied on all denial letters.
Author: Workers' Compensation Medical Services Board
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: New Rule: Filed August 9, 1996; effective September 13, 1996. **Amended:** Filed March 8, 2001; effective April 12, 2001. **Amended:** Filed December 5, 2008; effective January 9, 2009. **Amended:** Filed June 15, 2011; effective July 20, 2011.

480-5-5-.08 Pre-Certification Required.

(1) Application for pre-certification shall be made as early as possible by the provider prior to rendering of the medical services for a compensable illness or injury. If medical services are for treatment of a medical emergency, notification shall be made by the provider to the employer/agent no later than the next working day.

(2) The following medical services shall require authorization and pre-certification to be eligible for reimbursement:

(a) Non-emergency admissions to inpatient facilities of any type including, but not limited to skilled nursing facilities;

(b) Elective medical services performed in an ambulatory surgery center or the outpatient surgery department of a hospital or as part of an inpatient admission;

(c) Outpatient physical therapy, occupational therapy and speech therapy services;

(d) Chiropractic services;

(e) Repeat baseline diagnostic studies where the clinical condition of the patient is unchanged since the initial study, and the initial study is available to the specialist in an appropriate time frame;

(f) Cases selected by the employer/agent for focused medical management, which may include, but not be limited to, referrals to a specific specialist;

(g) Home health care;

(h) Home I.V. therapy;

(i) Pain management or outpatient pain clinics;

(j) Work hardening;

(k) Work conditioning;

(l) Durable medical equipment (other than braces, splints, etc., routinely provided in physician's office) including all items exceeding a reimbursement of $500.00, all Transcutaneous Electrical Nerve Stimulation (TENS) units, and all rental items;

(m) Biofeedback;

(n) Chemical dependency outpatient programs;

(o) Weight loss programs or clinics;

(p) Non-emergency dental services of all types;

(q) Magnetic Resonance Imaging (MRI);

(r) Computerized Axial Tomography (CAT) scans;

(s) Myelograms, discograms, or surface electromyograms;

(t) Psychiatric or psychological therapy or testing resulting from a compensable injury or trauma;

(u) Video fluoroscopy;

(v) Epidurals;

(w) Stellate Ganglion Blocks; and

(x) Beryllium Blocks.

(y) Ambulance Services

(3) The review process may be used to identify and refer cases for discharge planning, generally, as related to post hospitalization services.

(4) The RUE or employer/agent shall in the case of a denial of pre-certification or medical services, provide written (letter or facsimile) notification of the review decision to the requesting provider.

(5) The employer/agent shall maintain appropriate internal documentation of each request for pre-certification to verify the process and the decision for claims processing, reporting, and audit purposes.

(6) Physicians and other referring providers shall, except for an emergency, request pre-certification at least 48 hours or two working days prior to hospitalization or other medical services requiring pre-certification.

(7) This Rule is not intended to and shall not be deemed to supersede any agreement or other arrangements between providers and payors regarding what procedures or sites shall be precertified.
Author: Workers' Compensation Medical Services Board
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: New Rule: Filed August 9, 1996; effective September 13, 1996. **Amended:** Filed July 14, 1997; effective August 18, 1997.

480-5-5-.09 Procedure For Pre-Certification.

(1) Pre-certification review shall be conducted by telephone and/or facsimile during normal business hours (8:30 a.m. to 4:30 p.m. Central time, Monday through Friday, excluding legal holidays). Written requests may be processed by the RUE or employer/agent on a case-by case basis.

(2) The physician, hospital, or other provider shall initiate the process by calling the employer/agent at least 48 hours or two working days in advance, except for an emergency. The RUE or employer/agent shall respond with a review determination to the physician, hospital, or other provider- within 48 hours or two working days after the receipt of necessary information. If a patient does not enter the hospital or receive other medical

services on the proposed date or within 15 days following that date, rectification shall be required. In such cases, the caller shall contact the RUE or employer/agent to reaffirm the previously submitted data for recertification.

(a) The provider shall supply the following information to the employer/agent:

1. Employee's name;

2. Employee's identifying number;

3. Date of injury;

4. Employee's address;

5. Sex;

6. Employee's date of birth;

7. Name of provider or facility;

8. Provider's or facility's address;

9. Anticipated treatment or admission date;

10. Diagnosis (to include ICD-10-CM codes);

11. Expected length of stay, if applicable;

12. Major procedures and related CPT 4 codes;

13. Plan of treatment;

14. Complications or other factors requiring the setting requested;

15. Medical justification for planned treatment or inpatient admission;

16. Anticipated surgical procedure, if any;

17. General anesthesia requirement;

18. Attending physician's name;

19. Attending physician's address;

20. Attending physician's phone number;

21. Attending physician's tax ID or identifying number;

22. A brief summary of how the proposed procedure is related to the patient's work related injury; and

23. Caller's name and number.

(b) The provider shall furnish descriptive/narrative information and the RUE or employer/agent shall assist in providing the ICD-10-CM and/or CPT-4 codes.

(3) Criteria for Admission - All non-emergency hospital admissions shall be reviewed using generally accepted criteria to assess the need for the level of care.

(4) The criteria for length of stay shall be based on medical necessity and generally accepted criteria.

(5) Hospital admission requests that clearly conform to paragraph (3) of this Rule 480-5-5-.09 shall be approved and an initial length of stay may be assigned.

(6) Diagnosis or symptoms that do not conform to established clinical criteria shall be reviewed by a registered nurse or physician before approval for treatment or admission is issued.

(7) Physicians shall make the decision on all denials of certification, which constitutes the Second Level Clinical Review as set forth in Rule 480-5-5-.07. Any denial is subject to Peer Clinical Review (Third Level Clinical Review) as outlined in Rule 480-5-5-.07.

(8) A response shall be generated in writing (letter or facsimile) if the treatment or admission is denied. Verbal or facsimile response shall be given within two working days from the time of the receipt of all necessary information. Copies of the written response, if required, shall be sent to the requesting provider and shall notify the party of the right to appeal and the appeal process. The denial letter shall contain the following elements: claimant's name, identifying number and address; date of accident; date of requested service; procedure requested; name of provider or facility; reason for denial; and the appeals process. The claimant shall be copied on all denial letters.

Author: Workers' Compensation Medical Services Board
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: New Rule: Filed August 9, 1996; effective September 13, 1996. **Amended:** Filed March 8, 2001; effective April 12, 2001. **Amended:** Filed December 5, 2008; effective January 9, 2009. **Amended:** Filed April 26, 2016; effective June 10, 2016.

480-5-5-.10 Continued Stay Review Procedures.

(1) The RUE or employer/agent is responsible for initiating the medical necessity review for continued hospitalization before the initial assigned length of stay expires. The responsibility to request an extension may be delegated to the hospital, if requested by the hospital and agreed to in writing by the RUE or employer/agent.

(2) Continued stay review shall include telephone/on-site discussions/review with the hospital, or with the physician for the information required. All pertinent information necessary to determine if continued hospitalization is medically necessary shall be gathered (i.e., treatment, diagnosis, current medications and methods of administration used, frequency, lab values, and results of diagnostic tests).

(a) If continued stay is appropriate, additional days shall be based upon the medical condition of the patient and the treatment plan. This process shall continue until the patient is discharged.

(b) If continued stay is not medically necessary or appropriate, based upon documentation reviewed, the reviewing physician, Second Level Clinical Review as defined in Rule 480-5-5-.06 (3), shall issue a denial to the physician and hospital the same day of the review.

(3) The RUE or employer/agent shall use generally accepted criteria to assess the need for continued stay in the hospital. Physicians, board certified in the same or similar specialty as defined in Rule 480-5-5-.06 (4), Peer Clinical Review, (Third Level Clinical Review) or the specialty that normally treats the patient's condition shall review all adverse decisions and make the final decisions on all denials of certification. The appeals process Peer Clinical Review (Third Level Clinical Review) in Rule 480-5-5-.07 and/or 480-5-5-.23, may be followed in, cases of denied services disputes.

(4) The continued stay review process shall be used to identify and refer cases, for discharge planning pursuant to Rule 480-5-5-.24.

(5) The review shall include telephone or facsimile notification of the decision to the physician, hospital or other providers, and written notification of adverse decisions.

(6) The RUE or employer/agent shall maintain appropriate internal documentation to verify the process and the decision, for claims processing, reporting, and audit purposes.

(7) The RUE or employer/agent shall announce the results of the review process to the admitting/treating physician and the hospital in writing. The denial letter shall contain the following elements: employee's name, identifying number, and address; date of service; date of injury; name of provider and facility; pre-certification number; reason for denial and the appeals process.
Author: Workers' Compensation Medical Services Board
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: New Rule: Filed August 9, 1996; effective September 13, 1996. **Amended:** Filed December 5, 2008; effective January 9, 2009.

480-5-5-.11 Technical Considerations For Review (Bill Screening) Of Claims.

(1) Prior to a detailed medical review, a review of the claim shall be accomplished as a part of the initial bill screening process and shall include at least the following:

(a) Identifying the job related illness/injury;

(b) Identifying each service/item billed;

(c) Identifying the billing period;

(d) Determining that appropriate forms were used and filled out completely.

(2) If the review indicates that sufficient information is present, review of the claim shall proceed. If the review indicates information is lacking, the employer/agent shall take immediate and appropriate action, as outlined in Rule 480-5-5-.03(1), to obtain the information required.

(3) The determination of Medical Necessity/Cost Effective Setting shall:

(a) Be consistent with the diagnosis and treatment of a condition or complaint;

(b) Be consistent with the standard of care for good medical practice;

(c) Not be solely for the convenience of the patient, family, hospital, physician or other provider;

(d) Be in the most appropriate and cost effective medical care setting as determined by the patient’s condition; and

(e) Be the responsibility of the physician or other provider for the final decision regarding the setting in which the procedure is to be performed.

(f) Reimbursement shall be made according to the place of service in which the treatment or service was pre-certified.

(4) Confidentiality - When it is necessary to request additional information to clarify the need for services or to substantiate coverage for a claim being reviewed, the employer/agent shall take particular care to ensure that all of its employees adhere to strict policy guidelines regarding the claimant's privacy. If written material is required, the request shall be made in accordance with Rule 480-5-5-.03. The employer/agent shall require only sufficient information to allow a reviewer to make an independent judgment regarding diagnosis and treatment.

(5) In addition to the claim form, the following shall be the minimum documentation requirements of any documentation requested by the payer prior to payment in accordance with Rule 480-5-5-.03:

(a) Documentation for all services shall be legible and signed by the health care provider; and

(b) Submitted documentation shall contain sufficient data to substantiate the diagnosis and need for treatment on each date of service.

(c) To substantiate medical necessity:

1. The most complete and precise diagnosis shall be reported on the claim;

2. Service(s) billed shall be appropriate for the diagnosis;

3. Documentation in the clinical record (i.e., physical findings and historical data) shall confirm the diagnosis(es) and support the medical necessity and appropriateness of the medical service billed; and

4. Documentation shall be available for each service billed.

(6) Detection - The employer/agent shall conduct an ongoing program to detect the misuse of benefits through routine claims review, claims audit and the investigation of complaints. Referrals of misuse shall be made to the applicable agency.

(7) Complaints - Complaints from claimants, carriers, employers, physicians, other practitioners, health care facilities, referrals from internal areas of the Workers' Compensation Division, and other information concerning utilization review or bill screening

may be referred to an Ombudsman for medical dispute resolution whose decision is reviewable by the Medical Services Board.

(8) On-site Audit of Charges - The employer/agent shall be authorized to conduct an on-site audit, as stated in Rule 480-5-5-.25, of any provider of services related to a compensable injury or illness.
Author: Workers' Compensation Medical Services Board
Statutory Authority: Code of Ala. 1975, §25-5 293.
History: New Rule: Filed August 9, 1996; effective September 13, 1996.

480-5-5-.12 Physician Of Record.

(1) The employer's authorized treating physician (other than emergency medical services) shall be the physician of record for attending or referral purposes. All referrals shall be pre-approved by the employer/agent. The employer/agent shall keep all interested parties involved in the compensable case informed of any authorized change of treating physician.
Author: Workers' Compensation Medical Services Board
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: New Rule: Filed August 9, 1996; effective September 13, 1996.

480-5-5-.13 Emergency Care.

(1) Emergency Services - The provider who provides care under the "medical emergency" exception shall demonstrate that "emergency services" occurred as defined in Rule 480-5-5-.02.
Author: Workers' Compensation Medical Services Board
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: New Rule: Filed August 9, 1996; effective September 13, 1996.

480-5-5-.14 Second Or Opposing Surgical Opinion.

(1) When elective surgery has been recommended by the treating physician, the employee, subject to the limitations of Code of Ala. 1975, §25-5-77(b), or the employer/agent is entitled, but not required, to obtain a second professional opinion from a physician board certified in the same or similar specialty or the specialty that normally treats the patient's condition.

(a) Regardless of the second opinion, the employee remains free to elect not to undergo surgery after the consultation,

subject to the possibility of denial of benefits for refusal of said surgery.

(b) The employer/agent shall be responsible for informing the employee when a second surgical opinion is requested and for referring the employee to second surgical opinion physician.

(c) The designated physician of record shall be notified of the request in order to assist the coordination of related medical services. There shall be no duplication of medical services.

(2) The employer/agent shall have in place a process to request second surgical opinions.

(3) The employer/agent shall develop manual procedures or automated systems for administering program requirements, selecting consulting physician, documenting employee compliance with the program and efficiently handling employee and physician contacts.

(4) The fees for the consultation and any tests necessary for the consulting physician to render an opinion on the proposed surgery shall be paid by the employer/agent, if requested by the employer/agent.

(5) The same provisions in effect for a worker wishing to use a different physician shall be applied in cases of an opposing medical opinion. The patient shall ultimately maintain the right to accept or reject treatment, subject to the possibility of denial of benefits for refusal of said treatment.

(6) In the event of a dispute, the issue(s) may be resolved by an Ombudsman under Code of Ala. 1975, §25-5-77(i).
Author: Workers' Compensation Medical Services Board
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: **New Rule:** Filed August 9, 1996; effective September 13, 1996.

480-5-5-.15 Bill Screening.

(1) **Global Surgery Fees** - Ongoing services prior to surgery shall be covered on a fee-for-services basis. The global surgery allowance shall encompass the actual surgery procedure and normal post-operative services. Post-operative visits after six weeks from the date of surgery shall be reimbursable separately. The six week global period applies only to those codes which have been assigned a 90-day global period by Medicare. Global surgery fees include specialty surgical techniques such as, but not limited to, the use of microscopes, videoscopes or lasers, with the exception of unusual situations or extremely long procedures. Reimbursement,

in such cases, shall be handled with appropriate individual consideration for the circumstances. A separate charge for a history and physical examination shall be reimbursable for new patients. Global surgery fee includes any anesthesia administered by the operating surgeon.

(2) **Multiple Surgery Procedures**

(a) For operations performed by the same physician during the same operative session, at the same operative site, reimbursement shall be made at 100 percent (100%) for the procedure with the highest Workers' Compensation fee schedule allowance and 50 percent (50%) of the approved rate for all additional procedures which are medically necessary and not incidental to the other.

(b) For unrelated operations performed by the same physician in different body areas or systems during the same operative session, the multiple procedure reimbursement rule shall apply independently to each body system when the procedures are medically necessary and not incidental to the other procedures.

(c) When bilateral procedures that require preparation of a separate operative site during the same operative session are performed by the same physician, aggregate reimbursement shall be 180 percent (180%) of the allowance of the unilateral procedure.

(d) Certain codes, by the nature of their description, are never to be billed as primary procedures. The value assigned in the fee schedule has already been reduced as a secondary procedure and, therefore, the procedure should be reimbursed at 100 percent (100%) of the allowance. These codes may be identified by the description in the CPT manual specifying each additional service, i.e., 11001, 63091, 63057.

(3) **M.D. Assistant Surgeon** - Medicare guidelines shall be used to determine when payment for M.D. assistant surgeon is permitted. Reimbursement amounts shall be determined by multiplying the reimbursement made to the primary surgeon by 25 percent (25%).

(4) **Non-M.D. Certified Surgeon's Assistant** - Medicare guidelines shall be used to determine situations when payment for non-M.D. Certified Surgeon's Assistant shall be made. Reimbursement amounts shall be made at one-half the rate for M.D. assistant surgeon. Claims shall be billed using the appropriate HCFA modifier indicating services were performed by a non-M.D. Certified Surgeon Assistant.

(5) **Supplies and Materials**

(a) Certain supplies and materials provided by the physician may be listed and reimbursed separately. Braces and splints are reimbursable when they are provided for the treatment of injuries that do not involve fracture or dislocation care. The appropriate HCPCS code should be used. Braces and splints are reimbursable separately for the treatment of fractures or dislocations only in accordance with CPT guidelines. When requested, the provider shall furnish the payer a copy of the vendor's invoice for the supply item being billed.

(b) Routine inexpensive supplies such as ace bandages, gauze, tongue depressors, adhesive bandages, ointments or creams used in minimal quantities, etc., are not reimbursable as separate items.

(c) Ointments or creams dispensed in quantities intended for repeated use by the patient are reimbursable separately when properly itemized and appropriate.

(d) Sterile trays used in the process of performing minor office surgical procedures are included in the reimbursement for the procedure itself and are not reimbursable as a separate item.

(6) **Minor surgeries and endoscopies:**

(a) When the minor surgery or endoscopy is performed at the time of the initial visit and this procedure constitutes the major service rendered during the initial visit, payment shall be only for that procedure code. If Medicare has assigned a surgical procedure 10-day global period, then this procedure shall have a 10-day global period.

(b) If a significant separately identifiable cognitive service is also documented, the appropriate evaluation and management doe (established or new patient) with modifier – 25 is reimbursable. Billing for the evaluation and management code is not appropriate, if the physician only identified the need for the minor surgery or endoscopy procedure.

(7) When a procedure has been specified as a separate procedure (CPT-4 procedure code), the following applies:

(a) Some of the listed procedures are commonly carried out as an integral part of a total service, and, therefore, do not warrant a separate identification.

(b) When, however, such a procedure is performed independent of, and is not related to other services, it may be listed as a separate procedure.

(8) **Cosurgery and Team Surgery**

(a) Cosurgery involves two surgeons usually with different specialties who are performing a single procedure for a specific surgical problem. Payment when reporting the same surgical procedure is allowed at 150 percent (150%), divided between the two surgeons.

(b) Team surgery is when two or more surgeons with different skills are operating for different conditions. The procedure may be performed in the same or different operative site(s) (incisions). Each physician's reimbursement is considered independently. Multiple surgery rules apply to each physician's reimbursement.

(9) **Anesthesia Services** - Employers/agents or UREs shall utilize the current American Society of Anesthesiologists (ASA) Relative Value Guide when determining reimbursement for anesthesiology services:

(a) For determination of basic unit values;

(b) Physical status modifier units as identified in the ASA Relative Value Guide;

(c) Qualifying circumstance units as stated in the ASA Relative Value Guide; and

(d) Time units based upon 15-minute increments and/or fraction thereof.

1. Items listed below shall apply when professional fees are billed separately by either an M.D. anesthesiologist or Certified Registered Nurse Anesthetist (CRNA). When professional services are rendered by the M.D. Anesthesiologist or a CRNA who is in the employ of a facility, these professional services for the employed M.D. Anesthesiologist or employed CRNA shall be billed separately from the facility charges.

(i) When the M.D. anesthesiologist personally performs all anesthesia related services, payment shall be made to the M.D. anesthesiologist at 100 percent (100%) of the full fee schedule amount;

(ii) When the CRNA, who is not in the employ of the M.D. Anesthesiologist or facility and is not under the supervision of an M.D. anesthesiologist, personally performs all anesthesia related services, payment shall be made at 65 percent (65%) of the full fee schedule amount to the CRNA; and

(iii) When the M.D. anesthesiologist supervises a CRNA in the employ of the M.D. anesthesiologist, payment shall be as follows:

(I) Payment shall be made at 100 percent (100%) of the full fee schedule amount to the M.D. anesthesiologist; and

(II) No payment shall be made to the CRNA.

2. When the M.D. anesthesiologist supervises a CRNA in the employ of the facility, payment shall be made at 50 percent (50%) of the full fee schedule amount to the M.D. anesthesiologist. Payment for professional services provided by the CRNA shall be made at 50 percent (50%) of the full fee schedule amount and to the facility.

3. When the M.D. anesthesiologist supervises a CRNA who is not in the employ of an M.D. anesthesiologist or facility, payment shall be made at 50 percent (50%) of the full fee schedule amount to the M.D. anesthesiologist and 50 percent (50%) of the full schedule amount to the CRNA.

4. The M.D. anesthesiologist shall remain within the immediate vicinity of the CRNAs that are receiving medical direction, and shall not simultaneously extend supervision to more than four (4) anesthetists at one time.

5. When the M.D. anesthesiologist is acting as the operative surgeon in procedures such as pain management and blocks, the physician shall be reimbursed per the Maximum Fee Schedule for Physicians as appropriate for the procedure performed per the CPT-4 manual in current use. The M.D. anesthesiologist, in cases such as this, shall not charge for direction, supervision or performance of any anesthesia services.

6. When the M.D. anesthesiologist is acting as the deliverer of anesthesia for those services not addressed in the ASA Relative Value Guide a relative value of 4 base units shall be assigned with no time. Reimbursement shall be based on the 4 units and the Maximum Fee Schedule for Anesthesia.

7. When the M.D. anesthesiologist is acting as the deliverer of anesthesia for pain blocks a relative value of 4 base units shall be assigned. Billing shall include the 4 base units and the time expended for the performance of the procedure. Reimbursement shall be based on the 4 base units, 2 units of time, and the Maximum Fee Schedule for Anesthesia."

(i) When the operative surgeon requests monitoring by a CRNA, and anesthesia services is dictated by medical necessity, and the CRNA monitors the

anesthesia during the flat rate procedure, the CRNA shall be reimbursed at 50 percent (50%) of the Basic Unit Value allowed the M.D. anesthesiologist. The operative surgeon shall justify through documentation the medical necessity of the request.

(ii) When the CRNA is not medically directed by the M.D. anesthesiologist and medical necessity is met, the CRNA shall be reimbursed at 65 percent (65%) of the allowed amount or at 2.6 Basic Value Units per the Maximum Fee Schedule for Anesthesiologists.

8. When the M.D. anesthesiologist places specialized invasive monitoring devices, such as central venous catheters, arterial lines, and flow directed catheters (e.g., Swan-Ganz), the M.D. anesthesiologist shall be reimbursed per the Maximum Fee Schedule for Physicians as appropriate for the procedure performed per the CPT-4 manual in current use.

9. When the M.D. anesthesiologist is responsible for medically necessary postoperative pain management, payment shall be made as follows:

(i) For the insertion of continuous epidural catheter (CPT-4 code 62279) when placed the day of surgery or during the first postoperative day, provided the catheter was not used to deliver the anesthesia during the surgical procedure. This code includes placement of the catheter and injection of the anesthetic substance. Reimbursement shall be per the Maximum Fee Schedule for Physicians.

(ii) For the daily management of the epidural for a reasonable period of time over the subsequent postoperative days (CPT-4 code 01996). Daily management of the epidural shall not be allowed on the same day as insertion of the catheter.

(iii) Patient Controlled Analgesia (PCA) shall be reimbursed at four (4) basic units for initiation of pumps and evaluation of needs, regardless of the period involved.

(10) **Modifiers** - The CPT-4 Manual identifies all performed procedures that warrant the use of modifiers. Only those modifiers found in the guidelines to each section of the CPT-4 may be applied. Multiple surgery procedures have been addressed in Rule 480-5-5-.15(2). Modifiers shall be used only as medically necessary and appropriate. When multiple procedures are performed by the same provider on the same day or during the same session, reimbursement for Modifier -51 shall be made at 100 percent (100%) for the procedure with the highest Workers' Compensation fee

schedule allowance and 50 percent (50%) of the approved rate for all additional procedures which are medically necessary and appropriate and not incidental to the other. Other reimbursement adjustments shall be dependent upon the individual modifier and the Alabama Department of Industrial Relations Administrative Code, Utilization Management and Bill Screening Chapter.

(11) **Psychologist Services -** Psychologist services shall be reimbursed as follows:

(a) Central nervous system assessments/tests, as defined in the Physicians' Current Procedural Terminology Manual, performed by a clinical psychologist shall be reimbursed at 100 percent (100%) of the allowable amount as stated in the Maximum Fee Schedule for Physicians.

(b) All other clinical psychologist services, other than central nervous system assessments/tests, furnished outside of the hospital inpatient setting shall be reimbursed at 75 percent (75%) of the allowable amount as stated in the Maximum Fee Schedule for Physicians.

(c) Central nervous system assessments/tests, if ordered by a physician, performed by a non-clinical psychologist shall be reimbursed at 100 percent (100%) of the allowable amount as stated in the Maximum Fee Schedule for Physicians. All other services provided by a non-clinical psychologist shall not be reimbursable.

(12) **Physician Assistant/Nurse Practitioner -** Utilization of the physician assistant/nursing practitioner shall be defined as an extension of the authorized treating physician. These providers may perform procedures and treatments at the direction of the authorized treating physician in accordance with their certification and do evaluation and management of patients at a very minimal decision making capacity, such as:

(a) Evaluation and management of a new patient which requires a problem focused history, a problem focused examination, and straightforward medical decision making (CPT code 99201 or subsequent code); or

(b) Evaluation and management of an established patient that may not require the presence of a physician. Usually, the presenting problem is minimal (CPT code 99211 or subsequent code).

1. Any written documentation/report/statement by the physician assistant/nurse practitioner shall be approved and counter-signed by the treating physician within 48 hours or two working days of the visit.

2. If the treating physician employs a physician assistant/nurse practitioner, the M.D. treating physician shall obtain authorization from the employer/agent after the first visit for the physician assistant/nurse practitioner to provide continued service. The authorization shall determine the number of visits which shall require the treating physician's presence, and the number of visits that the physician assistant/nurse practitioner may examine/treat the patient without the presence of the treating physician.

3. The authorized treating physician must personally determine all return to work, work restrictions, maximum medical improvement, impairment ratings, and referrals as these are complicated medical decision issues which are impacted by legal issues within the Workers' Compensation Law.

(2) Reimbursement for the services of the physician assistant/ nurse practitioner shall be consistent with the following:

(a) The bill for services shall reflect whether a service was rendered by the M.D. physician or the non-physician practitioner. The modifier AN shall be used if services are solely provided by the physician assistant. The appropriate HCPCS modifier shall be used to indicate services that have solely been provided by the nurse practitioner.

(b) The fee for service shall be 100 percent (100%) of the fee schedule for treatments and procedures as directed by the M.D. physician. The appropriate evaluation and management code may be used when the M.D. physician is providing the services with the physician assistant or nurse practitioner augmenting or assisting in some capacity. If the physician assistant or nurse practitioner is the sole provider of service, then the evaluation and management codes are limited to 99201 or 99211, or subsequent code.

(c) No payment shall be allowed for evaluation and management services should it be determined by the employer/agent that the services were billed improperly and/or that the physician assistant or nurse practitioner was providing services other than simple straightforward evaluation and management services.

(d) Payment is to be made directly to the facility or physician that employs the physician assistant or nurse practitioner. Nurse practitioners who have their own independent practice may bill using the HCFA 1500 claim form and CPT/HCPCS codes.

(13) **NEW AND ESTABLISHED PATIENT** - The guidelines for determining if an injured worker will be classified as a new or established patient for the purposes of coding and billing for medical treatment shall be found in the Evaluation and Management (E/M) Services Guidelines of the Physicians' CPT-4.

(14) **INDEPENDENT MEDICAL EXAMINATION** - Physicians performing an independent medical examination shall code the service using CPT-4 Code 99245, Office Consultation, for the first eighty (80) minutes of time, CPT-4 Code 99354, Prolonged Physician Service, for the next thirty to seventy-four (30 - 74) minutes of time, and CPT-4 Code 99355, Prolonged Physician Service, for each additional thirty (30) minutes or fraction thereof, except pursuant to Code of Ala. 1975, §25-5-314, Contracts for medical services at mutually agreed rates.

(15) **ERECTILE DYSFUNCTION MEDICATION** - Workers' compensation will cover erectile dysfunction medication when used for the treatment of men with organic erectile dysfunction resulting from a definitive organic disorder as the result of a compensable work related injury. Organic impotence is defined as that which may be reasonably expected to occur following certain traumatic injuries or surgical procedures. Psychological or psychiatric reasons will not be accepted as organic impotence.

(a) Conditions that may result in organic erectile dysfunction are:

1. Spinal cord injuries;

2. Injuries to the genital and lower urinary tract;

3. Severe fracture of the pelvis that resulted in injury to the bladder or urethral pelvic nerves;

4. Surgery of the genital or lower urinary tract;

5. Removal of the rectum causing injuries to nerves or vessels resulting in erectile dysfunction; or

6. Any surgery that may interfere with the pelvic nerves or circulation.

(b) Coverage for up to five (5) tablets per 30 days may be provided if:

1. Treatment is being provided for an accepted workers' compensation claim;

2. One of the above conditions has been satisfied;

3. An evaluation has been conducted by an urologist to determine that an organic erectile dysfunction as herein described does exist; and

4. A letter is received from either the urologist, who performed the above subject evaluation, or from the treating physician stating the medical necessity of erectile dysfunction medication prior to the authorization of the prescription.

(16) **Explanation of Review (EOR) -** An EOR shall be issued with each payment for medical services rendered to an injured worker. The EOR at a minimum shall contain the following information:

(a) The medical provider's name, address, city, state, and zip code;

(b) The claimant's name, identifying number or patient account number, and the insurer's claim number;

(c) The employer, if self-insured, or the insurance company's name, address, city, state, zip code, and phone number;

(d) The review company's name, address, city, state, zip code, and phone number, if applicable;

(e) The third party administrator's name, address, city, state, zip code, and phone number, if applicable;

(f) The date of injury;

(g) The date the review was conducted;

(h) The ICD-10 code that identifies the principal diagnosis;

(i) The medical services that are reviewed:

1. The date the services were rendered;

2. The services shall be identified by the appropriate CPT, HCPCS;

3. The amount charged for each code that is listed;

4. Any adjustment to the billed dollar amount shall be stated and identified as a fee schedule, preferred provider organization (PPO) discount, and/or bill review discount; and

5. The amount recommended for payment.

(j) The reason or justification for the adjustment to the recommended payment amount; and

1. The name of the PPO Agreement, if applicable; or

2. Other specific justification for the adjustment.

(k) The business name, address, city, state, zip code, and phone number of the entity to contact, if the provider disagrees with the recommended payment. The initial and second reconsideration requests shall be directed to the payor or review company, as indicated on the EOR, before requesting assistance from the State.

Author: Workers' Compensation Medical Services Board
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: **New Rule:** Filed August 9, 1996; effective September 13, 1996. **Amended:** Filed July 14, 1997; effective August 18, 1997. **Amended:** March 8, 2000; effective April 12, 2000. **Amended:** Filed May 31, 2002; effective July 5, 2002. **Amended:** Filed July 19, 2005; effective August 23, 2005. **Amended:** Filed August 9, 2006; effective September 13, 2006. **Amended:** Filed December 5, 2008; effective January 9, 2009. **Amended:** Filed June 15, 2011; effective July 20, 2011. **Amended:** Filed April 26, 2016; effective June 10, 2016.

480-5-5-.16 Conflict Of Interest: Health Facility Owner-Ship By A Provider.

(1) All providers or payors performing or making referrals of workers' compensation cases to facilities in which the provider has an ownership interest, financial interest or fiduciary interest, shall notify the carrier, provider or their respective agent of such interest at the request of the employer, carrier or their respective agent.

Author: Workers' Compensation Medical Services Board
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: **New Rule:** Filed August 9, 1996; effective September 13, 1996.

480-5-5-.17 Optometric Services.

(1) **Covered Expenses**

(a) Only services and products necessitated by an on-the-job injury or illness shall be covered. Such services and, or products shall be provided as a result of damage to the eye(s) due to a work injury or exposure. In addition, lenses and contact lenses not originally purchased by the employer shall be repaired or replaced if damaged or broken in a work-related accident.

(b) There are three distinct types of covered services:

1. Professional;

2. Optical Fitting; and

3. Eye Appliance.

(c) The reimbursement allowed for contact lenses shall include the normal follow-up to check for proper fit, vision correction and comfort. Any other follow-up services routinely provided free of charge by the provider to other patient or customers shall be provided free of charge to workers' compensation claimants.

(2) **Benefit Detail and Limitations**

(a) Upgrades shall not be payable by the employer/agent unless specifically justified on medical grounds or as a replacement for eyewear of like-quality damaged in an on-the-job injury.

(b) Covered vision care services shall include examinations, lenses, frames, and contact lenses prescribed by at licensed physician (M.D. or D.O.), or by an optometrist (O.D).

(c) Lenses shall be like kind and quality and shall meet American National Standard Institute's standard Z80.1 or Z80.2.

(d) Standard eyeglass frames adequate to hold lenses which qualify for payment shall be covered. Any additional charges for "oversize" or designer frames shall be the claimant’s liability.

(e) Therapeutic contact lenses shall be covered if the patient's visual acuity cannot otherwise be corrected to 20/70 in the better eye or if they are the only effective treatment and shall be inclusive of the fee for the initial clearing and storage kits.

(f) The contact lens suitability examination shall be included in the dispensing fee if the claimant is able to wear contact lenses or payable as a separate expense if the claimant is unable to wear contact lenses.

(g) Prism, slab-off prism, and special base curve lenses shall be covered when prescribed due to their therapeutic necessity.

(h) Payment for covered frames and lenses shall be based on the provider's net acquisition cost.

1. Net acquisition cost shall include the frame, the lens ground on both sides with the edges ground for placement in the frame, plus laboratory cost associated with

mounting in the frame, and applicable sales tax. The component of net acquisition cost shall consist of:

(i) Material costs:

(I) Cost (including shipping and handling) of lens blank purchased directly from the manufacturer or wholesaler; and

(II) Rose tints or their equivalent, when prescribed for therapeutic reasons;

(ii) Laboratory Costs:

(I) Grinding to prescription;

(II) Safety hardening;

(III) Drop ball testing;

(IV) Coating and edging;

(V) Application of tints when prescribed, if not provided by manufacturer;

(VI) Assembly; and

(VII) Laboratory overhead.

(iii) Applicable Sales Tax

(3) The dispensing fee shall compensate a provider for dispensing lenses and frames pursuant to this Rule. It shall include measuring and verifying the lenses as well as selecting, fitting, and adjusting the frames. There shall be a unique reimbursement for single vision, bifocal, or trifocal lenses. Contact lenses and special lenses shall be given individual consideration based on reported details and circumstances.

(4) Reimbursement shall be based upon the Maximum Fee Schedule for Optometrists or a mutual agreement pursuant to Code of Ala. 1975, §25-5-314.
Author: Workers' Compensation Division
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: New Rule: Filed August 9, 1996; effective September 13, 1996.

480-5-5-.18 Chiropractic Services.

(1) **Initial Evaluation**

(a) An evaluation shall be performed to determine if a patient will benefit from chiropractic services.

(b) Where a chiropractor examines a patient and an evaluation for chiropractic services is performed, the billing of the office visit shall include the initial evaluation.

(c) For acute cases, up to three (3) visits during the certification process may be allowed after the initial evaluation, if same day certification cannot be obtained. If subsequent pre-certification results in an adverse determination, reimbursement shall be allowed for the initial evaluation and up to three visits during the certification period, if medically necessary and the treatment is for a c compensable injury .

(2) **Qualifications for Reimbursement**

(a) The patient's condition shall have the potential for restoration of function.

(b) The chiropractor care shall be specific for the improvement of the patient's condition.

(c) The chiropractic care shall be provided under a current written plan of care.

(3) **Plan of Care**

(a) A plan of care shall be developed and filed with the RUE or employer/agent.

(b) The plan of care content, at a minimum, shall include, but may not be limited to, the following:

1. The potential degree of restoration and measurable goals;

2. The specific services to be provided including the estimated frequency and estimated duration of each; and

3. The estimated duration of the treatment regimen.

(c) The chiropractor shall be responsible for providing documentation of medical necessity to the RUE or employer/ agent when there are questions regarding the extent of chiropractic services being provided or appropriateness of the treatment regimen.

(d) The plan of care shall be updated at least every 30 days, if goals and objectives as set out in the treatment plan are not being met, and the revised plan is approved by the RUE or employer/agent.

(e) The appropriate CPT-4 procedure code shall be used when billing for an initial evaluation.

(4) **Manipulations**

(a) Definition of body areas for workers' compensation:

1. The "spine" shall be the posterior region of the trunk including the cervical, thoracic, lumbosacral, and sacroiliac areas;

2. The "upper extremity" shall be the upper limb including the shoulder, upper arm, elbow, forearm, wrist and hand; and

3. The "lower extremity" shall be the lower limb including the hip, thigh, knee, leg, ankle and foot.

(b) Billing for workers' compensation:

1. The appropriate CPT-4 procedure code shall be used when billing for a manipulation of one area; and

2. The appropriate CPT-4 procedure code shall be used when billing for manipulation of each additional area.

3. Manipulation codes may be billed at each visit but may not be billed in conjunction with an office visit or any other evaluation and management code.

4. The appropriate CPT procedure code may be used to bill for an office visit, but may not be used in conjunction with manipulation codes.

(c) Reimbursement:

1. No more than one visit per day for the purpose of manipulation(s) is recommended without prior certification;

2. Reimbursement for manipulation(s) is limited to two body areas (a combination of the spine and one extremity, or two extremities); and

3. Reimbursement for manipulation(s) shall be limited to the Maximum Fee Schedule for Chiropractors or mutual agreements pursuant to Code of Ala. 1975, §25-5-314 for each area.

(5) **Modalities and Procedures**

(a) The following three body areas, or any portions thereof, shall be recognized for the provision of modalities and procedures:

1. The "trunk" shall be the entire body including the spines, excluding the head and limbs (Synonym: Torso); or

2. Any two extremities:

(i) An "upper extremity" shall be the upper limb including the shoulder, upper arm, elbow, forearm, wrist and hand.

(ii) A "lower extremity" shall be the lower limb including the hip, thigh, knee, leg, ankle and foot.

3. The head.

(b) Billing:

1. Single Modality/Procedure.

(i) The appropriate CPT-4 procedure code and the unique descriptor for each shall be used when billing for a single (one) modality or procedure to a single body area.

(ii) Billing for a single therapeutic procedure shall presume up to 15 minutes.

(iii) Physical medicine modalities that do not require direct (one-on-one) patient contact by the provider are not billed and reimbursed on a time-oriented basis.

(iv) Medical necessity and actual treatment time shall be documented in the patient's record.

2. Multiple Body Areas

(i) When chiropractic services are billed for more than one body area, there shall be more than one diagnosis code and descriptor in Element 23 and the reference numbers 1, 2, 3, etc., shall be listed in 24D of the HCFA 1500.

(ii) When chiropractic services are provided to more than one body area, modifier-51 shall be added to the procedure code(s) billed for the additional body area.

(iii) Reimbursement

(I) No more than one visit per day for the purpose of chiropractic service is recommended without prior certification.

(II) Reimbursement for additional time shall be in accordance with the appropriate CPT-4 procedure code for each body area treated regardless of the procedure codes used for orthotics training, prosthetic training, therapeutic activities requiring direct patient contact by the provider or training in activities of daily living.

(III) Reimbursement for chiropractic services to a single body area shall be limited to the Maximum Fee Schedule for Chiropractors for the applicable procedure code or mutual agreement pursuant to Code of Ala. 1975, §25-5 314.

(IV) Reimbursement for chiropractic services shall be limited to two body areas.

(V) The RUE or employer/agent shall compare the billing with the plan of care to ensure that only the services that are itemized in the plan of care are reimbursed.

(VI) The CPT-4 procedure code for Hubbard Tank shall not be reimbursed unless full body immersion chiropractic service is medically necessary and prescribed.

(VII) All chiropractic care is subject to peer clinical review (Third Level Clinical Review) by a chiropractor, trained in utilization review principles, as specified in Rule 480-5-5-.06.

(6) **Re-evaluation**

(a) A re-evaluation of an established patient shall be reimbursed in addition to physical medicine only when:

1. There is a definitive change in the patient's condition;

2. The patient fails to respond to treatment;

3. The patient reaches maximum medical improvement or is ready for discharge; or

4. It is medically necessary to provide evaluation services over and above those normally provided during therapy services.

(b) The provider shall submit documentation with the HCFA 1500 to substantiate the medical necessity for the services over and above the evaluative services normally performed during chiropractic treatments.

(c) The appropriate CPT-4 procedure code shall be used when billing for a re-evaluation.

(7) **Tests and Measurements**

(a) Extremity Testing, Muscle Testing and Range of Motion Measurements shall be reimbursed only once in a 30-day period for the same body area.

(b) When two or more extremity testing, muscle testing and range of motion procedures are performed on the same day, reimbursement shall not exceed the Maximum Fee Schedule for physician for the procedure code for total evaluation of the body, including hands.

(c) The appropriate physical performance test or measurement procedure code shall be used when a physical performance test or measurement is performed by means of mechanical equipment.

(d) The physical performance test or measurement procedure code includes a printout of test results and separate reimbursement shall not be made under procedure code for analysis of information data stored in computer.

(8) **Diagnostic Imaging**

(a) A decision on whether or not to use diagnostic imaging studies shall be made following a carefully performed history, physical and regional evaluation, and consideration of cost/ benefit/radiation exposure ratios. The decision shall be based on sound clinical reasoning and the likelihood that significant information may be obtained from the study regarding diagnosis, prognosis and therapy and shall be consistent with the pre-certification requirements of Rule 480-5-5-.08.

Author: Workers' Compensatory Division
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: **New Rule:** Filed August 9, 1996; effective September 13, 1996.

480-5-5-.19 Physical Therapy/Occupational Therapy/Speech Therapy Services.

(1) **Applicability** - The following shall apply to non-physician therapy providers (hospital outpatient, freestanding, and independent practicing facilities). Practicing physical

therapists, physical therapist assistant, occupational therapists, occupational therapists assistants and speech therapists shall be currently licensed or certified.

(2) **The following criteria shall be met for therapy to qualify for reimbursement:**

(a) The patient's condition shall have the potential for restoration of function and require a skilled level of care;

(b) The therapy shall be specific for the improvement of the patient's condition;

(c) The therapy shall be provided under a current plan of care which is developed by the therapist, a copy of which is sent to and approved by the referring physician and substantiated in the physician's office notes and in the therapist’s office notes; and

(d) The referring physician shall concur, and upon request, submit to the employer/agent or RUE documentation substantiating the medical necessity of therapies ordered.

(e) For acute cases, up to three (3) visits during the certification process may be allowed after the initial evaluation, if same day certification cannot be obtained. If subsequent pre-certification results in an adverse determination, reimbursement shall be allowed for the initial evaluation and up to three visits during the certification process, if the treatment is medically necessary and is for a compensable work injury.

(3) **Plan of Care**

(a) On the initial visit, a therapist shall 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 referring physician's orders. The therapist shall obtain pre-certification for the treatment plan from the RUE or employer/agent subsequent to the initial evaluation.

(b) After the initial visit, the written plan of care shall be forwarded from the therapist to the RUE or employer/agent and to the referring physician within five (5) working days for review and retention in the patient's records.

(c) The referring physician shall acknowledge that the plan is approved and medically necessary by signing the plan of care. A signed copy of the original plan of care shall be returned to the therapist.

(d) At a minimum, but not limited to, the plan of care shall contain:

1. The potential degree of restoration and measurable goals;

2. The specific therapies to be provided including the frequency of each treatment; and

3. The estimated duration of the therapeutic regimen.

(4) **Plan of Care Review**

(a) The therapist shall review the plan of care at least every 30 days to evaluate the treatment results with the plan of care goals and make necessary revision recommendations to the referring physician and the RUE or employer/agent.

(b) When revisions are made to the plan per the referring physician's recommendations, the therapist shall forward the revised plan to the RUE or employer/agent and referring physician for review and approval.

(c) When a revised plan of care is approved, the referring physician shall sign the revised plan, retain a copy for the patient's record and return the revised plan to the therapist.

(d) Upon receipt of the approved, revised plan of care from the referring physician, the therapist shall forward a copy of the revised plan of care to the RUE or employer/agent for certification.

(5) **Initial Assessment**

(a) Billing - The initial, written assessment developed by the therapist shall be reported to the RUE or employer/agent using the appropriate HCPCS procedure code.

(b) Reimbursement

1. Only one initial evaluation treatment assessment per injury shall be recommended for reimbursement without prior approval of the RUE or employer/agent. Re-evaluations shall be billed using the appropriate HCPCS procedure code.

2. Reimbursement for the use of additional initial assessment time shall not be allowed, unless supported by documentation.

3. Assessment of the patient's status shall include assessment of the neuromuscular system and reimbursement shall not be made for neuromuscular testing codes, extremity testing codes and/or range of motion codes in addition to the initial evaluation. These codes shall not

be used instead of the initial evaluation code when an initial assessment is performed.

(6) **Modalities and Procedures**

(a) Body Areas - The following three body areas, or any portions thereof, shall be recognized for the provision of modalities and procedures:

1. The trunk: the entire body including the spine excluding the head and limbs (Synonym: Torso);

2. Any two extremities;

(i) An upper extremity shall be the upper limb including the shoulder, upper arm, elbow, forearm, wrist and hand.

(ii) A lower extremity shall be the lower limb including the hip, thigh, knee, leg, ankle, and foot.

3. The head.

(b) Billing

1. Single Procedure/Modality.

(i) The appropriate CPT-4 procedure code and the unique descriptor for each shall be used when billing for a single (one) modality or procedure to a single body area.

(ii) Billing for single therapeutic procedures presumes up to 15 minutes unless otherwise indicated by the appropriate CPT-4 procedure code.

(iii) The appropriate CPT-4 procedure code shall be used when therapeutic exercises are performed regardless of whether or not mechanical equipment is used.

2. Multiple Body Areas

(i) When physical medicine therapies are provided to more than one body area, modifier-51 shall be added to the procedure code(s) billed for the additional body area.

(ii) When therapy is billed for more than one body area, there shall be more than one diagnosis code and descriptor in Element 23 and the reference numbers 1, 2, 3, etc., shall be listed in 24D of the HCFA 1500 Form.

(iii) Reimbursement

(I) No more than one visit per day for the purpose of therapy shall be recommended for reimbursement without being precertified by the RUE or employer/agent.

(II) Reimbursement for additional time shall be in accordance with the certified plan of care, the nature and severity of the condition(s).

(III) The RUE or employer/agent shall compare the billing with the plan of care to ensure that only the services that are itemized in the plan of care are reimbursed.

(IV) Unless full immersion therapy is medically necessary and prescribed, the CPT-4 procedure code for Hubbard Tank shall not be recommended for reimbursement.

(7) **Tests and Measurements**

(a) Extremity Testing, Muscle Testing, and Range of Motion Measurement shall be recommended for reimbursement only once in a 30-day period.

(b) When two or more procedures from muscle testing or range of motion codes are performed on the same day, reimbursement shall not exceed the prevailing charge for total evaluation for the body, including hands, unless approved by the RUE or employer/agent.

(c) The physical performance test or measurement procedure code shall be used when physical performance test or measurement is performed by means of mechanical equipment or standardized testing procedures.

(d) The procedure code for physical performance test or measurement shall include a printout of test results Separate reimbursement shall not be made under the CPT-4 procedure code for analysis of information data stored in computer.

(8) **Transcutaneous Electrical Nerve Stimulation (TENS)**

(a) TENS shall be provided to the injured worker when ordered by the physician, itemized in the plan of care, and authorized by the RUE or employer/agent.

(b) The procedure code for application of TENS shall be used to report TENS testing and training.

(c) Reimbursement for TENS testing and training shall be limited to four sessions per injury unless prior approval is obtained from the RUE or employer/agent;

(d) The procedure code for application of surface (transcutaneous) neurostimulator shall not be used to bill for electrical stimulation therapy. Providers shall use the appropriate physical medicine CPT-4 procedure code for electrical stimulation therapy.

(e) Billing for TENS Equipment

1. When the physician recommends TENS for long-term therapy, authorization shall be obtained from the RUE or employer/agent for rental or purchase of equipment for the patient on the most cost-effective terms.

2. The appropriate HCPCS code shall be used for either rented or purchased TENS equipment.

(9) **Medical Rehabilitation Supplies**

(a) Dressings that must be removed before treatment and replaced after treatment shall be billed and reimbursed under the appropriate HCPCS code.

(b) Rehabilitation supplies that are patient specific shall be billed using the appropriate HCPCS code.

(10) **Fabrication of Orthotics**

(a) The appropriate CPT-4 procedure code shall be used by the therapist for orthotics training.

(b) Supplies shall be billed separately under the appropriate HCPCS code.

(c) The cost of the orthotic shall include the cost of fabrication.

(11) **Work Conditioning/Hardening Program**

(a) Work conditioning assessment or a work hardening assessment shall be conducted prior to the request for either program and submitted to the RUE or employer/agent. Services shall be precertified and authorization from the RUE or employer/agent shall be received prior to providing services. No health care provider shall refer the employee to another health care provider, diagnostic facility, work conditioning/ hardening program, therapy center or other facility without prior authorization from the RUE or employer/agent. Providers shall render services that are medically necessary. Services shall be delivered in specific areas of expertise by

registered, certified, licensed or degreed personnel or shall be performed substantially in their presence and shall be provided on a regular continuing basis.

(b) Billing Information

1. The HCFA 1500 (UB92 for hospitals) shall be used to bill for services rendered.

2. The facility shall enter the appropriate CPT-4 or HCPCS codes as identified in the Maximum Fee Schedule for Physical Therapists.

3. Services shall be billed using a total or global charge concept.

(i) The bill shall include charges for the performance of the basic professional service and the normal range of essential, associated services provided to achieve the objective of the program.

(ii) Licensed personnel, including physicians, serving as part of the interdisciplinary team, shall not bill separately for their services. These services shall be included in the total cost of the program and their reimbursement shall be made through the facility.

4. Any physician or other provider serving on a consulting basis whose services have been authorized by the RUE or employer/agent in addition to the interdisciplinary team's services, shall bill on HCFA 1500.

(c) Work Conditioning Program

1. Work conditioning program utilizes physical conditioning and functional activities related to work. Work conditioning shall not begin after 365 days have elapsed following the injury without a comprehensive interdisciplinary assessment.

2. With pre-authorization from the RUE or employer/agent, work conditioning shall be reimbursed a maximum of four weeks with provisions that additional two-week increments may be approved by the RUE or employer/agent if substantial improvement is demonstrated by the patient.

3. To be eligible for work conditioning the patient shall:

(i) Have stated or demonstrated a willingness to participate;

(ii) Have identified systemic neuro-musculo-skeletal physical and functional deficits that interfere with work; and

(iii) Be at the point of resolution of the initial or principal injury that participation in the work conditioning program would not be prohibited.

4. The work conditioning program requires a maximum of four hours per day, five days per week, up to eight weeks.

5. The work conditioning program shall be provided by or under the direct supervision of a licensed physical therapist although other professionals may be work conditioning providers.

6. Progress shall be documented and reviewed to ensure continued progress.

7. The exit/discharge criteria for work conditioning shall include, but is not limited to, the patient:

(i) Meeting the program goals;

(ii) Developing behavioral or vocational problems which are not being addressed and which interfere with return to work;

(iii) Having medical contraindications;

(iv) Failing to comply with the requirements of participation;

(v) Reaching a plateau prior to meeting goals; or

(vi) Being discontinued by the referral source.

8. The exit/discharge summary shall include:

(i) Reason(s) for program termination;

(ii) The patient's clinical and functional status;

(iii) Recommendation(s) regarding return to work; and

(iv) Recommendation(s) for follow-up services.

9. The appropriate CPT-4 procedure code shall be used to bill for work conditioning.

(d) Work Hardening Program

1. Work hardening is a highly structure, goal Oriented, individualized treatment program designed to maximize the employee's ability to return to work. A work hardening program shall include real or realistically simulated job tasks based on a job description or analysis of the actual job, if a specific job is available, or on the physical demand factor of the occupational objective of the employee. These programs utilize real or simulated work activities in conjunction with conditioning tasks.

2. With pre-authorization from the RUE or employer/agent, work hardening shall be reimbursed a maximum of four weeks with provisions that additional two-week increments may be approved by the RUE or employer/agent if substantial improvement is demonstrated by the patient.

3. Entrance/admission criteria shall enable the program to admit:

(i) Persons who are likely to benefit from the program;

(ii) Persons whose current level of functioning due to illness or injury interferes with their ability to carry out specific tasks required in the work place; and

(iii) Persons whose medical condition does not prohibit participation in the program.

4. The Work Hardening Program requires a minimum of four hours per day except for the initial phase (one week) due to the patient’s inability to tolerate the full session. During the initial phase there is a two-hour per day minimum. Eight hour days shall be allowed only for the final week of work hardening. The Work Hardening Program may continue up to eight weeks.

5. The individualized work hardening plan shall be supervised by a licensed physical or occupational therapist and/or physician within a therapeutic environment. Although some time is spent on a 1:1 basis, more than 50 percent (50%) of the time is self-monitored under the supervision of a physical or occupational therapist and/or physician. Recommended group size is no larger than 5:1.

6. Progress shall be documented and reviewed to ensure continued progress.

7. Simultaneous utilization of work conditioning and work hardening shall not be allowed. Prior authorization shall

be required for either one of these services and requires documentation of specific goals and outcomes.

8. The exit/discharge criteria for work hardening shall include, but is not limited to, the patient’s:

(i) Returning to work;

(ii) Meeting program goals;

(iii) Declining further services;

(iv) Noncompliance with organizational policies;

(v). Limited potential to benefit; or

(vi) Requiring further health care interventions.

9. The exit/discharge summary shall delineate the person's:

(i) Present functional status and potential; and

(ii) Functional status related to the targeted job, alternative occupations, or competitive labor market.

10. The appropriate CPT-4 procedure code for the initial 2 hours and the appropriate CPT-4 procedure code for each additional hour shall be used to bill work hardening.

(e) A Functional Capacity Evaluation (FCE) may be performed to evaluate the injured worker’s functional/vocational status and when performed shall document a bench mark from which to establish an initial plan. This process shall follow the guidelines of the Commission for Accreditation of Rehabilitation Facilities, to include one or more of the following FCEs:

1. Baseline Evaluation of functional ability to perform work activities that includes the physical demand factors in the Dictionary of Occupational Titles;

2. Job Capacity Evaluation of the match between the individual's capabilities and the critical demands of a specific job;

3. Occupational Capacity Evaluation of the match between the individual's capabilities and the critical demands of an occupational group; or

4. Work Capacity Evaluation of the match between the individual's capabilities and the demands of competitive employment.

Author: Workers' Compensation Division
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: **New Rule:** Filed August 9, 1996; effective September 13, 1996.

480-5-5-.20 Hospital Services.

(1) **Covered Services** - Reasonable and necessary hospital care medical services for an occupational illness or injury including acute-care hospital inpatient, outpatient, and rehabilitation facilities, shall be reimbursable as stated in Rule 480-5-5-.04(3), if the services rendered are related to the compensable illness or injury and are ordered and certified by the attending physician.

(2) **Reimbursement** - If the claimant is receiving treatment for both compensable and noncompensable medical conditions, only those services provided in treatment of compensable conditions shall be listed on claim forms submitted to the adjudicator unless the noncompensable condition has a direct bearing on the treatment of the compensable condition. In addition, payments from private payors for noncompensable conditions shall not be listed on claim forms submitted to the employer/agent.

(a) The statement of charges shall be made in accordance with standard coding methodology as described in Rule 480-5-5-.04.

(b) When requested, the facility shall submit a copy of the outpatient charge master to the Department of Industrial Relations Workers' Compensation Division for the Ombudsman Program, or an itemized listing of the individual items and services that contribute to the outpatient charges.

(c) Inpatient reimbursement shall be limited to the prevailing reimbursement as described in Rule 480-5-5-.04(3) for participating and nonparticipating hospitals or limited to the lesser negotiated rates for privately contracted hospitals pursuant to Code of Ala. 1975, §25-2-314. The formula for calculating a per diem payment amount shall be "Per Diem Rate x Inpatient Days = Per Diem Amount." Any variations form a pure per diem payment methodology shall be controlled by the language of the agreement or statutory committee statement.

(d) Outpatient reimbursement shall be covered charges minus the applicable outpatient discount percentage (O.P.%) as stated in any participating hospital agreement or any nonparticipating hospital committee statement for reimbursement. The formula for calculating payment amount shall be "Billed Charges - Noncovered Charges = Covered Charges x O.P.% = Discount Amount. Covered Charges Discount Amount = Payment Amount."

(e) Professional medical services rendered on an outpatient basis by providers such as medical doctors, physical therapists, occupational therapists, speech therapists, or other providers as allowed pursuant to these rules and each provider's practice act, shall be reimbursed based on the appropriate provider's Maximum Fee Schedule. Any facility fees associated with delivery of these professional medical services shall be reimbursed at covered charges minus the outpatient percentage discounted amount. The formula for calculating payment is specified in (2)(d) of this Rule 480-5-5.20.

Author: Workers' Compensation Division
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: **New Rule:** Filed August 9, 1996; effective September 13, 1996.

480-5-5-.21 Prescribed Medications.

(1) **Prescribed Medication Services**

(a) "Medicinal drugs" or "drugs" shall be defined as "legend" or "prescription" drugs that may only be dispensed when prescribed by a currently licensed provider authorized by law to prescribe drugs.

(b) "Medicines" shall be defined as drugs prescribed by an authorized health care provider and include generic drugs or single-source patented (brand name) drugs for which there is no generic equivalent.

(c) Whenever medically appropriate, a pharmaceutical and therapeutically equivalent drug product may be selected by a physician or other authorized practitioner in accordance with the requirements of Code of Ala. 1975, §34-23-8.

(d) Reimbursement

1. Reimbursement to the provider shall not exceed the amount calculated by the pharmaceutical reimbursement formula for prescribed drugs as specified in the Maximum Fee Schedule for Pharmaceutics.

2. The provider shall bill for prescription drugs or "medicines" on the appropriate form as stated in Rule 480-5-5-.22.

(e) **Reimbursement Formula/Methodology**

1. The pharmaceutical reimbursement formula for prescribed drugs is contained in the Maximum Fee Schedule for pharmaceutics.

(i) Average Wholesale Price (AWP) shall be determined from the most recent issue, including updates, of Drug Topics Red Book, Prescription Pricing Guide, American Druggist Blue Book, or similar pharmaceutical publications.

(ii) The reimbursement amount shall be determined by multiplying the AWP by the percent factor as published in the Maximum Fee Schedule for Pharmaceutics and adding the dispensing fee.

(2) "Patent" or "Proprietary Preparations"

(a) Billing

1. Pharmacists shall bill and be reimbursed their usually and customary charge for any "over-the-counter drug."

2. The reimbursement formula shall not apply to "over-the-counter drugs" and no dispensing fee shall be reimbursed.

3. The following data shall appear on the billing form:

(i) Employee's Name;

(ii) Employee's Address;

(iii) Employee's Identifying Number;

(iv) Date Prescription was Filled;

(v) Prescription Number;

(vi) National Drug Code;

(vii) Drug Name;

(viii) Drug Quantity;

(ix) Total Charge;

(x) Employee's or Pharmacist's Signature; and

(xi) Provider's Name and Address.

Author: Workers' Compensation Division
Statutory Authority: Code of Ala. 1975, §25-5-293
History: **New Rule:** Filed August 9, 1996; effective September 13, 1996. **Amended:** Filed December 5, 2008; effective January 9, 2009.

480-5-5-.22 Approved Standardized Medical Reimbursement Forms.

(1) The following approved standardized reimbursement forms shall be used by providers as indicated below. Each form shall be completed in its entirety and shall comply with the Alabama Maximum Fee Schedule coding, if available.

(a) Providers: physicians; optometrists; chiropractors; durable medical equipment suppliers; diagnostic facilities; laboratory facilities; independently based speech therapy, physical therapy, and occupational therapy centers; home health providers; and other professional medical services. Professional medical services provided pursuant to Rule 480-5-5-.20(2)(e),e.g., medical doctors, physical therapists, etc.

1. Form: HCFA 1500 as currently revised with all subsequent revisions. Office notes and/or supporting documentation directly relating to the services provided are required to be attached to the HCFA 1500.

(b) Providers: hospitals and ambulatory surgical centers. Hospital outpatient technical services or facility fees provided in support of professional services as stated in Rule 480-5-5-.20(2)(e).

1. Form: UB-92 as currently revised with all subsequent revisions and itemized billing.

(c) Providers: licensed pharmacists dispensing pharmaceutical to their patients for pharmaceutical claims.

1. Form: The current Pharmacy Universal Claim Form or the National Council for Prescription Drug Programs (NCPDP) form and subsequent revisions or any form which contains the data as outlined in Rule 480-5-5-.21(2)(a)3.

(d) Providers: dentists.

1. Form: J510 (ADS85) Dental Form as currently revised and all subsequent revisions with chart notes.

(2) This rule is not intended to and shall not be deemed to supersede any agreement or other arrangements between providers and payors for the submission of claims, medical records, and any other claims related data.

Author: Worker's Compensation Medical Services Board
Statutory Authority: Code of Ala. 1975, §§25-5-3 and 25-5-293.

History: New Rule: Filed August 9 1996; effective September 13, 1996. **Amended:** Filed February 25, 1998; effective April 30, 1998.

480-5-5-.23 Appeals Process For Utilization Review Bill Screening, Peer Clinical Review And Denial Or Revocation Of Utilization Review Certificate.

(1) Adverse decisions rendered under Rule 480-5-5-.08 or 480-5-5-.10 regarding medical necessity shall be subject to peer review and/or administrative appeal at the request of any party as follows:

(a) Peer Clinical Review

1. All UREs or employers/agents shall have in place an appeal process through Peer Clinical Review (Third Level clinical Review) when an adverse decision is rendered.

2. The Peer Clinical Review (Third Level Clinical Review) process shall be initiated by the provider contacting the RUE or employer/agent by telephone or other immediate means following receipt of the decision to be followed by a written request that shall include medical records and/or data needed to reach a decision.

3. The Peer Clinical Review (Third Level Clinical) request shall be evaluated in accordance with Rule 480-5-5-.07. The reviewer shall make a decision within 30 calendar days, unless an expedited appeal pursuant to Rule 480-5-5-.07 is required.

(i) If the Peer Clinical Review (Third Level Clinical Review) decision is a reversal of noncertification or denial, the admitting physician, hospital or other provider shall be immediately notified via telephone and a follow-up letter or facsimile shall be sent to the physician, hospital or other provider.

(ii) If the Peer Clinical Review (Third Level Review) decision upholds noncertification or denial, the adjudicator shall verbally notify the admitting physician, hospital or other provider and shall immediately submit in writing the denial and case documentation to the requesting party and any other provider involved in the case.

(b) Administrative Appeal

1. Administrative appeals may be requested at the option of any party, by filing a letter of request with the Workers' Compensation Division.

(i) Medical Dispute Resolution

(I) Any adverse determination, resulting from the Peer Clinical Review (Third Level Clinical Review) process, may be submitted to medical dispute resolution at the written request of any party. Notice shall be given to all parties and the dispute may be decided by an Ombudsman after an informal hearing and/or an examination of the record. If the parties agree, the dispute may be presented to an Ombudsman for an alternative dispute resolution hearing through the mediation process. Decisions shall be rendered within 60 days of a hearing.

2. A party to a medical dispute that remains unresolved after a review of medical services has been accomplished pursuant to Code of Ala. 1975, §25-5-77(i), may petition the circuit court for relief. Medical dispute resolution through mediation in the Ombudsman Program is not a prerequisite to petitioning the circuit court for ruling.

(2) **Denial or Revocation of OUR Certificate** - Administrative appeal for denial or revocation of a certificate to a qualified Utilization Review Entity as described in Rule 480-5-5-.05 or 480-5-5-.06 shall be submitted in writing to the Workers' Compensation Division.

(a) The appealing party shall request a hearing on the denial or revocation within 30 days of the date of the receipt of the notice to deny or revoke. Failure to mail a request for hearing within the time prescribed shall result in the denial or revocation becoming effective 60 days from the date of mailing of the original notice. In no event shall any denial or revocation become effective prior to the date that a hearing is scheduled. The Department's written notice shall be by certified or registered mail to the interested parties.

(b) A Hearings Officer shall conduct a hearing on the denial or revocation of a certificate, in accordance with the Department of Industrial Relations Administrative Code, Rule 480-1-4 and render a decision.

(c) Further appeal may be petitioned with the circuit court whose jurisdiction includes the plaintiff’s last known business address.

Author: Workers' Compensation Medical Services Board
Statutory Authority: Code of Ala. 1975, §25-5-293.

History: New Rule: Filed August 9, 1996; effective September 13, 1996.

480-5-5-.24 Discharge Planning Procedures.

(1) Discharge planning shall be the joint responsibility of the RUE or employer/agent and the facility. The RUE or the employer/agent shall work with the facility's discharge planning department to ensure continuity of care as directed by the physician from the facility to the alternative care setting.

(2) The facility shall identify to the RUE or employer/agent patients who need discharge planning. The RUE or employer/agent shall identify and assist the facility with information on statutory coverage and alternative providers, and monitor facilities to assure that appropriate discharge planning services are provided. The facility discharge planning department shall recommend to the RUE or employer/agent medically necessary services are resources which will ensure continuity of care from the facility to the alternative care setting.

(3) The RUE or employer/agent shall require appropriate facility documentation on cases processed.
Author: Workers' Compensation Division
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: New Rule: Filed August 9, 1996; effective September 13, 1996.

480-5-5-.25 On Site Audit.

(1) Audit disputes between the RUE or employer/agent and billing party may be referred to the Workers' Compensation Ombudsman Program for medical dispute resolution in accordance with Code of Ala. 1975, §25-5-77(i).

(2) **RUE or Employer/Agent Responsibilities**

(a) The services to be audited shall be identified within fourteen (14) working days after the RUE or employer/agent receives the approved standard reimbursement form as stated in Rule 480-5-5-.22.

(b) The RUE or employer/agent or its audit firm shall make an appointment to do the audit at a time that is mutually agreeable, but no later than 30 days from receipt of the written request. At the time the appointment is made, the provider shall be informed of:

1. The name(s) of patient(s) whose records are to be audited.

2. The admission, discharge or treatment dates for each case.

3. The medical record numbers and billing numbers of the claims to be audited, as assigned by the billing party, if those appear on the claim.

4. The name(s) of the auditor(s) who will conduct the audit, if available, and the name of the audit firm if the RUE or employer/agent is contracting for auditing services.

5. The portion of the bill to be audited (i.e., drugs, respiratory therapy, etc.) if the entire bill is not to be audited.

(c) The auditor shall be a first level clinical reviewer familiar with billing practices, medical terminology and medical record charting if billing audit is done by the RUE or employer/agent.

(d) Auditors shall be properly authorized and identified as representatives of the RUE or employer/agent, or its audit firm.

(e) The RUE or employer/agent shall pay at least 80 percent (80%) of the reimbursement rate methodology, see Rule 480-5-5-.04, prior to the audit. If an audit fee is charged by the provider, it shall not exceed $50.00 per patient record plus copy charges, if copies are requested, in accordance with 1994 Alabama Act 609.

(f) Auditors shall itemize specific unsupported charges and unbilled charges found on provider bills. The final audit findings shall offset unbilled charges against unsupported charges in a reconciliation process that shall be completed by the RUE or employer/agent after receiving the audit report that shall include a listing of all unbilled charges and unsupported billings.

(g) Auditors shall conduct an exit interview with the provider’s audit coordinator and/or other appropriate personnel prior to leaving to permit review of the preliminary audit results before issuing a final report. If the exit interview is waived by the provider, this fact shall be indicated in writing.

1. A written report of the final audit results shall be sent to all interested parties within 25 working days.

(3) **Provider Responsibilities**

(a) Providers shall schedule an appointment to audit a bill promptly upon the receipt of a request for such an appointment, at a time mutually agreed upon, but no later than 30 days from receipt of written request.

(b) Providers shall respond promptly to a request for an itemized bill from the RUE, employer/agent or audit firm.

(c) Providers shall respond promptly to a request for additional information on the period of treatment, including information from the medical record and from the billing office.

(d) Providers shall designate one individual to be responsible for coordinating all audit activities, and act as a liaison between provider personnel and the auditor. This shall include informing appropriate provider departments of pending audits and audit results, answering auditor questions, issuing a refund to the appropriate party, etc. After notice of a proposed audit has been received by the provider, this individual shall coordinate the provision of medical records, financial records, and any other documentation needed to substantiate charges.

(e) The provider liaison shall acquaint the auditor with its record system and charging practices.

(f) All substances administered to the patient in any form, as well as all treatments or medical services, shall be specifically and accurately documented.

(g) The provider's representative shall be available to the auditor to conduct an exit interview. Discrepancies shall be reviewed, resolved, and agreed upon by both parties. This shall be done by oral confirmation followed by a written confirmation of the unbilled and/or undocumented charges identified during the audit and signed by both parties. In the event that same day resolution is not possible, the provider, in a timely manner, shall resolve differences in any unsupported or unbilled amounts resulting from the audit.

(h) The provider shall issue refunds within 25 working days if overcharges and/or undocumented services exceeding the balance of the RUE or employer/agent liability are discovered during the audit. In addition, the provider shall refund the audit fee, if charged.

(i) Providers shall not bill for undocumented charges discovered during the bill audit process. However, the provider shall bill for documented and previously unbilled

charges discovered during the bill audit process, for charges in excess of the audit fee charged by the provider.
Author: Workers' Compensation Division
Statutory Authority: Code of Ala. 1975, §25-5-293 and 1994 Alabama Act 609.
History: **New Rule:** Filed August 9, 1996; effective September 13, 1996.

480-5-5-.26 Ambulatory Surgery Centers.

(1) When medically appropriate, surgical procedures may be performed on an outpatient basis to reduce unnecessary hospitalization and to shift care to a less costly setting in accordance with Rule 480-5-5-.11(3). All freestanding Ambulatory Surgery Centers (ASCs) licensed in Alabama shall be subject to the policies and methodology for determining reimbursement using the Maximum Fee Schedule for Ambulatory Surgery Centers or according to any mutually agreed reimbursement pursuant to Code of Ala. 1975, §25-5-314.

(a) ASC facility services shall be those items and services provided by an ASC in connection with an authorized procedure including:

1. Nursing, technician and ancillary services;

2. Use of the ASC facility for preoperative services, surgery, and postoperative services;

3. Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances and equipment directly related to the performance of a surgical procedure;

4. Diagnostic or therapeutic services or items directly related to the performance of a surgical procedure;

5. Materials and supplies usually required for the administration of anesthesia; and,

6. Administrative, record keeping, and housekeeping items and services.

(b) Physician-owned/operated ASCs providing medical services other than elective (non-emergency) single-day surgery shall be covered by the Maximum Fee Schedule for Physicians and shall bill using the HCFA 1500 form.

(c) When requested, the ASC shall submit a copy of the charge master to the Department of Industrial Relations Workers' Compensation Division and/or an itemized listing of the individual items and services that contribute to the charge.

(2) Billing Information

(a) ASCs shall use Form UB-92 to bill for services rendered in workers' compensation cases. Any attachment to the UB-92 claim form shall be labeled with the patient's name, number, and date of accident prior to submission to the employer/agent.

(b) ASCs shall use the five-digit procedure codes and descriptors of the CPT-4 procedure codes when billing for services rendered to workers' compensation claimants.

(c) Use of the CPT-4 Procedure Codes.

1. CPT-4 Codes shall not be translated into a facility billing system.

2. The ASC shall use the CPT-4 procedure code that represents separate and distinct surgical procedures. The Medicare Guidelines shall be used as a guideline to differentiate between separate or inclusive surgeries.

(d) Global Charge Concept

1. ASC surgical services shall be billed using a global charge concept; that is, the charges for the usual preoperative, operative and postoperative services shall be entered in the appropriate block of the UB-92 as one total charge for the major surgical procedure performed.

2. The global billing concept includes charges for the following:

(i) Prevailing preoperative services that have been historically included within the global bill for nonworkers' compensation patients shall be included for workers' compensation patients;

(ii) All facility personnel services;

(iii) Facility use, including prestaging and poststaging areas, operating room, and recovery room;

(iv) Usual supplies, dressings, splints, casts, pharmaceuticals and equipment related to the surgical procedure(s);

(v) Anesthesia equipment, supplies, monitors, pulse oximetry, etc.;

(vi) Administrative services;

(vii) Standard laboratory tests including at least a CBC or hemogram and a urinalysis if done by the facility; and,

(viii) Surgical pathology services if done by the facility.

3. Global reimbursement for ASC services shall not include payment for professional services of the surgeon, anesthesiologist, nurse anesthetist, radiologist, pathologists, etc. These fees shall be billed separately by individual providers.

4. Global reimbursement shall not include reimbursement for an extended recovery. If an extended recovery is medically necessary and appropriate, the extended recovery charge shall be billed as a separate line item on the UB-92 Billing Form. The ASC shall furnish written documentation to support the requirement for the extended recovery beyond that which is normally required.

5. Multiple Procedures

(i) When multiple procedures are performed during the same surgical session, the reimbursement shall be made at 100 percent (100%) of the approved rate for the highest charge procedure and 50 percent (50%) of the approved rate for all additional procedures. Only separate and distinct surgical procedures shall be billed.

(ii) When applicable, the Medicare Guidelines shall be used in determining separate and distinct surgical procedures.

Author: Workers' Compensation Division
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: **New Rule:** Filed August 9, 1996; effective September 13, 1996. **Amended:** Filed July 14, 1997; effective August 18, 1997. **Amended:** Filed December 5, 2008; effective January 9, 2009.

480-5-5-.27 Admission Review Procedures.

(1) All nonelective acute care hospital admissions including emergencies, psychiatric admission, and all extended hospitalization shall be reviewed under generally accepted criteria.

Author: Workers' Compensation Division
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: **New Rule:** Filed August 9, 1996; effective September 13, 1996.

480-5-5-.28 Dental Services.

(1) Basic Information - The Rules set out in this chapter apply to providers rendering dental and maxillofacial surgery services. Providers of these services shall also, when applicable, follow the rules and policies in these Rules pertaining to pre-certification, utilization review, bill screening, and claims payment.

(2) Dental Services

(a) Dental codes and descriptors published in the American Dental Associations' (ADA) Current Dental Terminology Manual(CAT-2) shall be used for billing dental services.

(b) Dental procedures shall be identified by the ADA's five-digit code.

(c) Dental services may include professional consultations or visits in the office or hospital.

(d) Dental services shall be billed using the J510 (ADS85) form.

(e) Reimbursement for services rendered shall be limited to the provider's charge, the Maximum Fee Schedule for Dentists, or any mutually agreed upon reimbursement pursuant to Code of Ala. 1975, §25-5-314, whichever is less.

(f) For dental procedures not listed in the Maximum Fee Schedule for Dentists, reimbursement shall be based on usual and customary charges in the area where the service is provided and based on documentation submitted by the provider.

(3) Oral and Maxillofacial Surgery Services

(a) Oral and maxillofacial surgical services may be reimbursed if the services are medically necessary for the treatment of work related injuries or diseases to the jaw, structure contiguous to the jaw, and reduction of any fracture to the jaw or facial bone.

(b) Oral and maxillofacial surgery services shall be billed using the CPT-4 procedure codes, if appropriate, used by medical surgeons and found in the Maximum Fee Schedule for Physicians.

(4) Oral and Maxillofacial surgeons are subject to the billing and reimbursement rules and guidelines for medical surgeons.

(a) The reimbursement for surgical services shall include the procedure itself and the global period of six weeks.

(b) Multiple surgical procedures performed in the course of an operative session shall be reimbursed according to the rules pertaining to medical surgeons set out in Rule 480-5-5-.15. Removal of internal fixation devices are included in the global fee regardless of the period of time between their placement and removal.

(c) Starred (*) surgical procedures performed shall be reimbursed according to the rules pertaining to medical surgeons set out in Rule 480-5-5-.15.

(d) Any and all supplies, equipment, and devices used in the treatment of a compensable injury are included in the maximum fee amount for the procedure.

(5) Plan of Care

(a) Except in an emergency or urgent situation, a plan of care shall be provided to the RUE or employer/agent prior to the commencement of services.

(b) In regards to emergency situations, a plan of care shall be provided to the RUE or employer/agent after the initial stabilizing service has been provided, but prior to any extensive follow up treatment.

Author: Workers' Compensation Division
Statutory Authority: Code of Ala. 1975, §25-5-293
History: New Rule: Filed August 9, 1996; effective September 13, 1996.

480-5-5-.29 Medical Case Management.

(1) Medical case management determination shall be the responsibility of the employer/agent unless delegated. This service may be performed in conjunction with utilization management; however, it is differentiated by its designation to promote optimal recovery and physical rehabilitation by professional involvement in the physical rehabilitation process.

(2) Since medical case management is an integral components of a utilization management program, it shall, at the discretion of the employer/agent, be used as a component in the physical rehabilitation of the injured worker. The overall goal of medical case management is to facilitate the organizing and sequencing of appropriate health care services. This shall be done in the most cost effective manner without compromising quality of care in order to promote optimal outcomes for all parties involved.

(3) The employer/agent is the responsible party for determining the necessity of medical case management.

(4) Individuals or entities performing medical case management shall comply with the most current standards adopted by the International Association of Rehabilitation Professionals (IARP), professional performance criteria for medical case management, which pertains to workers' compensation cases or other nationally recognized medical case management standards. Notwithstanding the foregoing, nothing in this rule shall require a case manager to become a member of any association with recognized standards used in medical case management.

(5) The dispute resolution process shall be in accordance with Rule 480-5-5-.23.
Author: Workers' Compensation Division
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: New Rule: Filed August 9, 1996; effective September 13, 1996. **Amended:** Published March 31, 2022; effective May 15, 2022.

480-5-5-.30 Home Health Care Service.

(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 shall be pre-certified as medically necessary and not for the convenience of the patient and/or family.

(a) All nursing services and personal care services shall have prior authorization by the employer/agent.

(b) A description of needed nursing or other attendant services, as well as specifying the level of nursing care (R.N., L.P.N., sitter/nonprofessional), shall be included in the request for authorization.

(2) Nursing care by a registered nurse or licensed practical nurse and personal care by an attendant may be covered services when ordered by the authorized treating physician.

(3) Payment may be made for authorized services to the following provider types, subject to the following guidelines:

(a) Trained professional nursing personnel who provide services through the auspices of public or private home health agencies who are paid for their services by their employer.

(b) Nursing manpower agencies and home health agencies shall be reimbursed using the Maximum Fee Schedule for Home Health Agencies or any mutually agreed reimbursement pursuant to Code of Ala. 1975, §25-5-314.

(c) Authorized services by nonprofessional family members are reimbursable up to eight (8) hours in any 24-hour period. Any family member who is a medical professional may provide services under the same restrictions placed on self-employed nurses and attendants.

(d) Trained professional nursing personnel who are, self-employed may be paid directly for their services at a rate not to exceed the Maximum Fee Schedule for Home Health Agencies. Self-employed nurses and attendants are considered independent contractors; therefore, the employer/agent takes no responsibility for producing income tax forms for those individuals.

(e) Family members and other persons who are not trained professional nursing personnel may receive payment in the amount of the current minimum wage if the following requirements have been satisfied:

1. The attendant has received adequate instruction from the authorized treating provider regarding the services to be provided in the home;

2. The services provided must be beyond the scope of the normal household duties and must be in the nature of services ordinarily rendered by trained professional personnel in hospitals or nursing homes; and

3. The medical necessity justification shall be sufficient to identify the nature and approximate value of the services provided.

(f) The purpose of private duty nurses is to provide skilled constant attention and observation to a seriously ill patient. The need for, and the length of, service usually depends on the condition of the patient and the level of care required rather than the nature of the disease, illness or injury.

(g) Patients recovering from major surgery, severe systemic disease or one of the catastrophic diseases, frequently require a level of skilled care beyond that afforded by the general nursing services provided by a hospital or other institution.

(h) If an injured worker is receiving treatment for both compensable and noncompensable medical conditions, only those services provided in treatment of compensable conditions shall be listed on claims and invoices submitted to the employer/ agent. In addition, payments from private payers for noncompensable conditions shall not be listed on claims submitted to the employer/agent.

(4) Reimbursement shall be made for the lesser of:

(a) The provider's usual and customary fee;

(b) The Maximum Fee Schedule for Home Health Agencies; or

(c) Mutually agreed upon reimbursement pursuant to Code of Ala. 1975, §25-5-314.

(5) In computing the number of visits rendered an injured worker for compensable benefits, each personal contact in the residence of the injured worker for the purpose of providing covered services by a home health agency employee or by others under contract or arrangement with the home health agency shall be counted as a visit. A visit made simultaneously by two or more workers from a home health agency to provide a single covered service for which one supervises or instructs the other shall be counted as one visit.
Author: Workers' Compensation Division
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: New Rule: Filed August 9, 1996; effective September 13, 1996.

480-5-5-.31 Pain Management Program.

(1) Pain management program services shall receive authorization from the employer/agent prior to providing services. No health care provider may refer the employee to another pain management program without prior authorization from the employer/agent.

(2) **Billing Information**

(a) Pain management programs shall use the appropriate billing forms as stated in Rule 480-5-5-.22 to bill for services rendered. Any attachment to billing forms shall be labeled with the claimant's name, identifying number and date of accident prior to submission to the carrier.

(b) Pain management program services shall be billed using a total or global charge concept. The bill shall include charges for the performance of the basic professional service and the normal range of essential, associated services provided to achieve the objective of the program. Licensed personnel, including physicians, serving as part of the interdisciplinary team, shall not bill separately for their services.

(c) Any physician or other provider serving on a consulting basis to the pain management program, whose services have been authorized by the employer/agent in addition to the interdisciplinary team's services, shall bill on the appropriate form as defined in Rule 480-5-5-.22.

(3) If a Pain Management Program is utilized it shall follow the guidelines of the Commission of Accreditation of Rehabilitation Facilities and shall include, but not be limited to, one or more of the following programs:

(a) Relaxation Response Training. Activity or exercise group;

(b) Neuromuscular Training/Motor Education. Instruction and/or experiential activities designed to enhance the individual's use of the body, with emphasis on function and movement;

(c) Behavioral Counseling. Clinical interaction aimed at enhancing the individual's perceptual, emotional and cognitive framework as it relates to the present level of dysfunction and thereby minimizes its influence as an obstacle to rehabilitation;

(d) Job Simulation. The use of real or simulated work tasks to progressively improve the biomechanical, neuromuscular, cardiovascular/metabolic and psychosocial functions of the individual in preparation for return to competitive employment; and/or

(e) Musculoskeletal Management. Specific clinical intervention of dysfunction relevant to the individual's clinical picture. Emphasis should be on those aspects of dysfunction that are either impractical to self correct, or that the individual is unable to self correct through exercise, instruction, or other independent means.

Author: Workers' Compensation Medical Services Board
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: New Rule: Filed August 9, 1996; effective September 13, 1996. **Amended:** Filed December 5, 2008; effective January 9, 2009.

480-5-5-.32 Durable Medical Equipment.

(1) All services described in these rules, except those specifically noted, shall have prior authorization of the employer/agent before reimbursement shall be made. The authorized treating physician shall state that the condition was indeed work-related and that the durable medical equipment is medically necessary. Each authorization request shall include a prescription or statement of need from the authorized treating physician.

(2) If a claimant is receiving treatment for both compensable and noncompensable medical conditions, only those services provided in treatment of compensable conditions shall be listed on claims and invoices submitted to the employer/agent. In addition, items covered by private payers for noncompensable conditions shall not be listed on invoices submitted to the employer/agent.

(3) Durable Medical Equipment (DME) refers to those items which can withstand repeated use, are primarily used to serve a medical purpose, are generally not useful to a person in the absence of illness, injury or disease, and are appropriate for use in the claimant's home.

(a) The employer/agent reimburses for the purchase or rental of certain medical equipment and accessories and the purchase of certain medical supplies for the claimant's use in a noninstitutional setting.

(4) **Equipment Rental/Purchase Guidelines**

(a) Whenever the total of prospective rental payments for the period of medical need as stated by the authorized treating physician equals or exceeds the maximum purchase price, the DME provider, authorized treating physician and employer/agent shall purchase instead of renting the equipment.

(b) The return of rented equipment is the dual responsibility of the claimant and the DME supplier. The employer/agent is not responsible and shall not reimburse for additional rental periods solely because of a delay in equipment return.

(c) The repair or maintenance of rented DME is the responsibility of the DME supplier at no additional charge to the claimant. The employer/agent is responsible for DME repair and maintenance of purchased equipment (subject to warranty provisions). For purchased DME, the DME supplier shall provide at least a one-year warranty agreement to the claimant. If the warranty agreement requires some nominal monetary fee, it is billable to the employer/agent. The DME supplier shall always inform the claimant about any DME warranty provided by the manufacturer.

(d) Upon request or unless documented in the physician’s office notes, the provider shall attach a signed statement from the claimant acknowledging receipt of the equipment or supply item whenever submitting invoices to the employer/ agent.

(5) **Prosthetic and Orthotic Appliances**

(a) An employer/agent shall pay for only those orthotic and prosthetic devices prescribed by an authorized treating physician for recognized occupational injury or illness. The device must be described in commonly recognized language in accordance with HCPCS Medicare Regional Durable Medical Equipment Regional Carrier (DMERC) Prosthetic and Orthotics "L" codes included in this document.

(b) Repairs and modifications to achieve satisfactory adjustments of an appliance shall be made within 60 days of

initial fitting without additional charge by the supplier. The provider shall attach a signed statement from the claimant acknowledging receipt of the item whenever submitting invoices to the employer/agent for prosthetic appliances.

(6) **Braces and Other Nonfitted Items**

(a) Braces and other items which are not custom fitted, such as collars and prosthetic supplies that are prescribed by the authorized treating physician, are reimbursable without prior authorization if a prescription is secured and/or a letter of medical necessity.

(7) **Orthopedic Shoes**

(a) The employer/agent shall pay for orthopedic or specially constructed shoes following foot injuries as prescribed by the authorized treating physician or letter of medical necessity.

(8) **Non-1isted Items and Individual Considerations**

(a) Occasionally, there may be a workers' compensation claim where the HCPCS codes do not appear on the DMERC "L" Code Schedule. Where a medical necessity has been documented, the employer/agent shall pay for the prosthetic and/or orthotic equipment to the suppliers when a prescription is rendered to the employer/agent.

(9) **Non-Covered Services**

(a) In general, only those equipment items listed in the section of the DMERC/HCPCS "L" Codes shall be reimbursed. If otherwise unlisted HCPCS codes are used, the maximum allowance may be covered when medical necessity is documented and a prescription is secured and rendered at time of billing.

(10) **Applicability**

(a) Only practitioners certified by the American Board of Certification shall be entitled to provide custom prosthetic and orthotic appliances.

(11) **Billing Instructions**

(a) All initial claims for the rental or purchase of DME shall be filed with a statement of medical necessity. The authorized treating physician shall supply the durable medical equipment provider with a prescription stating the medical necessity for such services with the claimant's diagnosis, prognosis, and expected time span for which the equipment or supplies shall be required.

Author: Workers' Compensation Medical Services Board
Statutory Authority: Code of Ala. 1975, §25-5-293.

History: New Rule: Filed August 9, 1996; effective September 13, 1996. **Amended:** Filed February 25, 1998; effective April 1, 1998.

480-5-5-.33 Time Limits For Claims Payments.

(1) In accordance with Code of Ala. 1975, Section 25-5-77(h), the employer/agent shall process and pay all undisputed claims within 25 working days of receipt of an approved claim form. However, all authorized workers' compensation claims shall be filed to allow processing and reimbursement within twelve (12) months from the date of service. All actions against an authorized claim cease when the said 12-month time limitation has expired.

(2) A provider who submits an authorized claim to the employer/ agent shall receive reimbursement, notice of dispute, or a request for additional information in accordance with Rule 480-5-5-.03. If payment is not received within the time constraints of Rule 480-5-5-.03, the provider should contact the employer/agent for the current status of an authorized claim.

(3) Providers should contact the Workers' Compensation Division if there are problems with an authorized workers' compensation claim. However, when a provider's efforts are fruitless, the provider should write to the Workers' Compensation Division before the 12-month limitation expires.

(4) Administrative Review of Claims Denied as Outdated.

(a) A provider who is denied payment on an outdated authorized claim may request an administrative review of the claim. A written request for an administrative review, conducted by the Medical Services Dispute Resolution Section, shall be addressed to the Workers' Compensation Division within sixty (60) days of the date the authorized claim becomes outdated, which is 12-months from the date of service.

(b) It is the responsibility of the provider, when submitting an outdated authorized claim for an administrative review, to furnish adequate documentation of the provider's good faith attempts to obtain payment of the claim, including copies of relevant explanation of payments (EOP) and correspondence with the employer/agent. The provider shall also include an error free claim to furnish the employer/agent in cases where the decision is favorable.

(c) When the provider has timely requested an administrative review, and research of the claim reveals that the authorized claim was originally filed in accordance with Rules 480-5-5-.04 and .22, and the provider has established a good faith effort to file an authorized claim on the approved claim form, the Workers' Compensation Division shall have the authority to

instruct the employer/agent to waive the filing limitation and process the authorized claim.

(d) The provider shall be notified in writing of the administrative review decision. A provider who has timely requested an administrative review and received an adverse decision may request an appeal in accordance with the Department of Industrial Relations Administrative Code 480-1-4. Such request shall be in writing and received by the Workers' Compensation Division within 60 days of receipt of the date of the administrative review denial letter.

(e) If all administrative remedies have been exhausted and the authorized claim is denied, the provider cannot collect from either the employer/agent or employee.

Author: Workers' Compensation Medical Services Board
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: New Rule: Filed July 14, 1997; effective August 18, 1997.

480-5-5-.34 Ambulance Services.

(1) All non-emergency ground and air ambulance service rendered to workers' compensation claimants shall be pre-certified. Emergency ground and air ambulance services shall be retro-certified within 24 hours of the service or on the next working day.

(2) All ground and air ambulance services shall be medically necessary and appropriate. Documentation, trip sheet(s), shall be submitted with the bill that states the condition(s) that indicates the necessity of the ground or air ambulance service provided. It should readily indicate the need for transport via this mode rather than another form of transportation. The service billed shall be supported by the documentation submitted for review.

(3) Reimbursement shall be made if the injured employee expires while enroute to or from a health care facility. Reimbursement shall not be payable if the responding ambulance or air ambulance service did not transport the injured employee, or if the employee was pronounced dead by a legally authorized individual prior to transport.

(4) Billing for services shall be submitted to the payer on a properly completed HCFA 1500 claim form by HCPCS code. Hospital based or owned providers must submit the charges on a HCFA 1500 by HCPCS code.

(5) Reimbursement shall be:

(a) Based upon the lesser of the submitted charge or the Prevailing Reimbursement/Maximum Fee Schedule for Ambulances. These payments shall not exceed the prevailing charges in that locality for comparable services under comparable circumstances; and,

(b) Commensurate with the services actually performed. Services rendered are independent of the type of call received or the type of staff and/or equipped ambulance responding.

Author: Workers' Compensation Medical Services Board
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: **New Rule:** Filed July 14, 1997; effective August 18, 1997.

480-5-5-.35 Impairment Rating Guide.

(1) The American Medical Association Guides to the Evaluation Of Permanent Impairment, Fourth Edition, shall be the recommended guide used by physicians in determining impairment and/or disability ratings.

Author: Workers' Compensation Medical Services Board
Statutory Authority: Code of Ala. 1975, §25-5-293.
History: **New Rule:** Filed February 25, 1998; effective April 1, 1998.

480-5-5-.36 Time Limits For Employee Filing Incurred Expense Claims.

(1) In accordance with Code of Ala. 1975, Section 25-5-77(c), the employer shall pay reasonable charges for the employee's necessary board, lodging, and travel, if vocational rehabilitation requires residence at or near a facility away from the employee's customary residence. Code of Ala. 1975, Section 25-5-77(f) requires the employer to pay mileage costs to and from medical and rehabilitation providers at the same rate as provided by law for official state travel.

(a) All mileage is subject to verification.

(b) Claims for mileage to a medical provider or rehabilitation that incurred between the claimant's work location and normal residence shall not be eligible for payment.

(c) Both mileages to drop off a prescription and return mileage to pickup a prescription shall not be reimbursable. Only one round trip shall be approved.

(2) The employer shall notify the injured employee in writing that he is entitled to reimbursement for expenses as stated Code of

Ala. 1975, Sections 25-5-77(c) and (f). This notice shall be furnished within two weeks of acceptance of the claim as a compensable work-related injury.

(3) In certain situations, the employee may pay for prescribed medications and/or supplies for treatment of the compensable work-related injury. In turn, the employee will file a claim for reimbursement with the employer. However, over the counter medications (i.e., Advil, Tylenol, etc) that may be used by any family member are non-reimbursable.

(4) The employee has one year from the date of incurred expense, as stated above, to file the claim with the employer/agent.

(5) Any disputes regarding reimbursement for incurred expenses should first be directed to the employer/agent. Employees may contact the Workers' Compensation Division for assistance, if there are problems with payment for an incurred expense associated with the employee's workers' compensation claim and contact with the employer/agent is fruitless.
Author: Workers' Compensation Division
Statutory Authority: Code of Ala. 1975, §25-5-77.
History: **New Rule:** Filed December 5, 2008; effective January 9, 2009.

480-5-5-.37 Out-Of-State Medical Providers.

(1) Occasionally an employee, whose injury falls under Alabama's jurisdiction, may require treatment by a medical provider in another state. Alabama's fee schedules are developed under the premise that treatment will be provided in this state. The hospital and ambulatory surgery fee schedules are unique to that particular Alabama facility. Other Alabama medical provider's reimbursement schedules are derived from the most common payer of health care services in this state.

(2) Code of Ala. 1975, §25-5-77 limits the employer's liability to the prevailing rate or maximum schedule of fees. Prevailing is defined in Code of Ala. 1975, §25-5-1(15) and Department of Industrial Relations Administrative Code, Rule 480-5-5-.02(61). If another state has a workers' compensation schedule for that provider type, that schedule constitutes the prevailing rate for treatment of a workers' compensation injury.

(3) For any injury under Alabama's jurisdiction, the out-of-state medical provider is paid:

(a) According to that state's workers' compensation fee schedule for that provider;

(b) According to a mutually negotiated payment rate pursuant to Code of Ala. 1975, §25-5-314; or

(c) According to the Alabama workers' compensation fee schedule for non-facility medical providers.

Author: Workers' Compensation Division
Statutory Authority: Code of Ala. 1975, §25-5-77.
History: **New Rule:** Filed February 11, 2011; effective March 18, 2011.