Workforce Services, Department of

Workers' Compensation Division

Chapter 9: Fee Schedules

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CHAPTER 9
FEE SCHEDULES

Section 1. General Guidelines. Pursuant to Wyoming Statutes § 27-14-401(b), (e), and (g) medical and or hospital care shall be reviewed for appropriateness and reasonableness and shall be reimbursed according to the adopted schedule(s). The following guidelines are applicable to each section within this chapter.

(a) All claims shall be paid in accordance with the fee schedule in effect at the time of service.

(b) Certain services may be subject to preauthorization pursuant to Chapter 10 of these rules. These guidelines can be found at: https://dws.wyo.gov/dws-division/workers-compensation/resources-information/provider-bulletins

(c) The Division shall use accepted medical resources and publications to aid in adjudicating bills. This shall include, but not be limited to, the most recent edition of the following sources at the time services are rendered the American Medical Association (AMA), Current Procedural Terminology codebook (CPT), the AMA Knowledge Base System and The American Academy of Orthopaedic Surgeons, Complete Global Values Service Data for Orthopaedic Surgery Guidelines, Centers for Medicare and Medicaid Services (CMS), and the Division's medical advisors.

(d) The Division may change billed codes to achieve compliance with the current rules and regulations. The provider payment statement shall advise of code changes and the right to appeal.

(e) Codes where no value is established in the Geographically Adjusted Resource Based Relative Value Scale (RBRVS) methodology will pay By Report (BR). A comparable code value will be assigned; if no value is found, the billed charges will be reduced by 20%.

(f) In no case shall any provider bill for charges greater than those charged the general public for like services.

(g) The Division shall not pay more than the total billed amount.

Section 2. Fee Schedules.

(a) The Division adopts the most recent version published prior to the date of service for the following references *Geographically Adjusted Resource Based Relative Value Scale (RBRVS),* as published by Optum360, LLC, as authored by the American Medical Association (AMA), insofar as it addresses medical matters under the Act unless otherwise defined in this chapter and, the *Relative Values for Dentists (RVD),* as published and authored by Relative Value Studies, Inc., Thornton, Colorado, insofar as it addresses dental matters under the Act.

(i) The Division has determined that incorporation of the full text in these rules would be cumbersome or inefficient given the length or nature of the rules;

(ii) The incorporation by reference does not include any later amendments or editions of the incorporated matter beyond the applicable date identified in subsection (a) of this section; and

(iii) The incorporated code, standard, rule or regulation is maintained at 5221 Yellowstone Road, Cheyenne, WY 82002 and is available for public inspection and copying at cost at the same location.

(b) Each code incorporated by reference in these rules is further identified as follows:

(i) *RBRVS* and *RVD*, as they were in effect on the date of service submitted, and adopted by the Department of Workforce Services, Wyoming Workers' Compensation Division.

(ii) National Correct Coding Initiative (NCCI) and Medicare Unlikely Edits (MUE) as they were in effect on January 1, of the year for the date of service submitted, and adopted by the Department of Workforce Services, Wyoming Workers' Compensation Division found at: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd

(A) MUE edits under the Centers for Medicare and Medicaid Services (CMS) having a value of 0 (zero) will be overridden and reviewed for medical necessity and relatedness to the injury and treatment.

(c) There are six (6) conversion factors (CF) for the Professional Fee Schedule, Wyoming uses the National RBRVS system and recognizes the below conversion factors:

SPECIALTY GROUP	CONVERSION FACTOR
Anesthesia	$ 53.38
Spine Procedures	$ 77.49
Evaluation and Management	$ 37.84
Physical Med/Radiology/Surgery	$ 66.67
Radiology- MRI Services Only	$ 106.74
Dental	$ 55.73

(d) Modifiers for Anesthesia and Surgical Assistants.

(i) Surgical Assistants.

(A) MD assistants shall be paid 20% of the surgical allowance.

(B) Non-MD assistants shall be paid 15% of the surgical allowance.

(ii) Anesthesia.

(A) All services are paid in accordance with the Wyoming Fee Schedules in effect at the time that services are rendered.

(B) At least one of the following anesthesia modifiers must be submitted with each bill.

(C) Modifiers P1-P6 are suggested but not required.

(D) AA-anesthesia services performed by the Anesthesiologist, are paid at one hundred percent (100%) of the allowable fees.

(E) AD-medical supervision by a Physician with more than four (4) concurrent anesthesia procedures are paid at fifty percent (50%) of the allowable fees.

(F) QK-medical direction of two (2), three (3) or four (4) concurrent anesthesia procedures involving qualified individuals are paid at fifty percent (50%) of the allowable fees.

(G) QX-qualified non-physician anesthetists with medical direction by a Physician are paid at fifty percent (50%) of the allowable fees.

(H) QY-medical direction of one qualified non-physician Anesthetist by an Anesthesiologist are paid at fifty percent (50%) of the allowable fees.

(I) QZ-CRNA (Certified Registered Nurse Anesthetist) without medical direction by a Physician are paid at one hundred percent (100%) of the allowable fees.

(e) Fees for Independent Medical Evaluations (IME), Permanent Partial Impairment Ratings (PPI), Medical Testimony and Deposition(s). See Chapter 10, and Chapter 9, Section 1 for additional guidelines. Medical bills must indicate total time spent on review of records, actual examination and writing of the report on the written report and the CMS-1500 claim form. The medical report must include a breakdown of the total time spent. Medical bills must also include time spent on travel, if applicable.

(i) Independent Medical Evaluations (IME) or Impairment Ratings. The Division shall pay according to the following fee schedule:

(A) If the IME or Impairment Rating is completed by the treating physician, use Code 99455. If the IME or Impairment Rating is completed by a physician, other than the treating healthcare provider, use Code 99456.

Code	**Time**	**Payment**
99455-99456	1st hour	$750.00
	Each additional 15 minutes	$93.75

(B) Fees for No Call/No Show appointments, where a paper file review with report is submitted to the Division will be paid in accordance with the above fee schedule.

(C) Fees for No Call/No Show appointments, where a paper file review with report is not completed or submitted to the Division must be billed to the claimant.

(ii) Medical Testimony and Deposition Charges. The Division shall pay according to the following fee schedule:

Code	Time	Payment
99075	1st hour	$750.00
	Each additional 15 minutes	$65.00

Section 3. Fees for Home Health Nursing.

(a) The Division adopts the following fee-based schedule guidelines for home health nursing services being provided by independent Medicare/Medicaid certified agencies. This is a straight fee, no overtime, holiday rate, or shift differential shall be paid and Fair Labor Standards Act (FSLA) exempt. A visit equals a range of fifteen (15) minutes to a maximum of four (4) hours per day. See Chapter 10, Section 17 and Chapter 9, Section 1 for additional guidelines.

Type of Nursing	Per Visit Rate
RN	$146.50
LPN	$146.50
CNA	$66.34

(b) The Division adopts the following fee-based schedule guidelines for Private duty services/attendant care. This fee schedule is for long term daily care at home and is Fair Labor Standards Act (FSLA) exempt. This is a straight hourly fee, no overtime, holiday rate or shift differential shall be paid. See Chapter 10, and Chapter 9, Section 1 for additional guidelines.

Type of Nursing	Hourly Rate
RN	$35.00
LPN	$35.00
CNA	$16.00
*Attendant	*Federal minimum wage

*Attendant care includes personal care for activities of daily living. A physician prescription and time limit is required. Attendant care shall be provided by individuals approved by the primary treating health care provider.

Section 4. Fees for Supplies, Implants, Durable Medical Equipment (DME), Orthotics and Prosthetics.

(a) The Division adopts the Non-Rural Wyoming Medicare rate plus thirty percent (+30%) of the Healthcare Common Procedure Coding System (HCPCS) as the rates were published as of January 1, of the year for the date of service submitted, for the payment of supplies, DME, orthotics and prosthetic devices prescribed by a health care provider. See Chapter 9, Section 1 for additional guidelines. The Division shall not pay for any supplies, DME, orthotics, or prosthetics unless prescribed by the primary health care provider. The Division will not include quarterly updates for these payments, the payments will remain consistent with the January 1, of the year for the date of service submitted published rates.

(i) The Division has determined that incorporation of the full text in these rules would be cumbersome or inefficient given the length or nature of the rules;

(ii) The incorporation by reference does not include any later amendments or editions of the incorporated matter beyond the applicable date identified in subsection a of this section; and

(iii) The incorporated code, standard, rule or regulation is maintained at 5221 Yellowstone Road, Cheyenne, WY 82002 and is available for public inspection and copying at cost at the same location.

(b) Each code incorporated by reference in these rules is further identified as follows:

(i) Reference to the Non-Rural Wyoming Medicare rate of the Healthcare Common Procedure Coding System (HCPCS) is adopted by the Division and effective on January 1, of the year for the date of service submitted found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSFeeSched/DMEPOS- Fee-Schedule.html

(c) Please refer to CMS Medicare Learning Network (MLN) document at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/DMEPOSQuality/DMEPOSQualBooklet-905709.html for the required documentation to be submitted with each supply, DME, orthotic, or prosthetic order. Prior authorization is only completed for items over two thousand five-hundred dollars ($2,500) and is voluntary.

(d) Any related charges for supplies, DME, orthotics and prosthetics not listed in the Medicare HCPCS fee schedule shall be paid at eighty percent (80%) of billed charges. Charges deemed excessive shall require additional documentation for justification.

(i) Any single supply/DME item/orthotic or prosthetic; not listed in the Non-Rural Medicare HCPCS fee schedule, charged at $1,000.00 or more, shall require a supplier's invoice. Reimbursement shall be at 130% of invoice cost. Shipping and handling charges shall not be reimbursed.

(ii) Reimbursement for HCPCS code E0676-Intermittent Limb Compression Device will be paid at a flat rate of four hundred dollars ($400) for use of this device during the surgical procedure only.

(iii) The Division shall not provide direct payment to suppliers or manufacturers for implantable items.

(e) The preceding fees are not intended to address newly developed items or technologies.

Section 5. **Fees for Hearing Aids/Prescription Lenses.** See Chapter 10, and Chapter 9, Section 1 for additional guidelines.

(a) The Division shall pay 130% of the supplier's/manufacturer's invoice price for hearing aids when the provider submits the invoice to the Division.

(b) The Division shall reimburse for frames and lenses as prescribed for compensable vision loss, or replacement due to a work-related accident, not to exceed 80% HCPCS usual and customary benchmarks as determined annually by the Division. The Division may demand additional documentation and justification for any charges deemed excessive by the Division.

(c) The Division shall reimburse an injured worker for the repair or comparable replacement of a hearing aid device or prescription lens damaged or destroyed in a work-related accident.

Section 6. Fees for Pharmacy Items. Pharmaceuticals must be billed with a National Drug Code (NDC) and the correct units for the NDC. See Chapter 10, and Chapter 9, Section 1 for additional guidelines.

(a) Pharmaceuticals shall be reimbursed at the lower of:

(i) Average Wholesale Price (AWP) minus 10% plus a $5.00 dispensing fee; or

(ii) The provider's usual and customary charge. In no case shall any provider bill for charges greater than those charged to the general public for like services. The Division reserves the right to review such charges and reimburse at the usual and customary rate if a discrepancy is found.

(b) Reimbursement shall be decreased by $2.50 per prescription if a paper claim is submitted unless:

(i) The provider has received prior approval from the Division to submit a claim on paper.

(ii) Electronic billing is unavailable at the time of service making it unreasonable to submit the claim through the online process.

(c) Over the counter items that do not have a valid NDC number shall be considered supplies and shall not be paid with an added dispensing fee. See Chapter 9, Section 4 for additional guidelines.

(i) Please see the nutritional supplements section in Chapter 10, Section 18 for additional information.

(d) If the pharmaceutical is a repackaged drug, as determined by the NDC for the product dispensed, reimbursement shall be calculated per Section 6(a) using the AWP of the lowest cost therapeutic equivalent product.

(e) If a pharmaceutical intended for outpatient use is dispensed through the office of a medical care provider, reimbursement will be calculated per Section 6(a) – (d), equivalent to

the reimbursement provided to a retail pharmacy.

Section 7. **Fees for Compounded Medications. –** See Chapter 10, Section 7, and Chapter 9, Section 1 for additional guidelines.

(a) Physicians billing for compounded drugs must provide the pharmacy invoice. The Division shall pay 130% of the supplier's/manufacturer's invoice price.

(b) Compounding pharmacies that bill directly, shall be compensated for the drugs prescribed and related materials in accordance with Chapter 9, Section 6. The Division shall allow a fee for compounding services. Compounding medications shall be reimbursed per line item if each ingredient is determined to be coverable per Chapter 10, Section 7, Compound Prescription Medications.

Section 8. Fees for Ambulance Services.

(a) Ambulance services shall be paid the lesser of the billed charge or the maximum allowable rate for the code appropriate for the documented service. The maximum allowable rates are all-inclusive. Mileage shall be reimbursed per documented loaded statute mile. See Chapter 9, Section 1 for additional guidelines. Contact the Division for additional information regarding Air Ambulance codes and reimbursement.

(b) The Division adopts CMS Rural Wyoming Medicare rates plus 30%, these rates can found at: https://med.noridianmedicare.com/web/jfb/fees-news/fee-schedules/ambulance-fees

(c) Please contact the Division's Provider Service Unit for information regarding Air Ambulance reimbursement at: (307) 777-7441.

Section 9. Facility Fees.

(a) Fees for Inpatient Hospital Services.

(i) Inpatient hospital services shall be reimbursed in accordance with the CMS IPPS (Inpatient Prospective Payment System) payment methodology. With the Wyoming Base Rate at 150% of Medicare; updated on July 1st of each year; and the MS-DRG (Medicare Severity-Diagnosis Related Group) weight according to the CMS Table 5 (for the corresponding year of service) found at: https://www.cms.gov/medicare/acute-inpatient-pps/fy-2022-ipps-final-rule-home-page

(ii) If the inpatient admission and discharge occurs across different calendar years, the Base Rate and MS-DRG weight of the admission year shall be used for the entirety of the inpatient stay.

(iii) Required documentation to support billed charges are as follows:

(A) Detailed itemization;

(B) Anesthesia graphic;

(C) Operative report;

(D) History and physical;

(E) Discharge summary;

(F) Implant Log and itemization; and

(G) Supplier's invoice for any supplies and/or implants charged at five thousand dollars ($5,000.00) or more, per episode of care, for device intensive procedures as indicated by Medicare. Such items shall be reimbursed at one hundred fifteen percent (115%) of invoice amount. Shipping and handling charges shall not be reimbursed.

(iv) Bills shall be audited for unidentified and unrelated services and/or items.

(v) The Division shall provide a copy of the audit upon request.

(b) Critical Access Hospitals (CAH) will be paid at one hundred twenty-one percent (121%) of Rural Cost-to-Charge Ratio (CCR) in accordance with the Wyoming Medicare file CMS-1771-P Tables 8A and 8B for the year of service submitted. More information can be found at: https://www.cms.gov/medicare/acute-inpatient-pps/fy-2023-ipps-proposed-rule-home-page

(c) Fees for Skilled Nursing Services.

(i) Inpatient Skilled Nursing Services shall be reimbursed in accordance with the Annual Skilled Nursing Facility Per Diem Room Rate Survey conducted by the Division.

(A) If the facility has not established a per diem room rate with the Division for the calendar year corresponding to the date of service, the average of the submitted rates will be used.

(ii) The per diem room rates for a semi-private bed shall be the usual and customary rates charged to the general public. Such rates shall be effective automatically on the first day of each calendar year.

(A) The per diem room rates will be all inclusive of the care for the claimant for the day. This includes but is not limited to:

(I) Administration of oxygen and related medication;

(II) Hand feedings;

(III) Incontinence Care;

(IV) Tray Service;

(V) Therapy Services, including physical therapy, occupational therapy, speech and language therapy; and

(VI) Over the counter medications.

(B) Certain items are permitted to be billed outside of the per diem rate, such as:

(I) Ambulance services when medically necessary;

(II) Some durable medical equipment (DME) items;

(III) Wheelchairs;

(IV) Braces;

(V) Medical services including laboratory, radiology and surgical procedures;

(VI) Physician and other practitioner services, excluding physical therapy, occupational therapy and speech and language therapy; and

(VII) Prosthetics.

(d) Fees for Inpatient Rehabilitation Services.

(i) Inpatient Rehabilitation Services shall be reimbursed at eighty percent (80%) of billed charges.

(ii) Required documents to support billed charges are as follows:

(A) History and physical;

(B) Daily notes including physician visits, therapy notes, nursing notes, etc.; and

(C) Discharge summary, if applicable.

(iii) Bills shall be audited for unidentified and unrelated services and/or items.

(iv) The Division shall provide a copy of the audit upon request.

(e) Fees for Ambulatory Surgery Services.

(i) Ambulatory Surgery Services shall be reimbursed in accordance with Wyoming Medicare Ambulatory Surgery Center (ASC) rates at one hundred fifty percent (150%) of the allowed amount, found at: https://www.cms.gov/medicare/medicare-fee-for-

service-payment/ascpayment/11_addenda_updates

(ii) Medical services for which there is no ASC weight listed shall not be reimbursed.

(iii) All payment status indicators shall be followed as indicated by Medicare.

(iv) In accordance with CMS guidelines, reimbursement will not be made to an ASC if service performed is on the Inpatient-Only list or is one that is excluded from the ASC setting.

(v) Required documentation to support billed charges are as follows:

(A) Operative report;

(B) Implant Log and itemization; and

(C) Supplier's invoice for any supplies and/or implants charged at one thousand dollars ($1,000.00) or more, per episode of care. Such items shall be reimbursed at one hundred fifteen percent (115%) of invoice amount. Shipping and handling charges shall not be reimbursed.

(vi) Bills shall be audited for unidentified and unrelated services and/or items.

(vii) The Division shall provide a copy of the audit upon request.

(f) Fees for Outpatient Facility Services.

(i) Outpatient Services shall be reimbursed in accordance with Wyoming Medicare Ambulatory Payment Classifications (APC) rates at one hundred fifty percent (150%) of the allowed amount, found at: https://www.cms.gov//Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates

(ii) Required documentation to support billed charges are as follows:

(A) Treatment notes to support the billed services.

(B) Physicians Order/Prescription.

(iii) Bills shall be audited for unidentified and unrelated services and/or items.

(iv) The Division shall provide a copy of the audit upon request.

Section 10. Fees for Home Infusion Therapy

(a) Home Infusion Therapy will be paid in accordance with the Wyoming Medicare Home Infusion Therapy Fees, for the year of service submitted, plus a thirty percent (30%) increase.

(b) The Division shall pay only one of the G-codes per line item date of service when one of the drugs from the applicable category is billed with the same line item date of service or a date of service within thirty (30) days prior to the G-code visit.

(i) Healthcare Common Procedure Coding System (HCPCS) code S9328-Home Infusion Therapy, implanted pump pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem will be paid at Workers' Compensation Usual and Customary fee of two hundred dollars ($200.00).

(ii) The fees associated with the G-codes on the MPFSD fee file will be "a per day rate"; therefore, the units on the line should not be multiplied by the rate.

(iii) The drug remains separately payable from the G-code line item Home Infusion Therapy suppliers will report the following HCPCS G-codes associated with the payment categories for the professional services furnished in the individual's home and on an infusion drug administration calendar day.

(iv) For additional information regarding the Medicare rates and coding for these services, please visit: https://www.cms.gov/files/document/se19029.pdf and https://med.noridianmedicare.com/web/jfb/fees-news/fee-schedules/home-infusion-therapy-fees