

## **RULE 26**

### **SCHEDULES OF FEES FOR MEDICAL, SURGICAL, AND HOSPITAL SERVICES**

- A.** The following Nebraska Workers' Compensation Court fee schedules, including the instructions, ground rules, unit values, and conversion factors set out in such schedules, are hereby adopted pursuant to § 48-120(1)(b) of the Nebraska Workers' Compensation Act. Reimbursement for medical, surgical, and hospital services provided pursuant to § 48-120 shall be in accordance with such schedules, except for services covered by the inpatient hospital fee schedules established in § 48-120.04, and except for services covered by contract pursuant to § 48-120(1)(d).
1. Schedule of Fees for Medical Services, effective June 1, 2014.
  2. Schedule of Fees for Hospitals and Ambulatory Surgical Centers, effective January 1, 2012.
  3. Schedule of Fees for Implantable Medical Devices, effective January 1, 2012.
- Such schedules and the inpatient hospital fee schedules established in § 48-120.04 shall be available free of charge on the court's web site at <http://www.wcc.ne.gov>.
- B.** Schedule of Fees for Medical Services.
1. The Schedule of Fees for Medical Services shall apply to medical and surgical services provided by physicians and other licensed health care providers within the scope of their respective licenses.
  2. Effective January 1, 2016, the Schedule of Fees for Medical Services shall be established as follows. Adjustments to the schedule shall be made annually thereafter as provided herein, with such adjustments to become effective each January 1.
    - a. The schedule shall include the Medicare Resource-Based Relative Value Scale (RBRVS) applicable to Nebraska, as reflected in the applicable tables established and published by the federal Centers for Medicare and Medicaid Services (CMS) for the federal Medicare program and geographically adjusted for Nebraska.
    - b. The schedule shall include the Current Procedural Terminology (CPT) codes in the CMS tables and the relative value units established by CMS for each CPT code in the tables.
    - c. The schedule shall be adjusted annually to incorporate the CPT codes and relative value units in the then current CMS tables applicable to Nebraska.
    - d. The schedule may be supplemented with additional CPT codes, relative value units, follow-up days, base values, instructions, ground rules, or other components or factors as determined by the court.
    - e. The conversion factors and service categories of the schedule shall be as follows:
      - i. For calendar year 2016, sixty-three dollars and fifty-nine cents (\$63.59) for emergency department services, fifty dollars and one cent (\$50.01) for all other evaluation and management services, fifty dollars and seventy-seven cents (\$50.77) for anesthesia services, one hundred and six dollars and seven cents

(\$106.07) for orthopedic surgery services, seventy-two dollars and twenty-two cents (\$72.22) for all other surgery services, eighty-six dollars and ninety-two cents (\$86.92) for radiology services, seventy-six dollars and thirty-two cents (\$76.32) for pathology and laboratory services, fifty-four dollars and thirty-six cents (\$54.36) for medicine services, and forty-eight dollars and twenty-three cents (\$48.23) for physical medicine services. The specific services and related CPT codes to be included in each service category shall be determined by the court.

- ii. For calendar years after 2016, the conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factor for each service category identified in Rule 26,B,2,e,i. For purposes of this rule, the MEI means the input price index used by CMS to measure changes in the costs of providing physician services paid under the RBRVS.
3. Services subject to the Schedule of Fees for Medical Services shall be reimbursed at the lower of the fee schedule amount or the provider's billed charge. The fee schedule amount for a particular service shall be determined by first multiplying the relative value unit for the CPT code applicable to the service provided by the dollar conversion factor for the service category in which the code is located. The resulting amount may then be modified by instructions or ground rules for the service category in which the code is located to arrive at the final fee schedule amount. Medical or surgical services not covered under the schedule shall be paid in full unless the payor has evidence that the provider's charge exceeds the regular charge for such service by Nebraska providers.
4. Coding for services subject to the Schedule of Fees for Medical Services shall be in accordance with the CPT manual published by the American Medical Association, and in accordance with the National Correct Coding Initiative (NCCI) established by CMS. A provider shall not fragment or unbundle charges imposed for a service except as consistent with the CPT manual and the NCCI. Coding by a provider may be changed by a workers' compensation insurer, risk management pool, or self-insured employer, or any adjustor, third-party administrator, or other agent acting on behalf of any such workers' compensation insurer, risk management pool, or self-insured employer, only as consistent with the CPT manual and the NCCI and following consultation with the provider.
5. The Schedule of Fees for Medical Services shall not apply to costs and expenses incurred by or on behalf of any party for the purpose of proving or disproving a contested claim, except that X-rays, laboratory services, and other diagnostic tests provided in connection with a medical-legal evaluation shall be subject to the schedule.

C. The Diagnostic Related Group inpatient hospital fee schedule established in § 48-120.04 shall include the following Medicare Diagnostic Related Groups, effective January 1, 2015:

3	101	231	439	488	516	602	869	935
14	103	234	443	489	517	603	871	939
24	131	247	454	492	518	605	872	940
27	158	252	455	493	519	607	883	941
29	163	253	456	494	520	619	885	948
30	166	288	459	496	536	621	901	955
39	167	299	460	497	551	629	902	956
57	176	300	464	501	552	641	903	957
69	178	301	465	502	554	670	905	958
72	183	308	467	503	556	683	906	959
82	184	312	468	504	558	699	908	963
83	185	330	469	505	561	728	909	964
84	187	345	470	506	563	781	913	965
85	195	346	471	508	565	815	914	981
86	200	351	472	509	570	823	918	982
87	201	354	473	510	571	853	922	
88	204	355	479	511	574	854	923	
89	206	373	480	512	577	857	927	
90	207	391	481	513	579	858	928	
91	208	392	482	514	580	862	929	
93	216	394	483	515	581	863	934	

D. For inpatient hospital discharges prior to October 1, 2015, a claim for inpatient trauma services shall mean a claim which has at least one of the following ICD-9-CM diagnosis codes in UB-04 Form Locator 67: Injury codes in the range of 800-959.9, 994.1, 994.7, or 994.8; and either:

1. The patient was admitted to the hospital from the emergency department (UB-04 Form Locator 14 with Priority (Type) of Visit as: 1-Emergency, or 5-Trauma), or

2. The patient was transferred out of the hospital (UB-04 Form Locator 17 with Patient Discharge Status 02-Discharged/transferred to a Short Term General Hospital for Inpatient Care), or
  3. The patient was admitted directly to the hospital, bypassing the emergency department (UB-04 Form Locator 14 with Priority (Type) of Visit as: 1-Emergency, or 5-Trauma), or
  4. The patient died in the emergency department (UB-04 Form Locator 17 with Patient Discharge Status 20-Expired), or
  5. The patient was dead on arrival in the emergency department (UB-04 Form Locator 17 with Patient Discharge Status 20-Expired).
- E.** For inpatient hospital discharges on or after October 1, 2015, a claim for inpatient trauma services shall mean a claim which has at least one of the following ICD-10-CM diagnosis codes in UB-04 Form Locator 67: Injury codes in the range of M80, M84, S00-S99, T07-T34, T51-T79; and either:
1. The patient was admitted to the hospital from the emergency department (UB-04 Form Locator 14 with Priority (Type) of Visit as: 1-Emergency, or 5-Trauma), or
  2. The patient was transferred out of the hospital (UB-04 Form Locator 17 with Patient Discharge Status 02-Discharged/transferred to a Short Term General Hospital for Inpatient Care), or
  3. The patient was admitted directly to the hospital, bypassing the emergency department (UB-04 Form Locator 14 with Priority (Type) of Visit as: 1-Emergency, or 5-Trauma), or
  4. The patient died in the emergency department (UB-04 Form Locator 17 with Patient Discharge Status 20-Expired), or
  5. The patient was dead on arrival in the emergency department (UB-04 Form Locator 17 with Patient Discharge Status 20-Expired).

Sections 48-120, 48-120.04, R.S. Supp., 2014.  
Effective date December 9, 2014.