

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 January 1, 2016.
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 adjuster, 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, 2016:

3	90	200	378	470	504	561	853	927
4	93	203	379	471	505	562	854	928
23	100	204	388	472	506	563	855	935
25	101	206	390	473	507	565	857	941
27	102	208	392	475	510	570	858	948
29	103	246	395	476	511	572	863	956
30	131	251	419	480	512	573	870	957
39	152	287	442	481	513	578	871	958
41	156	300	453	482	514	579	872	959
42	158	301	454	483	516	580	885	963
65	159	310	455	486	517	581	902	964
66	166	312	457	487	518	603	903	981
70	167	313	458	488	519	605	904	982
71	175	329	459	489	520	607	906	988
83	176	330	460	492	536	638	907	989
84	177	337	463	493	549	640	908	
85	183	343	464	494	551	641	909	
86	184	352	465	496	552	683	914	
87	189	354	467	497	556	699	918	
88	191	355	468	501	558	801	920	
89	194	358	469	502	560	802	923	

- 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 48-120.04, R.S. Supp., 2014, and 48-120, R.S. Supp., 2015.

Effective date: December 9, 2015.