



**THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF LABOR AND WORKFORCE DEVELOPMENT
DEPARTMENT OF INDUSTRIAL ACCIDENTS**

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**INFORMATIONAL BULLETIN
REGARDING CPT/HCPCS CODES**

The Department of Industrial Accidents and the Executive Office of Health and Human Services are issuing this joint informational bulletin to serve as medical billing guidance for instances when a Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) code is not listed in the workers' compensation fee schedule or when the American Medical Association (AMA) has updated a code description. The regulation at 114.3 CMR 40.00 governs the payment for purchasers of health care services under M.G. L. c. 152, the Workers' Compensation Act.

The CPT/HCPCS codes set forth in the workers' compensation fee schedule in 114.3 CMR 40.00 remain in effect. When a CPT/HCPCS code is listed in 114.3 CMR 40.00, and the AMA has published changes to the code description, the health care provider should reference the updated code description. The rate for the code with an updated code description remains as established in the current fee schedule in 114.3 CMR 40.00. If a newer code for a service is not reflected in the regulation, providers and insurers, or other payers, may determine if there is a code in the regulation that would reflect comparable services provided; or whether the service provided is specifically referenced in the provider/insurer fee agreement. If the service is provided within the scope of 114.3 CMR 40.00, the provider and insurer may agree on the use of an alternative code for that service and its corresponding rate in the regulation, or use Individual Consideration (I.C.) for the service that does not have a code in the regulation. Reference to the regulation 114.3 CMR 40.04(3) about the criteria of I.C. follows.

Per 114.3 CMR 40.04(3) Individual Consideration (I.C.), services that are authorized but for which there are no established rates are designated as I.C. items. The purchaser under M.G.L. c. 152 will determine an appropriate payment rate. Unless otherwise provided in 114.3 CMR 40.05, the payment will be determined in accordance with all of the applicable following standards and criteria:

- (a) The amount of time required to perform the procedure,*
- (b) The degree of skill required to perform the procedure,*
- (c) The severity or complexity of the patient's disease, disorder or disability,*
- (d) The policies, procedures and practices of other third-party insurers,*
- (e) A copy of the current invoice from the supplier for items if the provider cost exceeds \$500.00. The provider is responsible for maintaining invoices for any items that cost less than \$500.00 for a minimum of three years from the date of the original bill to the carrier.*

The parties may also consider referencing fee schedules from private insurers, Medicare, or other payers if appropriate in order to determine a mutually agreeable rate for service.

The insurer, employer, and health care provider may agree upon a different payment rate for any service set forth in the fee schedule pursuant to 114.3 CMR 40.01(2) and M.G.L. c. 152 §13(1).

In accordance with 114.3 CMR 40.01(5), the appearance of a code in the regulation does not constitute authorization for or approval of the procedure or services. As set forth in M.G.L. c. 152, §13(1)(b), no employee may be held liable for payment of health care services determined compensable under Chapter 152.