Adopted Regulation

114 CMR DIVISION OF HEALTH CARE FINANCE AND POLICY

114.1 CMR 41.00: RATES OF PAYMENT FOR SERVICES PROVIDED TO INDUSTRIAL ACCIDENT PATIENTS BY HOSPITALS

Section

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41.01: General Provisions

(1) Scope, Purpose and Effective Date. 114.1 CMR 41.00 establishes payment rates effective April 1, 2009, for services provided to Industrial Accident Patients by Acute and Non-acute Hospitals under M.G.L. c. 152, the Worker's Compensation Act. Payment rates for services provided to industrial accident patients by other providers are set forth in 114.3 CMR 40.00. Program policies relating to medical necessity and clinical appropriateness are determined pursuant to M.G.L. c. 152 and 452 CMR 6.00. Hospitals must comply with the Department of Industrial Accidents billing requirements under 452 CMR 7.02.

(2) Coverage. The payment rates set forth in 114.3 CMR 41.00 are full payment for services provided under M.G.L. c. 152, § 13, including any related administrative or overhead costs. The insurer, employer and health care service provider may agree upon a different payment rate than that established by 114.1 CMR 41.00. No Industrial Accident Patient may be held liable for the payment for health care services determined compensable under M.G.L. c. 152, § 13.

(3) Authority. 114.1 CMR 41.00 is adopted pursuant to M.G.L. c. 118G and M.G.L. c. 152.

41.02: Definitions

Meaning of Terms. As used in 114.1 CMR 41.00, unless the context requires otherwise, terms shall have the meanings set forth in 114.1 CMR 41.02:

Acute Hospital. A Hospital licensed under M.G.L. c. 111, § 51, which contains a majority of medical-surgical, pediatric, obstetric, and maternity beds, as defined by the Department of Public Health.

Acute Median Payment on Account Factor. The median of all Payment on Account Factors determined for each Acute Hospital.

Base Year. The Hospital fiscal year for which DHCFP-403 data is used to compute the Payment on Account Factor. Only data from a complete or non-partial fiscal year is used in the computation of the Payment on Account Factor. If the Division determines that the data source is inadequate or not representative of the Hospital's ongoing costs, the Division may consider alternative data sources to determine Base Year costs. Criteria for such review will include but shall not be limited to peer group analysis.

Charge . A Hospital's uniform price for each specific service within a revenue center as filed with the Division.

DHCFP-403. The Hospital Statement of Costs, Revenues and Statistics.

Division. The Division of Health Care Finance and Policy as established under M.G.L. c. 118G.

Governmental Unit. The Commonwealth, any division, department, agency, board or commission of the Commonwealth, and any political subdivision of the Commonwealth.

Gross Patient Service Revenue. The total dollar amount of a Hospital's Charges for services rendered in a fiscal year.

Health Safety Net. The fund established under M.G.L. c. 118G, § 36 to pay Acute Hospitals and community health centers for health services provided to low-income uninsured and underinsured individuals.

Hospital. An Acute Hospital or a Non-acute Hospital

Hospital Uniform Assessment Percentage. Massachusetts Acute Hospitals' liability to the Health Safety Net, expressed as a percentage of statewide Acute Hospital private sector revenue. An individual Acute Hospital's gross liability to the Health Safety Net equals the Hospital Uniform Assessment Percentage multiplied by that Hospital's gross private sector Charges .

Implanted Durable Medical Equipment (DME). Implanted prosthetic devices, replacement parts (external or internal), accessories and supplies for implanted DME.

Industrial Accident Patient. A person who receives services for which an employer or insurer is in whole or part liable under M.G.L. c. 152, the Worker's Compensation Act.

New Hospital. A Hospital that was not licensed and operated as a Hospital in the base year or which did not report a full year of data for that year.

Non-acute Median Payment on Account Factor. The median of all Payment on Account Factors determined for each Non-acute Hospital.

Non-acute Hospital. A Hospital that is defined and licensed under M.G.L. c. 111, § 51, with less than a majority of medical-surgical, pediatric, maternity and obstetric beds, or any psychiatric facility licensed under M.G.L. c. 19, §19, or any public health care facility.

Observation Services. Outpatient services ordered by a physician that consist of intermittent monitoring by professional licensed staff that are reasonable and necessary to evaluate a patient's condition to determine the potential need for admission to the hospital.

Payment on Account Factor (PAF). The percentage applied to total Charges for services rendered to an Industrial Accident Patient to calculate payment as determined in accordance with 114.1 CMR 41.03.

Private Sector GPSR. Total Hospital Charges attributable to Industrial Accident, Managed Care and Non-Managed Care payer groups.

Public Health Care Facility. A facility operated by the Department of Public Health, the Department of Mental Health or a County of the Commonwealth.

Rate Year. For all Hospitals, the fiscal year beginning October 1st.

Rehabilitation Services. Comprehensive services performed to achieve objectives of improved health and welfare with the realization of optimal physical, social and vocational potential.

Restorative Services. Physical Therapy (PT), Occupational Therapy (OT) or Speech Therapy (ST) services rendered for maximum reduction of physical and/or speech disability and restoration of optimal functionality.

Speech/Language Pathology Services. The evaluation and treatment of communicative disorders of articulation (including aphasia and dysarthria, language, voice and fluency).

41.03: Payment for Inpatient Services

(1) General. Payment for inpatient services is equal to the product of the PAF and the hospital's Charge for the service. The PAF shall be applied to all billed Charges that are payable under 114.1 CMR 41.00. Payment is based on the applicable PAF and Charge effective on the date the service is provided.

(2) Rate Determination. The Division will determine a Hospital-specific industrial accident Rate Year Payment on Account Factor (PAF) as follows:

(a) Calculation of PAF. The rate year PAF equals the lower of 1.0 or the Hospital's base year Private Sector Gross Patient Service Revenue (PSGPSR) minus its base year private sector contractual adjustments divided by its base year Private Sector Gross Patient Service Revenue (PSGPSR). Private sector revenues and contractual adjustments used in this calculation will be those reported in the DHCFP-403 cost report from Industrial Accident, Managed Care and Non-Managed Care payer groups.

Rate Year PAF = the lower of 1.0 or

$$\frac{\text{Base Year PSGPSR - Base Year Private Sector Contractual Adjustments}}{\text{Base Year PSGPSR}}$$

(b) Mergers and Consolidations. For any Hospital resulting from a merger, consolidation, or other such arrangement, a single updated PAF will be calculated when merged data and Charges become available. Merged or consolidated Hospitals shall use the PAF approved for

the specific site of service until a single updated PAF is calculated and approved by the Division. If there is no individual PAF approved for the site of service, the Acute Median PAF for an Acute Hospital multiplied by the Charges will be used. If the Hospital is a Non-acute Hospital, the Non-acute Median Payment on Account Factor will be used.

(c) New Hospitals. For a New Hospital or Hospital for which an approved PAF is not yet determined, payment will be based on the Acute Hospital Median PAF multiplied by Charges if the Hospital is an Acute Hospital. If the Hospital is a Non-acute Hospital the Non-acute Median Payment on Account Factor will be used.

(3) Out of State Hospitals.

(a) Payment to out of state Acute Hospitals that provide inpatient services is based on the Acute Median Payment on Account Factor. If the Hospital is a Non-acute Hospital the Non-acute Median Payment on Account Factor will be used.

(b) Payment is determined by multiplying the applicable PAF by total Charges for services.

(4) Payment for Implantable Durable Medical Equipment (DME). The PAF will be applied to implantable DME payable under 114.1 CMR 41.00. A Hospital is not required to submit an invoice for these items.

41.04: Hospital Outpatient Rates

(1) General. Except as specified below, payments for outpatient services provided by Massachusetts hospitals shall be made at the rates established for comparable services in accordance with 114.3 CMR 40.00, Rates for Services Under M.G.L. c. 152, Worker's Compensation Act.

(a) Rehabilitation Clinic Services and Restorative Services

1. Fees for Sites of Service After July 1, 1993. Payment for rehabilitation clinic or restorative services provided in a program or location established after July 1, 1993, shall be equal to the rates specified in 114.3 CMR 40.00.

2. Fees for Sites of Service Before July 1, 1993. The rates for individual outpatient physical, occupational, and speech therapy services that a Hospital provided in a program established before July 1, 1993 are listed below. A list of these sites of service is available on the Division's web site at www.mass.gov/dhcfp.

a. Fees for Physical Therapy and Occupational Therapy in OPD Clinics and Satellites Owned and Operated by a Hospital Prior to July 1, 1993.

CODE	FEE	DESCRIPTION
97002	43.46	Physical therapy re-evaluation (per 30 minutes)
97004	53.45	Occupational therapy re-evaluation (per 30 minutes)
97012	16.10	Application of a modality to one or more areas; traction, mechanical
G0283	14.24	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care
97016	15.55	Application of a modality to one or more areas; vasopneumatic devices
97018	7.41	Application of a modality to one or more areas; paraffin bath
97022	16.46	Application of a modality to one or more areas; whirlpool
97024	5.24	Application of a modality to one or more areas; diathermy
97026	5.24	Application of a modality to one or more areas; infrared

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CODE	FEE	DESCRIPTION
97028	6.45	Application of a modality to one or more areas; ultraviolet
97032	17.83	Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes
97034	15.41	Application of a modality to one or more areas; contrast baths, each 15 minutes
97035	13.24	Application of a modality to one or more areas; ultrasound, each 15 minutes
97036	25.51	Application of a modality to one or more areas; Hubbard tank, each 15 minutes
97039	12.85	Unlisted modality (specify type and time if constant attendance)
97110	30.55	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	31.55	Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and proprioception
97113	32.77	Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	27.00	Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing)
97124	24.32	Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97139	17.58	Therapeutic procedure, one or more areas, each 15 minutes; unlisted therapeutic procedure (specify)
97140	29.04	Manual therapy techniques (e.g., mobilization/ manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes
97150	20.52	Therapeutic procedure(s), group (two or more individuals)
97530	31.16	Therapeutic activities, direct (one on one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97532	26.08	Development of cognitive skills to improve attention, memory, problem solving, (includes compensatory training), direct (one-on-one) patient contact by the provider, each 15 minutes
97533	27.82	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact by the provider, each 15 minutes
97535	33.72	Self care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures,and instructions in use of assistive technology devices/adaptive equipment) direct one on one contact by provider, each 15 minutes
97537	29.51	Community/work reintegration training (e.g., shopping, transportation,

CODE	FEE	DESCRIPTION
		money management, avocational activities and/or work environment/modification analysis, work task analysis), direct one–on-one contact by provider, each 15 minutes
97542	30.38	Wheelchair management/propulsion training, each 15 minutes
97545	147.92	Work hardening/conditioning; initial two hours
97546	73.96	Work hardening/conditioning; each additional hour
97750	33.55	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
97799	I.C.	Unlisted physical medicine/rehabilitation service or procedure

b. Fees for Speech Therapy in OPD Clinics and Satellites Owned and Operated by a Hospital Prior to July 1, 1993.

CODE	FEE	DESCRIPTION
92507	88.56	Treatment of speech, language, voice, communication, and/or auditory processing disorder (includes aural rehabilitation); individual
92508	73.38	Treatment of speech, language, voice, communication, and/ or auditory processing disorder (includes aural rehabilitation); group, two or more individuals
92526	92.33	Treatment of swallowing dysfunction and/or oral function for feeding

c. Exceptions. To comply with the requirements of M.G.L. c.152, §13, the rates for the following Hospitals shall equal the higher of the rates contained in 114.3 CMR 40.00 or the product of the fees listed in 114.1 CMR 41.04(1)(b)2.a. and 114.1 CMR 41.04(1)(b)2.b. and the Hospital specific percentage listed below:

Hospital Name	Physical Therapy: Fee X %	Occupational Therapy: Fee X %	Speech Therapy: Fee X %
Brockton Hospital	79%	100%	100%
Fairlawn Hospital	99%	99%	99%
Mass. Eye and Ear	100%	92%	100%
New England Rehabilitation Hospital	86%	86%	86%
North Shore Medical Center – Shaughnessy Kaplan Rehab	87%	91%	82%
Southwood Community Hospital	88%	100%	100%

3. Functional Capacity Assessments. To report a functional capacity assessment (or Key functional assessment), hospitals shall use CPT code 97750 that may be billed up to a maximum of nine (9) units per session.
4. Work Hardening and Work Conditioning. Work hardening and work conditioning are goal-oriented therapies designed to prepare injured workers for their return to work. Hospitals shall use CPT codes 97545 and 97456 to report these services.
5. Modalities. Hospitals may assess a Charge for supportive services (CPT codes 97012-97039) only in conjunction with a procedure performed during the course of the same visit. When determining the correct units allowed, Hospitals shall round partial units to one decimal place.

(b) Outpatient Services Available Only in Hospitals. Payers shall pay for the following services and any other services incidental to the visit by applying the Hospital's PAF, as established in 114.1 CMR 41.03, to the Charges for services.

1. Emergency Department Services. All Emergency Department Services shall be paid using the PAF. Non-emergent visits shall be paid pursuant to 114.3 CMR 40.00.
2. Observation Services. All Observation Services shall be paid using the PAF. Other services provided during a visit that results in an observation stay shall be paid pursuant to the other provisions of 114.1 CMR 41.00 or, when applicable, the provisions of 114.3 CMR 40.00.
3. Ambulatory Surgery. All surgical procedures performed in an outpatient surgical department not approved by Medicare to be performed in a free-standing ASC shall be paid using the PAF. A CPT code described as an unlisted procedure, typically one denoted by “xxx99”, shall be paid using the PAF only if documentation supports the necessity to perform the operation in a hospital based ASC.

(c) Individual Consideration (I.C.). Services that are authorized but for which there are no established rates are designated as I.C. services. The purchaser will determine the appropriate payment rate in accordance with the following standards and criteria:

1. the amount of time required to perform the procedure;
2. the degree of skill required to perform the procedure;
3. the severity or complexity of the patient’s disease, disorder or disability; and
4. the policies, procedures, and practices of other third party insurers.

(d) Acute Hospital Uniform Assessment. For payments for outpatient services provided by a Massachusetts Acute Hospital, payers shall pay a separate and additional Health Safety Net fee to reflect the costs that such Hospitals incur for their gross liability to the Health Safety Net. The additional fee is the hospital uniform assessment percentage multiplied by the total Charges billed for outpatient services. No additional fee shall be paid when payment is made to Massachusetts Acute Hospitals for services provided pursuant to 114.1 CMR 41.03(2), or when payment is made to Massachusetts Non-acute Hospitals or to out-of-state Hospitals

(2) Out of State Outpatient Services

(a) Payers shall compensate out of state Hospitals for outpatient services listed in 114.1 CMR 41.04(1)(b) by applying the out of state PAF, as established in 114.1 CMR 41.03(3).
(b) Industrial accident payers shall compensate out of state Hospitals for all other outpatient services as provided in 114.3 CMR 40.00.

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41.05 Other Provisions

(1) Administrative Bulletins. The Division may issue Administrative Bulletins to clarify its policies on and understanding of substantive provisions of 114.1 CMR 41.00, or to publish Hospital PAFs, Hospital Uniform Assessment Percentages or procedure code updates and corrections. For coding updates and corrections, the bulletin will list:

(a) new code numbers for existing codes, with the corresponding cross references between existing and new code numbers;

(b) deleted codes for which there are no corresponding new codes; and

(c) codes for entirely new services that require pricing. The Division will designate these codes to be paid by individual consideration (I.C.) under 114.1 CMR 41.04(1)(c) until appropriate rates are developed.

(2) Administrative Adjustment. The Division may correct the calculation of a Hospital's PAF if it determines there is an error in the calculation. A hospital may request that the Division correct an arithmetic, mechanical or clerical error. A Hospital may not request an Administrative Adjustment to reverse a substantive determination pursuant to 114.1 CMR 41.00. The request for an Administrative Adjustment must be received by the Division within 20 business days of the notification date of the Division's determination. The request must be in writing and contain a precise explanation of the perceived error as well as any documentation to support the request.

(3) Hospital PAFs. The Division will publish the Hospital PAFs on or by July 1st of the calendar year following the Base Year by an Administrative Bulletin.

(4) Hospital Uniform Assessment Percentage. The Division will publish the Hospital Uniform Assessment Percentage on or by October 1st of each year by an Administrative Bulletin.

41.06: Severability

The provisions of 114.1 CMR 41.00 are severable. If any provision of 114.1 CMR 41.00 or the application of such provisions to any Hospital, person, or circumstances is held invalid or unconstitutional, such determination shall not be construed to affect the validity or constitutionality of any other provision of 114.1 CMR 41.00 or the application of such provisions to other Hospitals, persons or circumstances.

REGULATORY AUTHORITY

114.1 CMR 41.00: M.G.L. c. 118G and M.G.L. c. 152.