Medical Fee Schedule (MFS)
Frequently Asked Questions (FAQs)

General FAQs

1. What is the Medical Fee Schedule (MFS)?

The MFS is the schedule of maximum fees payable for scheduled medical services rendered to injured workers under the Virginia Workers' Compensation Act (the Act) in the absence of a contract for the payment of such services. The fee scheduled medical services include services provided by physicians, surgeons, hospitals, ambulatory surgery centers, other healthcare service providers and suppliers.

2. What is the authority for the Medical Fee Schedule?

Va. Code Sec. 65.2-605; Chapters 279 and 290 of the 2016 Virginia Acts of Assembly and Chapter 478 of the 2017 Virginia Acts of Assembly.

3. How was the MFS developed?

The approach to develop the MFS included the identification of a 10-member Regulatory Advisory Panel and selection of an actuarial consultant. Guided by the requirements outlined in statute, the Regulatory Advisory Panel, Oliver Wyman (actuarial consultant) and the Commission participated in many working sessions over several months defining the project's purpose and scope to include type of data, actuarial methodology and structure of the MFS. Virginia-specific workers' compensation data was gathered and reviewed. Only valid and statistically reliable data (approximately 74 percent of the total Virginia workers' compensation market in 2014 and 2015) was used in the direct development of the MFS.

4. Has the state officially mandated the use of ICD-10?

Hospital in-patient medical services shall be coded and billed through the International Statistical Classification of Disease and Related Health Problems as in effect at the time the medical services were provided to the claimant, as indicated in Subsection N of Va. Code Sec. 65.2-605.

5. When will the MFS become effective?

The regulations implementing the fee schedule shall become effective January 1, 2018 and apply to health care services provided to an injured worker for any dates of service on or after this date, regardless of the date of injury.

6. Who will manage the MFS?

The Commission will monitor and manage the application of the MFS via the Medical Fee Services Department, within the VWC.

7. Will the Commission make changes to the MFS?

The Commission will review the MFS on an on-going basis, informally and formally, and shall review the MFS after the transition year and biennially thereafter on or about January 15th of the review year. If necessary, the Commission will adjust the Virginia fee schedules in order to address inflation or deflation and other specific criteria enumerated in Subsection D of Va. Code Sec. 65.2-605 on or about April 1st of the review year.

8. If there are changes to the MFS, when will the MFS changes become effective?

The regulations implementing revisions to the fee schedule shall become effective on April 1 of the year following the review or as otherwise directed by the Commission.

9. What if the contract or network agreement reimbursement is lesser or greater than the Medical Fee Schedule for the medical services I provide?

The amount agreed upon by all parties to the contract for reimbursement of fee scheduled medical service may be less than or exceed the maximum fee amount.

10. What if I access a preferred provider network (PPO), does it need to be listed on the EOR to be reimbursed?

The MFS applies in the absence of a contract.

11. What if providers and payers cannot resolve reimbursement disputes arising under the MFS?

Parties that cannot amicably resolve a dispute arising under the MFS may request an administrative review of the dispute by the MFS Department. A MFS Dispute Request Form must be completed and forwarded to the MFS Department with supporting documentation. A link to the Form is posted on the VWC Medical Services Department page.

http://www.workcomp.virginia.gov/content/medical-fee-schedule-dispute-resolution-process

12. What if I do not agree with the MFS Department's administrative decision?

You may request a hearing before a Deputy Commissioner where the dispute may be fully litigated. Such a hearing request must be filed within 30 days after the issuance of the MFS Department's administrative decision. Parties participating in a hearing before a Deputy Commissioner must be represented by an attorney licensed to practice law in the Commonwealth of Virginia.

13. Will the Commission issue special notices regarding MFS changes?

The Commission has an email distribution listing that will be used to communicate MFS changes. Please email medicalfeeservices@workcomp.virginia.gov to be included in the distribution list.

14. Is there a way to obtain a copy of the Medical Fee Schedule?

The Commission has provided a link to the MFS on the website. The fee schedule can be downloaded via the link.

http://www.workcomp.virginia.gov/content/virginia-medical-fee-schedules

Medical Provider/FAQs

1. How do I determine the region?

There are six regions. Regions are determined by the first three digits of your zip code. For a complete listing of the zip codes for each region, please refer to the Region Map located in the Grounds Rules Document on the Commission's Website.

2. Should I change my charge for services to the fee schedule amount?

Pursuant to Subsection I of Va. Code Sec. 65.2-605, "No provider shall use a different charge master or schedule of fees for any medical service provided under (the Virginia Workers' Compensation Act) than the provider uses for health care services provided to patients who are not claimants under (the Act)."

3. I am a provider with multiple locations; do I have the option to select which office location is listed for reimbursement on the billing statement?

The applicable fee schedule will be determined by the place of service per Subsection A of Va. Code Sec. 65.2-605, which defines "Virginia fee schedule" as "…a schedule of maximum fees for fee scheduled medical services for the medical community where the fee scheduled medical service is provided…"

4. If I provide services for a Virginia jurisdiction injury and I am an out-of-state provider, does my state's fee schedule and rules apply?

Any health care provider located outside of the Commonwealth of Virginia who provides health care services under the Act to a claimant shall be reimbursed based on the fee schedule applicable to the principal place of business of the employer if located in the Commonwealth or, if no such location exists, then the location where the Commission hearing regarding a dispute is conducted.

5. Is there a standard for billing medical services in order to receive MFS reimbursement?
Yes. To be eligible for MFS reimbursement, medical service(s) must be billed using the appropriate coding convention.

6. What if I bill a coding convention for a medical service that is not listed in the MFS?

The Ground Rules Document provides additional information and instruction on reimbursement for applicable coding conventions of fee scheduled medical services.

http://www.workcomp.virginia.gov/content/virginia-medical-fee-schedules-ground-rules

7. Will the MFS Department determine if I billed for charges using the correct coding convention to receive the appropriate reimbursement?

Outside of the administrative determination of a formal dispute for which a Dispute Resolution Form has been filed, the MFS Department will not instruct/determine if the appropriate coding

convention was billed. However, the MFS Department does establish and maintain medical fee schedule quality standards by providing direction, training, and information to the public on the medical fee schedule requirements.

8. Will I need to provide to the employer/insurer medical reports for MFS reimbursement?

Yes. If medical records are requested for billed medical services, they must be provided to the employer/insurer.

9. When does Table Q, Professional Services Billed by a Physician Non-Surgeon for Surgical procedures apply?

Table Q applies to medical professionals that are not assigned a CMS provider specialty which has been designated as a surgeon as defined in the Ground Rules.

10. Does the Medical Fee Schedule define maximum fees for pharmacy and durable medical equipment?

Retail or mail order prescription drugs and durable medical equipment (DME) dispensed through a retail provider are excluded from the MFS. The maximum fees listed for pharmacy and DME codes are based on only those pharmacy and DME fee scheduled medical services dispensed by physicians and are reflective of reimbursement paid to providers during 2014 and 2015. After transition, providers billing DME codes must use the applicable modifiers for fee scheduled medical services.

11. Why are there blank modifiers for some DME codes?

Durable medical equipment (DME) dispensed through retail suppliers routinely billing modifiers RR, NU, and UE are excluded from the MFS. The maximum fees listed for DME codes and identified modifiers are based on DME fee scheduled medical services reimbursed to medical providers during 2014 and 2015. After transition, medical providers billing DME codes must use the applicable modifiers for each fee scheduled medical service.

12. The Medical Fee Schedule contains current coding conventions for DRG Version 35 with maximum fees. Why are these codes present in the MFS?

To provide for more comprehensive schedules, the average of the paid amount per DRG weight by region, Type One Teaching Hospital, and Other than Type One Teaching Hospital provider types was utilized to establish the max fees listed for DRG Version 35 codes.

Employer/Insurer FAQs

1. How do I determine if I must reimburse using the MFS?

In the absence of a contract, reimbursement for fee scheduled medical service provided on or after January 1, 2018, regardless of the date of injury, shall be determined by the MFS.

2. What if I do not agree with the medical provider's billing or the medical provider billed incorrectly for services rendered?

Medical services must be billed using the appropriate coding standards (i.e. NCCI, AMA CPT, ICD, and HCPCS). To the extent that a medical bill is submitted in a manner inconsistent with these standards, and the itemization or a portion thereof is contested, denied, or considered incomplete, the employer or the employer's workers' compensation insurance carrier shall notify the health care provider within 45 days after receipt of the itemization that the itemization is contested, denied, or considered incomplete. The notification shall include the following information:

- The reasons for contesting or denying the itemization, or the reasons the itemization is considered incomplete;
- If the itemization is considered incomplete, all additional information required to make a decision; and
- The remedies available to the health care provider if the health care provider disagrees.

3. Are there deadlines by which the employer/insurer must issue payment for a billed medical service?

Yes, payment for any properly documented health care service that is not contested, denied or considered incomplete must be made within 60 days after receipt of the itemization.

4. Are physician non-surgeon rates considered as rates for non-facility place of service and surgeon rates for facility place of service for each region?

The physician non-surgeon and surgeon schedules are maximum fees for professional services. Determination as to whether the physician or non-physician maximum fee applies is based on the provider's CMS provider specialty code. The maximum fee does not vary based on the location where the service is provided.

5. How will we know the medical provider's taxonomy code?

To be eligible for reimbursement, all claims for professional services must include the rendering provider's taxonomy code.

6. Must both operative reports be present prior to making payment for two physicians performing separate functions of a surgery (modifier 62)?

When codes are billed with modifiers consistent with National Correct Coding Initiative rules, as in effect at the time a medical service was provided shall serve as the basis for processing a

healthcare provider's billing form. Please reference the Ground Rules under the CPT/HCPCS Modifiers section.

7. Can a 99455 be billed by the same provider on the DOS as a special report using 99080?

For all other CPT/HCPCS codes, maximum fees presented on the MFS apply when billed without any of the modifiers defined in the ground rules and represent the reimbursement applicable when the service is delivered consistent with the definition of the CPT/HCPCS code. Please reference the Ground Rules under the CPT/HCPCS Modifiers section.

8. Air Ambulance payment methodology- is it to be paid in full?

The MFS does not define a maximum fee reimbursement for Air Ambulance.

9. Is E&M down coding permitted?

The MFS maximum fee reimbursement is applicable when the service is delivered consistent with the definition of the CPT/HCPCS code. Please reference the Ground Rules under the CPT/HCPCS Modifiers section.

10. Are there requirements for prior authorization?

The MFS does not define requirements for prior authorization.

11. Can a MD bill on behalf of a PA, and Anesthesiologist bill for CRNA?

Yes.

12. How do you distinguish a hospital from a Type One Teaching hospital?

Type One Teaching Hospital is a state owned hospital on January 1, 1996. VCU Health System and UVA Health System are designated as Type One Teaching Hospitals.

13. Are there any guidelines for payments concerning Physician Assistants or Nurse practitioners when they are not an assistant for surgery?

Non-physician practitioners (NPPs) include professionals such as a nurse practitioner, physician assistant, clinical nurse specialist, clinical psychologist, clinical social worker, physical therapist, occupational therapist, or speech therapist outlined in the Maximum Fee Reimbursement section. No adjustment shall be applied to the applicable maximum fee appearing on the MFS, regardless of whether the NPP bills for the service under the physician's NPI or their own, beyond those outlined in the CPT/HCPCS Modifiers section

14. How are Critical Access Hospitals reimbursed for outpatient services?

Provider Group 4 includes all hospitals, exclusive of Type One Teaching Hospitals or other previously excluded hospitals as listed in the Ground Rules Document.

15. Are the CCI/OCE, MUE edits, and endoscopy grouped calculation, Radiology or Physical Therapy MPPR applicable?

The CPT code and National Correct Coding Initiative rules, as in effect at the time a medical service was provided to the claimant, shall serve as the basis for processing a health care provider's billing form or itemization for such items as global and comprehensive billing and the unbundling of medical services. Hospital in-patient medical services shall be coded and billed through the International Statistical Classification of Diseases and Related Health Problems as in effect at the time the medical service was provided to the claimant.

16. The Physician's fee schedule is separated into Surgeon and Non-Surgeon sections. under what circumstances would a "Non-Surgeon" be associated with codes typically found within the CPT Surgery code range?

The Ground Rules documents provides a listing of CMS Provider Specialty Codes for Surgeons based on the rendering provider's taxonomy code. The Non-Surgeon maximum reimbursement applies to surgical codes billed by a rendering provider that is not assigned one of the CMS Provider Specialty Codes defined in the Ground Rules as a "Surgeon."