

**VIRGINIA WORKERS' COMPENSATION  
MEDICAL FEE SCHEDULES  
GROUND RULES**

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## Introduction

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The Virginia Workers' Compensation Medical Fee Schedules (MFS) outline maximum fees for health care providers, hospitals, and ambulatory surgical centers, rendering health care services to injured employees as provided in the Virginia Workers' Compensation Act, Title 65.2 of the Code of Virginia. **The MFS will apply to health care services provided to an injured person for any dates of service on or after January 1, 2018, regardless of the date of injury.**

The MFS have been developed in accordance with Chapters 279 and 290 (amended) of the 2016 Acts of Assembly and Chapter 478 of the 2017 Virginia Acts of Assembly of the Commonwealth of Virginia. The Virginia General Assembly passed this law providing for the development and implementation of the MFS. Governor Terry McAuliffe approved the law on March 7, 2016. In accordance with the statutory mandate, the MFS have been designed to reflect actual average historical costs for services provided in the Commonwealth in the treatment of workers' compensation injuries, including observed variation by medical community and procedure/service, to the extent the data available was determined to be statistically reliable. As such, relative reimbursement for any subset of procedures shall vary by medical community and by provider group (*please refer to the Definitions section*).

This document is intended to provide general information and instruction on how to interpret the MFS. This document reflects MFS development as of April 2017. To address considerations identified in the process of developing the MFS, it is anticipated there may be some substantive changes to the enabling legislation in subsequent years.

Significant time, effort and resources were invested by the Commission, the regulatory Advisory Panel members, and the Commission's actuarial consultant, Oliver Wyman, in developing the MFS. These parties participated in many working sessions over the course of several months. Virginia-specific workers' compensation experience was gathered for the analyses from various sources including, but not limited to, the National Council on Compensation Insurance, Inc., many medical providers, group self-insureds, individual self-insureds and third party administrators. Only data that was found to be valid and statistically reliable was ultimately used for the analyses. It is estimated that the data used in the direct development of the MFS represent roughly 74 percent of the total Virginia workers' compensation market. Valid and statistically reliable data sources not ultimately used in the direct development of the MFS were used to validate the results. The regulatory Advisory Panel provided valuable guidance and direction to Oliver Wyman in the selection of the actuarial methodology used, among several valid actuarial methodologies, and the desired structure for of each of the various MFS. The fee schedules were designed to achieve revenue neutrality within each provider group and medical community combination.

## Definitions

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**"ACCREDITED OFFICE-BASED SURGERY CENTER"** means an office-based surgery center that has been accredited by the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC).

**"ACUTE INPATIENT HOSPITAL STAY"** means stays at an acute care hospital for reasons other than rehabilitation, treatment of a serious burn, or admission to a Level I or Level II trauma center.

**"ADD-ON PROCEDURES"** means certain codes that, by the nature of their description and unit values assigned, have already been reduced, as they are not to be billed as primary procedures. For a complete list of codes which are add-on codes, refer to the appropriate appendix found within the most recent publication of the *AMA Current Procedural Terminology*.

**"AMBULATORY SURGICAL CENTER"** means a free-standing health care facility that specializes in providing surgery, pain management, and certain diagnostic services in an outpatient setting. ASC-qualified procedures are typically more complex than those done in a doctor's office, but not so complex as to require an overnight stay. For purposes of the MFS, services delivered in an accredited office-based surgery center will be treated and subject to the same reimbursement as if they were provided in an ambulatory surgical center.

**"BURN CENTER"** means a treatment facility designated as a burn center pursuant to the verification program jointly administered by the American Burn Association and the American College of Surgeons, and verified by the Commonwealth.

**"BY REPORT (BR)"** means a service or procedure requiring additional justification in the form of a report that contains sufficient supportive information to permit proper identification. Pertinent information should be furnished concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary to provide the service, etc.

**"CASE MIX GROUP (CMG)"** means a patient classification system that groups together inpatient medical rehabilitation admissions that are expected to have similar resource utilization needs and outcomes.

**"CATEGORIES OF PROVIDERS OF FEE SCHEDULED MEDICAL SERVICES (PROVIDER GROUPS)"** means the classifications of providers for which unique fee schedules will apply, as listed below:

- **Provider Group 1** – Physicians, exclusive of surgeons
- **Provider Group 2** – Surgeons
- **Provider Group 3** – Type One Teaching Hospitals
- **Provider Group 4** – Hospitals, exclusive of Type One Teaching Hospitals
- **Provider Group 5** – Ambulatory surgical centers

- **Provider Group 6** – Providers of outpatient medical services not covered by provider groups 1, 2 or 5
- **Provider Group 7** – Purveyors of miscellaneous items and any other providers not covered by provider groups 1 through 6, as established by the Commission in regulations

"**CODES**" mean, as applicable, CPT codes, HCPCS codes, CMG classifications, or DRG classifications.

"**CPT CODES**" means the medical and surgical identifying codes using the *Physicians' Current Procedural Terminology* (CPT<sup>®</sup>) published by the American Medical Association (AMA). CPT codes represent a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals.

CPT<sup>®</sup> is a registered trademark of the American Medical Association.

"**DIAGNOSIS RELATED GROUP (DRG)**" means the system of classifying inpatient hospital stays adopted for use with the Inpatient Prospective Payment System. DRGs included in the MFS are based on MS-DRG Version 30.

"**DURABLE MEDICAL EQUIPMENT**" means rented or purchased equipment ordered by a healthcare provider that can withstand repeated use, and provides therapeutic benefits to a patient in need because of a certain medical condition and/or illness.

"**FEE SCHEDULED MEDICAL SERVICE**" means a medical service exclusive of a medical service provided in the treatment of a traumatic injury or serious burn.

"**HEALTH CARE COMMON PROCEDURE CODING SYSTEM (HCPCS) CODES**" means Healthcare Common Procedure Coding System Level II codes maintained by the US Centers for Medicare and Medicaid Services (CMS) and used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services, durable medical equipment, prosthetics, orthotics, medical supplies, and injectable drugs.

"**INCIDENTAL SURGERY**" means a surgery which is performed on the same patient, on the same day, by the same health care provider, but is not related to the diagnosis.

"**IMPLANTABLE MEDICAL DEVICE**" means those items identified by Revenue Codes 274 (prosthetic/orthotic devices), 275 (pace makers), 276 (intraocular lens), and 278 (other implants), which involve an item or device intended for permanent placement in the body. Implantable items can include, but are not limited to, rods, pins, screws, plates, prosthetic joint replacements, and other items properly coded using Revenue Codes 274, 275, 276, or 278.

"**INJECTABLE DRUGS**" means drugs administered other than orally, and chemotherapy drugs billed with a HCPCS code starting with "J" or one of the CPT/HCPCS codes in the following table.

**CPT Codes**

90371	90586	90656	90669	90685	90703	90732	90744
90375	90630	90657	90670	90686	90714	90733	90746
90376	90632	90660	90672	90687	90715	90735	90747
90385	90654	90661	90673	90688	90717	90740	
90585	90655	90662	90675	90691	90718	90743	

**HCPCS Codes**

A9575	P9045	Q0167	Q0179	Q2043	Q4081	Q4113	Q9958
A9576	P9046	Q0168	Q0180	Q2044	Q4101	Q4114	Q9960
A9577	P9047	Q0169	Q0515	Q2046	Q4102	Q4115	Q9961
A9578	P9048	Q0170	Q2009	Q2047	Q4104	Q4116	Q9963
A9579	Q0138	Q0171	Q2017	Q2048	Q4105	Q4121	Q9965
A9581	Q0139	Q0172	Q2035	Q2049	Q4106	Q4123	Q9966
A9583	Q0162	Q0173	Q2036	Q2050	Q4107	Q4131	Q9967
A9585	Q0163	Q0175	Q2037	Q2051	Q4108	Q5101	Q9970
A9606	Q0164	Q0176	Q2038	Q3025	Q4110	Q9954	Q9974
P9041	Q0165	Q0177	Q2040	Q3027	Q4111	Q9956	Q9975
P9043	Q0166	Q0178	Q2041	Q4074	Q4112	Q9957	Q9979

**"INPATIENT SERVICES"** means services rendered to a person who is formally admitted to a hospital and whose length of stay exceeds 23 hours.

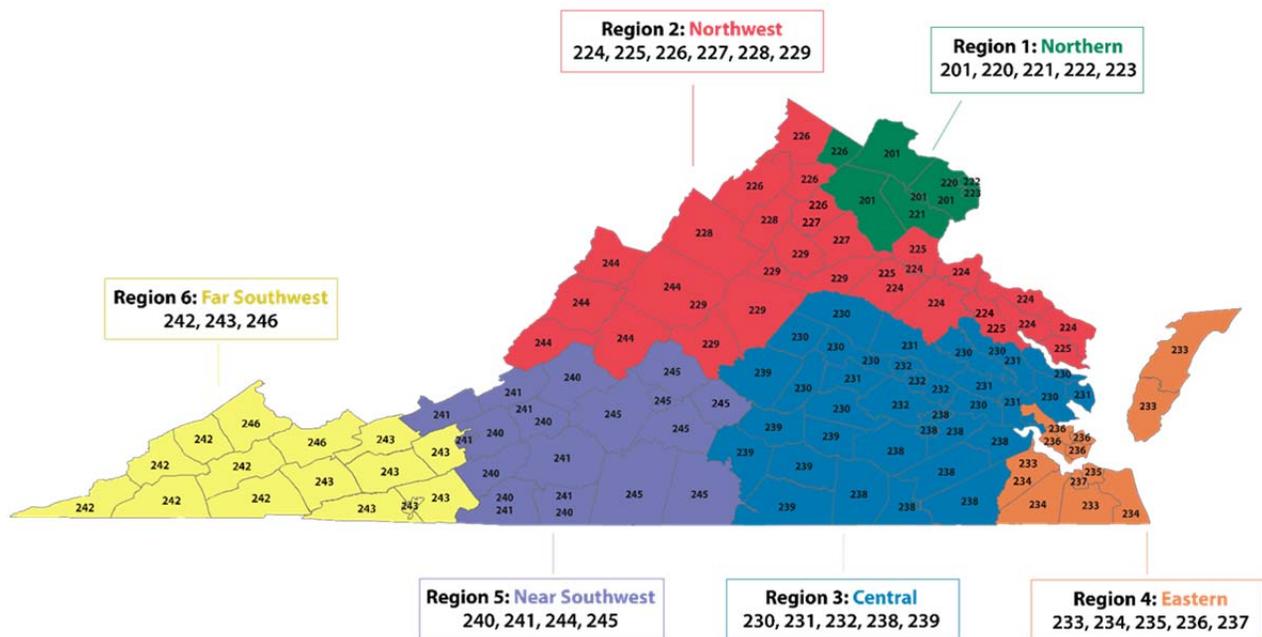
**"LEVEL I OR LEVEL II TRAUMA CENTER"** means a hospital in the Commonwealth designated by the Board of Health as a Level I or Level II trauma center pursuant to the Statewide Emergency Medical Services Plan developed in accordance with § 32.1-111.3.

**"MEDICAL COMMUNITY"** means one of six regions of the Commonwealth defined by three-digit ZIP code prefixes.

- **Region 1 (Northern Region)** - The area for which three-digit ZIP code prefixes 201 and 220 through 223 have been assigned by the U.S. Postal Service.
- **Region 2 (Northwest Region)** - The area for which three-digit ZIP code prefixes 224 through 229 have been assigned by the U.S. Postal Service.
- **Region 3 (Central Region)** - The area for which three-digit ZIP code prefixes 230, 231, 232, 238, and 239 have been assigned by the U.S. Postal Service.
- **Region 4 (Eastern Region)** - The area for which three-digit ZIP code prefixes 233 through 237 have been assigned by the U.S. Postal Service.

- **Region 5 (Near Southwest Region)** - The area for which three-digit ZIP code prefixes 240, 241, 244, and 245 have been assigned by the U.S. Postal Service.
- **Region 6 (Far Southwest Region)** The area for which three-digit ZIP code prefixes 242, 243, and 246 have been assigned by the U.S. Postal Service.

The six defined medical communities are shown visually below:



**"MEDICAL FEE SCHEDULE (MFS)"** means the Virginia schedule of maximum fees for fee scheduled medical services for the provider group and medical community where the fee scheduled medical service is provided (see *"Virginia Fee Schedule"*).

**"MEDICAL SERVICE"** means any medical, surgical, or hospital service required to be provided to an injured person pursuant to the Virginia Workers' Compensation Act.

**"MEDICAL SERVICE PROVIDED FOR THE TREATMENT OF A SERIOUS BURN"** means any services provided by a burn center, and any professional services rendered during the dates of service of an admission or transfer to a burn center.

**"MEDICAL SERVICE PROVIDED FOR THE TREATMENT OF A TRAUMATIC INJURY"** means any services provided by a Level I or Level II trauma center, and any professional services rendered during the dates of service of an admission or transfer to a Level I or Level II trauma center, which are associated with the treatment of a traumatic injury.

**"MISCELLANEOUS ITEMS"** means medical services provided under this title that are not included within subdivisions 1 through 6 of the definition of categories of providers of fee scheduled medical services. "Miscellaneous items" does not include (i) pharmaceuticals that are dispensed by providers, other than hospitals or Type One teaching hospitals as part of inpatient

or outpatient medical services, or dispensed as part of fee scheduled medical services at an ambulatory surgical center or (ii) durable medical equipment dispensed at retail.

**"MODIFIER"** means a two digit value attached to a CPT/HCPCS code that allows the reporting provider to indicate that a service or procedure that has been performed has been altered due to a specific circumstance. Modifiers may be used to indicate events such as, but not limited to:

- A service or procedure has only a professional component or only a technical component
- A service or procedure was performed by more than one physician or on more than one site
- A service or procedure has been increased or reduced from the level represented by the code
- Only part of a service was performed
- Multiple procedures were performed on a single surgical site
- A procedure was performed bilaterally

**"MODIFIER 51 EXEMPT PROCEDURES"** means procedures that are not subject to the multiple procedure reduction rules. For a complete list of codes that fall into this category, refer to the appropriate appendix found within the most recent publication of the *AMA Current Procedural Terminology*

**"NEW TYPE OF TECHNOLOGY"** means an item resulting or derived from an advance in medical technology, including implantable medical devices or items of medical equipment, that has been cleared or approved by the Federal Food and Drug Administration (FDA) after January 1, 2018 and prior to the date of the provision of medical service using the item.

**"OTHER THAN TYPE ONE TEACHING HOSPITAL"** means a hospital other than one that was a state-owned teaching hospital on January 1, 1996.

**"OUTLIER THRESHOLD"** means a value equal to 300 percent of the maximum fee set forth in the applicable fee schedule for acute inpatient hospital stays.

**"PHYSICIAN"** means a person licensed to practice medicine or osteopathy in the Commonwealth pursuant to Chapter 29 (§ 54.1-2900 et seq.) of Title 54.1.

**"PHYSICIAN NON-SURGEON"** means a physician that is not assigned a CMS provider specialty code of a surgeon (*see the definition of Surgeon for a listing of the referenced provider specialty codes*).

**"PROFESSIONAL SERVICE"** means any medical or surgical service required to be provided to an injured person pursuant to the Virginia Workers' Compensation Act that is provided by a physician or any health care practitioner licensed, accredited, or certified to perform the service consistent with state law.

**"PROPERLY BILLED"** means billed in accordance with National Correct Coding Initiatives.

**"PROVIDER"** means a person licensed by the Commonwealth to provide a medical service to a claimant under the Virginia Workers' Compensation Act.

**"PROVIDER GROUPS"** means the classifications of providers for which unique fee schedules will apply (see *"Categories of Providers of Fee Scheduled Medical Services"*).

**"REIMBURSEMENT OBJECTIVE"** means the average of all reimbursements and other amounts paid to providers in the same category of providers of fee scheduled medical services in the same medical community for providing a fee scheduled medical service to a claimant under the Virginia Workers' Compensation Act during the most recent period preceding the transition date for which statistically reliable data is available, as determined by the Commission.

**"REVENUE CODES"** means a method of coding used by hospitals or health care systems to identify the department in which a medical service was rendered to the patient, or the type of item or equipment used in the delivery of medical services.

**"REVENUE NEUTRALITY"** means achieving the reimbursement objective and resulting in a MFS that produces the same aggregate reimbursement as that which was paid to providers in the same provider group and medical community as was paid during calendar 2014 and 2015 (see *"Reimbursement Objective"*).

**"SERIOUS BURN"** means a burn for which admission or transfer to a burn center is medically necessary.

**"SURGEON"** means a physician assigned one of the CMS provider specialty codes listed below based on the rendering provider's taxonomy code.

**CMS Provider Specialty Codes Defined as Surgeons**

02	General Surgery	28	Colorectal Surgery
04	Otolaryngology	33	Thoracic Surgery
14	Neurosurgery	40	Hand Surgery
18	Ophthalmology	77	Vascular Surgery
19	Oral Surgery	78	Cardiac Surgery
20	Orthopedic Surgery	85	Maxillofacial Surgery
24	Plastic & Reconstructive Surgery	91	Surgical Oncology

**"TRAUMATIC INJURY"** means an injury for which admission or transfer to a Level I or Level II trauma center is medically necessary, and that is assigned a DRG number of 003, 004, 011, 012, 013, 025 through 029, 082, 085, 453, 454, 455, 459, 460, 463, 464, 465, 474, 475, 483, 500, 507, 510, 515, 516, 570, 856, 857, 862, 901, 904, 907, 908, 955 through 959, 963, 998, or 999. Claimants who die in an emergency room of trauma or burn before admission shall be deemed to be claimants who incurred a traumatic injury.

**"TYPE ONE TEACHING HOSPITAL"** means a hospital that was a state-owned teaching hospital on January 1, 1996.

**"UNLISTED SERVICES OR PROCEDURES"** means services and procedures too unusual or variable in the nature of their performance, too new, or too infrequently performed to permit the assignment of a maximum fee. Unlisted services and procedures are typically billed with CPT or

HCPCS codes ending in '99' and are identified as those with 'BR' listed as the maximum fee in the MFS.

**"VIRGINIA FEE SCHEDULE"** means a schedule of maximum fees for fee scheduled medical services for the medical community where the fee scheduled medical service is provided, as initially adopted by the Commission pursuant to subsection C, and as adjusted as provided in subsection D.

# General Information

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## Application of the Medical Fee Schedules

The MFS apply to health care providers, hospitals, and ambulatory surgical centers, rendering health care services to injured employees, as provided in the Virginia Workers' Compensation Act, Title 65.2 of the Code of Virginia. **The MFS applies to health care services provided to an injured person for any dates of service on or after January 1, 2018, regardless of the date of injury.**

## Exclusions from the Medical Fee Schedules

The MFS do not apply to:

- Health care services subject to a written contract between a health care provider and an employer or insurance carrier;
- Health care services for which voluntary payments in excess of the reimbursement levels of the MFS are made by a self-insured employer or an insurance carrier;
- Physician dispensed, retail or mail order prescription drugs;
- Air ambulances;
- Durable medical equipment dispensed through a retail DME provider;
- Facility services associated with a traumatic injury;
- Professional services associated with a traumatic injury;
- Facility services associated with a serious burn; and
- Professional services associated with a serious burn.

## Applicable Coding Conventions

The inpatient hospital services portion of the MFS utilizes DRGs as the primary coding system. The inpatient rehabilitation facility services portion of the MFS utilize DRG codes, Revenue Codes, and CMG codes as the coding system.

Most outpatient hospital services, services provided in an ambulatory surgical center setting, and professional services utilize *Current Procedural Terminology*, (CPT<sup>®</sup>) codes which are copyrighted by the American Medical Association (AMA). The CMS Healthcare Common Procedures Coding System (HCPCS) Level II coding is used for certain supplies and materials, and for ambulance services.

The five character codes included in the MFS are those reflected in the CPT<sup>®</sup> 2017 data files, obtained from *Current Procedural Terminology*, copyright 2016 by the AMA. CPT is developed by the AMA as a listing of descriptive terms and five-character identifying codes and modifiers for reporting medical services and procedures.

The responsibility for the content of the MFS is with the Commission and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in the MFS. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT outside of the MFS should refer to the most recent *Current Procedural Terminology* which contains the complete and most current listing of CPT codes and descriptive terms.

CPT is a registered trademark of the American Medical Association.

## Maximum Fee Reimbursement

A fee scheduled medical service shall be limited to:

1. The amount provided for the payment for the fee scheduled medical service, as set forth in a contract under which the provider has agreed to accept a specified amount in payment for the service provided, which amount may be less than or exceed the maximum fee for the service as set forth in the MFS.
2. In the absence of a contract described in item 1, ***the lesser of the billed charge amount or the maximum fee listed for the fee scheduled medical service***, as set forth in the applicable MFS that is in effect on the date the service is provided, for services that are not reimbursed as a percentage of billed charges. This lesser of logic shall be applied at the claim line level. For fee scheduled medical services identified as reimbursable as a percentage of billed charges, the maximum fee shall be the applicable percentage listed, multiplied by the provider's billed charge amount for the service.
3. In the absence of a provider contract as described in item 1 and a provision in a MFS that sets forth the maximum fee for the medical service on the date it is provided, the maximum fee shall be determined by the Commission. The Commission's determination of the employer's maximum liability for the medical service shall be effective until the Commission sets a maximum fee for the fee scheduled medical service and incorporates such maximum fee into an adjusted MFS.

## New Type of Technology and Procedures

The maximum fee for a new type of technology, including an implantable medical device or item of medical equipment, that is supplied by a third party shall not exceed 130 percent of the provider's invoiced cost for such device, as evidenced by a copy of the invoice. The "invoice" means the document from the manufacturer or purchase order that itemizes the implant(s) and the "provider's invoiced cost" means a value equal to the actual manufacturer's wholesale or purchase invoice cost at the time of billing, inclusive of applicable sales tax, shipping, and handling fees.

An employer's maximum pecuniary liability for a new type of procedure that has not been assigned a maximum fee on the MFS shall not exceed 80 percent of the provider's charge for the service, based on the provider's charge master or schedule of fees, provided the employer and the provider mutually agree to the provision of such procedure.

## Reimbursement for Unlisted Services and Procedures

Unlisted services and procedures are not accompanied by maximum fees on the MFS. When an unlisted service or procedure is performed, the service or procedure should be identified and the billed charge for such service or procedure needs to be justified "by report" (BR). The report should contain sufficient supportive information to permit proper identification. Pertinent information should be furnished concerning the nature, extent, and need for the procedure or service, the time, the skill, and equipment necessary to provide the service, etc. For any procedure/service where the maximum fee is listed as "BR" in the MFS, the health care provider shall establish a billed charge that is consistent with the billed charge for other similar services that are shown in the MFS. The insurance carrier or self-insured employer should review all submitted "BR" amounts to ensure that an excessive charge for services provided is not occurring. The unlisted service or procedure shall then be reimbursed at the specified percentage of billed charges.

## Inpatient Outlier Provisions (see "Outlier Threshold" in the Definitions Section)

When the total charges of a hospital, based on the provider's charge master, for non-rehabilitation inpatient hospital services exceed 300 percent of the maximum fee for the service as presented in the MFS, reimbursement for the inpatient hospital service shall equal the total of:

1. The maximum fee for the service, as set forth in the applicable MFS, and
2. 80 percent of the provider's total charges for the service which are in excess of 300 percent of the maximum fee for the service, as set forth in the applicable MFS.

## Identification of Surgeons and Non-Surgeons

As indicated in the Definitions section, surgeons shall be identified as physicians assigned one of the CMS provider specialty codes listed, based on the rendering provider's taxonomy code. To be eligible for reimbursement, all claims for professional services must include the rendering provider's taxonomy code. Claims submitted without the rendering provider's taxonomy code will be considered incomplete.

## Reimbursement of Other Qualified Healthcare Professionals

For services that fall into Provider Category 6 and therefore have their own MFS, non-physician qualified healthcare professionals shall be reimbursed based on the maximum fee appearing on the applicable MFS. This includes services for physical medicine and rehabilitation procedures (Table Z), osteopathic and chiropractic manipulation procedures (Table AA), acupuncture services (Table AB), and dental services (Table AC). For all other services that appear on the physician MFS, when these services are provided by a non-physician qualified healthcare professional, the professional shall be reimbursed based on the applicable maximum fee appearing on the Non-Surgeon MFS, adjusted as required for the presence of any modifiers.

## Reimbursement of Non-Physician Practitioners

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. NPPs shall be reimbursed according to the rules

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 below.

## CPT/HCPCS Modifiers

Modifiers augment CPT/HCPCS codes to more accurately describe the circumstances of services provided. The fee schedules for certain services, such as Radiology and Lab/Pathology, contain global fees as well as fees associated with those same codes when billed with a 26 or TC modifier. CPT/HCPCS codes with the 26 modifier attached indicate the provider is billing for only the professional component. CPT/HCPCS codes with the TC modifier attached indicate the provider is billing for only the technical component.

In addition, modifiers NU and RR appear on the fee schedule for HCPCS codes that represent certain durable medical equipment. Codes with the NU modifier attached indicate the provider is billing for new equipment. Codes with the RR modifier attached indicate the provider is billing for rental equipment.

For all other CPT/HCPCS codes, maximum fees presented on the MFS apply when billed without any of the modifiers listed below and represent the reimbursement applicable when the service is delivered consistent with the definition of the CPT/HCPCS code. When these codes are billed with modifiers consistent with National Correct Coding Initiative rules the following reimbursement adjustments apply:

- A prolonged E&M service, as identified by the presence of modifier 21 on the claim line, shall be reimbursed at 125 percent of the maximum fee appearing in the MFS.
- An unusual procedure, as identified by the presence of modifier 22 on the claim line, shall be considered By Report.
- Unusual anesthesia, as identified by the presence of modifier 23 on the claim line, shall be considered By Report.
- Anesthesia administered by a surgeon, as identified by the presence of modifier 47 on the claim line, shall be reimbursed at 50 percent of the maximum fee appearing in the MFS.
- Procedures identified with "Yes" in the "Bilat Surg" column of the applicable fee schedule may be subjected to a bilateral surgery adjustment. Bilateral surgery adjustments are never applicable to those procedures with "No" reflected in the "Bilat Surg" column. For procedures that may be subjected to a bilateral surgery adjustment, the procedure shall be reimbursed at 150 percent of the maximum fee appearing in the MFS when modifier 50 is present on the claim line.
- Payment reductions may apply when multiple surgeries are performed on the same patient during the same session by the same physician. Procedures that may be subjected to multiple procedure reduction rules are identified with "Yes" in the "Mult Surg" column of the applicable fee schedule. Multiple procedure reduction rules shall never apply to procedures with "No" reflected in the "Mult Surg" column. When two

procedures that may be subjected to multiple procedure reduction rules appear on the same claim, the primary surgery is defined as the procedure for which the highest maximum fee appears in the MFS, and the primary procedure shall be reimbursed at 100 percent of the applicable maximum fee. Secondary and subsequent procedures shall be identified by appending modifier 51 to the claim line, and shall be reimbursed at 50 percent of the applicable maximum fee. These rules do not apply to add-on procedures or modifier 51 exempt procedures; therefore, these procedures reflect "No" in the "Mult Surg" column in the fee schedules.

- A reduced service, as identified by the presence of modifier 52 on the claim line, shall be reimbursed at 50 percent of the maximum fee appearing in the MFS.
- A discontinued procedure, as identified by the presence of modifier 53 on the claim line, shall be reimbursed at 70 percent of the maximum fee appearing in the MFS.
- Surgical intraoperative care only, as identified by the presence of modifier 54 on the claim line, shall be reimbursed at 80 percent of the maximum fee appearing in the MFS.
- Postoperative management only, as identified by the presence of modifier 55 on the claim line, shall be reimbursed at 10 percent of the maximum fee appearing in the MFS.
- Preoperative management only, as identified by the presence of modifier 56 on the claim line, shall be reimbursed at 10 percent of the maximum fee appearing in the MFS.
- A co-surgeon, as identified by the presence of modifier 62 on the claim line, shall be reimbursed at 62.5 percent of the maximum fee appearing in the MFS.
- A discontinued procedure prior to anesthesia, as identified by the presence of modifier 73 on the claim line, shall be reimbursed at 75 percent of the maximum fee appearing in the MFS.
- A discontinued procedure after anesthesia, as identified by the presence of modifier 74 on the claim line, shall be reimbursed at 75 percent of the maximum fee appearing in the MFS.
- A repeat procedure performed by the same physician, as identified by the presence of modifier 76 on the claim line, shall be reimbursed at 70 percent of the maximum fee appearing in the MFS.
- When a patient is returned to the operating room for a related procedure during the post-operative period, as identified by the presence of modifier 78 on the claim line, reimbursement shall be equal to 70 percent of the maximum fee appearing in the MFS.
- Services provided by an assistant surgeon in the same specialty as the primary surgeon, as identified by the presence of modifier 80, 81 or 82 but without the presence of modifier AS on the claim line, shall be reimbursed at 50 percent of the maximum fee appearing in the MFS.

- A nurse practitioner or physician assistant serving as an assistant-at-surgery, as identified by the presence of modifier AS on the claim line, shall be reimbursed at 20 percent of the maximum fee appearing in the MFS.
- Medical direction of 2, 3 or 4 anesthesia procedures involving qualified individuals, as identified by the presence of modifier QK on the claim line, shall be reimbursed at 50 percent of the maximum fee appearing in the MFS.
- Administration of anesthesia by a certified registered nurse anesthetist with medical direction by a physician, as identified by the presence of modifier QX on the claim line, shall be reimbursed at 50 percent of the maximum fee appearing in the MFS.
- Medical direction of a certified registered nurse anesthetist, as identified by the presence of modifier QY on the claim line, shall be reimbursed at 50 percent of the maximum fee appearing in the MFS.

All other services shall be billed with appropriate CPT/HCPCS codes and modifiers according to National Correct Coding Initiative rules and the CPT/HCPCS codes, as in effect at the time the health care was provided.

When developing the draft fee schedules, the modifier adjustments outlined above were assumed in establishing revenue neutrality.

## Provider Group 7

In developing the MFS, consideration was given to miscellaneous items and providers that would meet the definition of Provider Group 7. It was determined that at this time no items, services or providers would be placed in this group.

## Billing and Payment

Bills submitted by employees, their representatives, or health care providers to employers/insurers for reimbursement of medical services must comply with the Virginia Workers' Compensation Act.

- The amount billed for a procedure for which the MFS does not provide a maximum fee shall be justified by a written report or BR. The health care provider may not charge a fee for the written report or BR.
- Nothing in these rules preclude the separate negotiation of fees between a provider and a payer to which the MFS do not apply.
- Any person that subcontracts for billing, payment or bill review services remains fully responsible for compliance with these rules.
- As provided in Virginia Code §65.2-714(D), medical providers are prohibited from balance billing the injured employee.
- Any health care provider located outside of the Commonwealth who provides health care services under the Virginia Workers' Compensation Act to a claimant shall be reimbursed pursuant to the MFS or in compliance with the Act.

- Payment for health care services that the employer does not contest, deny, or consider incomplete shall be made to the health care provider within 60 days after receipt of each separate itemization of the health care service provided. If the itemization, or a portion thereof, is contested, denied, or considered incomplete, the employer or the employers' 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:
  1. The reasons for contesting or denying the itemization, or the reasons the itemization is considered incomplete;
  2. If the itemization is considered incomplete, all additional information required to make a decision; and
  3. The remedies available to the health care provider if the health care provider disagrees.
- Payment or denial shall be made within 60 days after receipt from the health care provider of the information requested by the employer or employer's workers' compensation carrier for an incomplete claim.

# Hospital Inpatient Facility Medical Fee Schedules

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This section addresses maximum fees for facility charges associated with an inpatient hospital admission and corresponding discharge (hereafter referred to as an admission).

## Acute Inpatient Hospital Stays

Reimbursement for acute inpatient hospital stays shall be as set forth in a contract under which the provider has agreed to accept a specified amount in payment for the service provided. In the absence of such a contract, acute inpatient hospital stays shall be reimbursed on a per admission basis, based on the DRG (Version 30) that is associated with the admission. Reimbursement for all services, including any implantable medical devices, shall be covered by the scheduled payment amount.

## Admissions to a Level I or Level II Trauma Center or Burn Center

When admitted to a Level I or Level II Trauma Center or Burn Center, the treatment of a traumatic injury (see Definitions) or serious burn are not subject to the maximum fee amounts reflected in the MFS. Reimbursement for these services shall be as set forth in a contract under which the provider has agreed to accept a specified amount in payment for the service provided. In the absence of such a contract, the maximum fee shall be equal to 80 percent of the provider's charge for the service based on the provider's charge master. However, if the claim is contested and benefits for medical services are awarded which benefit a third-party insurance carrier or health care provider, then reimbursement for these services shall be equal to 100 percent of the provider's charge for the service, based on the provider's charge master.

## Outlier Claims

Claims for admissions that meet the definition of an outlier, as defined in the General Information section, shall be reimbursed according to the provisions as outlined (*see also "Outlier Threshold" in the Definitions section*).

### Example Calculation of Reimbursement for an Outlier Claim

Provider's Billed Charge for the Admission	[A] =	\$82,000
Maximum Reimbursement per the fee Schedule	[B] =	\$25,000
Outlier Threshold	[C] = [B] x 3 =	\$75,000
Excess Charges Above Outlier Threshold	[D] = [A] - [C] =	\$7,000
Additional Outlier Payment	[E] = 0.80 x [D] =	\$5,600
Total Reimbursement for the Admission	[F] = [B] + [E] =	\$30,600

## Specific Reimbursement Amounts

Reimbursement shall vary separately for Type One Teaching Hospitals and all other hospitals, and by region, based on the maximum fees shown in Tables A and B of the MFS, respectively. Admissions at an acute inpatient hospital for one of the DRGs listed in Tables A and B that are billed using ICD-10 diagnoses codes and contain at least one claim line reflecting revenue code

118, 128, 138, 148 or 158 are not considered an acute inpatient hospital stay and shall instead be considered a rehabilitation admission.

## Rehabilitation Stays

Reimbursement for rehabilitation hospital stays shall be as set forth in a contract under which the provider has agreed to accept a specified amount in payment for the service provided. In the absence of such a contract, rehabilitation admissions shall be reimbursed on a per diem basis, and the same per diem rate shall apply for all days of the stay based on the maximum per diem fees listed in Tables C and D of the MFS.

Inpatient stays billed using DRGs that meet the following conditions are defined as rehabilitation admissions, and the applicable reimbursement is presented in Table C of the MFS:

- For claims billed using ICD-9 diagnoses codes, admissions for DRG codes 945, 946, 949 or 950
- For claims billed using ICD-10 diagnoses codes, admissions with one or more of the following:
  - A claim line with revenue code 118, 128, 138, 148, or 158
  - A DRG of 945, 946, 949, or 950

Reimbursement for inpatient rehabilitation stays billed based on CMG codes is outlined in Table D of the MFS.

# Hospital Outpatient Facility Medical Fee Schedules

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This section addresses maximum fees for facility charges associated with services provided in a hospital outpatient setting. Services shall be reimbursed as set forth in a contract under which the provider has agreed to accept a specified amount in payment for the service provided. In the absence of such a contract, services subject to the MFS shall be reimbursed on either a percentage of billed charge basis or a fixed amount per service, as outlined below.

## Services Reimbursed as a Percentage of Billed Charges

The following services, when billed by an outpatient hospital facility, shall have a maximum fee established as a percentage of billed charges.

1. Pharmacy claims when properly billed using Revenue Codes in the range 250 – 259
2. Medical/Surgical Supplies when properly billed using Revenue Codes 270 – 273, 277, 279, 621, 622, or 623
3. Established implantable medical devices when properly billed using Revenue Codes 274, 275, 276 or 278
4. Anesthesia when properly billed using Revenue Codes 370 – 379
5. Recovery Room when properly billed using Revenue Codes 710 – 719
6. Injectable Drugs as defined by specific CPT/HCPCS codes in the Definitions section
7. Unlisted procedures and services, identified with “BR” as the maximum fee in the MFS

To be eligible for reimbursement, implantable devices and injectable drugs must be billed with the appropriate CPT/HCPCS code in addition to the appropriate Revenue Code. For implantable devices that do not yet have a code assigned, use HCPCS code L8699. When services for implantable medical devices are reimbursed as a percentage of billed charges, no documents relating to the cost of the device, such as the invoice from the device manufacturer, shall be required.

The applicable percentage of billed charges shall vary between Type One Teaching Hospitals and Other than Type One Teaching Hospitals, and by region, in accordance with the following tables. These percentages are also presented in Table E of the MFS. The same percentage shall apply to all services listed above.

### Applicable Percentage of Billed Charges – Type One Teaching Hospitals

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
N/A	80%	83%	N/A	N/A	N/A

**Applicable Percentage of Billed Charges – Other than Type One Teaching Hospitals**

<b>Region 1</b>	<b>Region 2</b>	<b>Region 3</b>	<b>Region 4</b>	<b>Region 5</b>	<b>Region 6</b>
78%	82%	75%	80%	79%	83%

## Services Reimbursed as a Fixed Amount per CPT or HCPCS Code

All other facility charges associated with services provided in a hospital outpatient setting that are subject to the MFS are captured by the CPT and HCPCS codes listed in Tables F through I of the MFS. The maximum fees are presented in these Tables as follows:

- Table F: Type One Teaching Hospitals – Services Billed with a CPT
- Table G: Type One Teaching Hospitals – Services Billed with a HCPCS
- Table H: Other than Type One Teaching Hospitals – Services Billed with a CPT
- Table I: Other than Type One Teaching Hospitals – Services Billed with a HCPCS

When multiple surgeries are performed on the same patient during the same session by the same physician and are subject to multiple procedure reduction rules, the primary procedure may be reported as listed, and additional procedures should be identified by appending modifier 51 to the additional procedure codes. All procedures shall be reimbursed based on the applicable maximum fee, after applying reimbursement adjustments as outlined in the General Information section, as applicable.

## Ambulatory Surgical Centers

This section addresses maximum fees for facility charges associated with services provided in an ambulatory surgical center. Facility charges associated with ambulatory surgeries performed in, and billed by, an accredited office-based surgery center shall also be subject to the maximum fees found on the MFS, applicable to ambulatory surgical centers. Services shall be reimbursed as set forth in a contract under which the provider has agreed to accept a specified amount in payment for the service provided. In the absence of such a contract, services subject to the MFS shall be reimbursed on either a percentage of billed charge basis or a fixed amount per surgery, as outlined below.

### Services Reimbursed as a Percentage of Billed Charges

The following services, when billed by an ambulatory surgical center or accredited office-based surgical center, shall have a maximum fee established as a percentage of billed charges.

1. Established implantable medical devices when properly billed using Revenue Codes 274, 275, 276 or 278
2. Unlisted procedures and services, identified with "BR" as the maximum fee in the MFS

To be eligible for reimbursement, implantable devices must be billed with the appropriate CPT/HCPCS code in addition to the appropriate Revenue Code. For implantable devices that do not yet have a code assigned, use HCPCS code L8699. When services for implantable medical devices are reimbursed as a percentage of billed charges, no documents relating to the cost of the device, such as the invoice from the device manufacturer, shall be required.

The applicable percentage of billed charges shall vary by region, in accordance with the following table. These percentages are also presented in Table J of the MFS.

<b>Applicable Percentage of Billed Charges - Ambulatory Surgical Centers</b>					
<b>Region 1</b>	<b>Region 2</b>	<b>Region 3</b>	<b>Region 4</b>	<b>Region 5</b>	<b>Region 6</b>
75%	60%	65%	77%	70%	70%

### Services Reimbursed as a Fixed Amount Per Surgery

The maximum fee for all other facility charges associated with services provided in an ambulatory surgical center or accredited office-based surgery center that are subject to the MFS are captured by CPT codes.

A single maximum fee shall cover all applicable services and supplies associated with the surgery, including, but not limited to, the use of the operating room or surgical suite, recovery room, anesthesia, medical/surgical supplies, radiology, etc., with the exception of associated professional services and the cost of any implantable devices which may be billed separately. The total cost for the surgery shall be billed under the applicable surgical CPT code(s). The applicable maximum fees are listed in Table K of the MFS.

When multiple surgeries are performed on the same patient during the same session by the same physician and are subject to multiple procedure reduction rules, the primary procedure

may be reported as listed and additional procedures should be identified by appending modifier 51 to the additional procedure codes. All procedures shall be reimbursed based on the applicable maximum fee, after applying reimbursement adjustments as outlined in the General Information section, as applicable.

When fluoroscopy procedures are performed on a stand-alone basis (i.e., not as part of a corresponding surgical procedure) in an ambulatory surgical center or accredited office-based surgical center, a separate fee shall apply. The maximum fees for these stand-alone fluoroscopy procedures are outlined in Table L of the MFS.

## Professional Services

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This section addresses maximum fees for professional charges billed by surgeons and physician non-surgeons. Services shall be reimbursed as set forth in a contract under which the provider has agreed to accept a specified amount in payment for the service provided. In the absence of such a contract, services subject to these MFS shall be reimbursed on either a percentage of billed charge basis or a fixed amount per service, as outlined below.

Professional services associated with an admission to a Level I or Level II Trauma Center or a Burn Center to treat a traumatic injury or serious burn are not subject to the maximum fees reflected in the MFS. Reimbursement for these services shall be as set forth in a contract under which the provider has agreed to accept a specified amount in payment for the service provided. In the absence of such a contract, the maximum fee for these services shall be equal to 80 percent of the provider's charge for the service, based on the provider's charge master. However, if the claim is contested and benefits for medical services are awarded which benefit a third-party insurance carrier or health care provider, then reimbursement for these services shall be equal to 100 percent of the provider's charge for the service based on the provider's charge master.

It is likely that, in many cases, claims for professional services associated with admissions for a traumatic injury at a Level I or Level II Trauma Center or a serious burn at a Burn Center may be received by the payer prior to receiving the bill for the associated facility charges. In this case, the payer may not be able to identify these professional claims as being associated with an admission for a traumatic injury at a Level I or Level II Trauma Center or a serious burn at a Burn Center. In this case, the payer shall reimburse the provider at the lesser of billed charges and the maximum fee shown in the applicable surgeon or physician non-surgeon fee schedule, with the lesser of logic being applied at the claim line level. Once the bill for the associated facility charges is received and the payer can identify the professional claim as being associated with an admission for a traumatic injury at a Level I or Level II Trauma Center or a serious burn at a Burn Center, the reimbursement amount for the claim shall be adjusted to be consistent with the alternate reimbursement methodology described in the preceding paragraph.

### Services Reimbursed as a Percentage of Billed Charges

The following services, when billed by a surgeon, or a physician non-surgeon, shall have a maximum fee established as a percentage of billed charges.

1. Injectable Drugs as defined by specific CPT/HCPCS codes in the Definitions section
2. Unlisted procedures and services, identified with "BR" as the maximum fee amount in the MFS

To be eligible for reimbursement, injectable drugs must be billed with the appropriate CPT/HCPCS code.

The same percentage of billed charges shall apply to surgeons and physician non-surgeons. The applicable percentage of billed charges shall vary by region, in accordance with the following table. These percentages are also presented in Table M of the MFS.

### Applicable Percentage of Billed Charges – Surgeons, Physician Non-surgeons, and Other Providers of Professional Medical Services

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
78%	79%	85%	79%	86%	77%

## Anesthesia

The values contained within this section apply when anesthesia care is provided by or under the medical supervision of a qualified physician, including anesthesia that is administered by a certified registered nurse anesthetist. This anesthesia care may include, but is not limited to, general, regional, monitored anesthesia care, or other supportive services in order to afford the patient the anesthesia care deemed optimal.

The maximum fee for a particular procedure or service in this section is determined by multiplying the applicable anesthesia conversion factor times the sum of the listed **BASE UNITS** plus **TIME UNITS** plus **PHYSICAL STATUS UNITS** (if any).

**BASE UNITS:** The BASE UNITS associated with each anesthesia CPT code shall be in accordance with Table N of the MFS.

**TIME UNITS:** Anesthesia time begins when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or other appropriate setting, and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under other post-anesthesia supervision. Time units are computed by allowing one unit for each 15 minutes or significant fraction thereof (7.5 minutes or more) of anesthesia time.

**PHYSICAL STATUS UNITS:** Physical status is included to distinguish between various levels of complexity of the anesthesia service provided. Physical status units (if any) are determined based on the physical status modifier attached to the anesthesia CPT code. Physical status units shall be assigned based on modifiers as follows:

Physical Status Units	
Modifier	Units
P1	0
P2	0
P3	1
P4	2
P5	3
P6	0

**CONVERSION FACTORS:** Anesthesia conversion factors shall vary by region, in accordance with the following table.

### Anesthesia Conversion Factors

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
\$77.00	\$65.00	\$66.00	\$59.00	\$66.00	\$48.00

As an example, the maximum fee for CPT code 00100 in Region 1 that includes 3 time units and physical status modifier P3 would be \$693, calculated as follows:

$$= \text{Region 1 conversion factor} \times (5 \text{ base units} + 3 \text{ time units} + 1 \text{ physical status unit})$$

$$= \$77.00 \times (5 + 3 + 1) = \$693$$

When multiple surgical procedures are performed during the same period of anesthesia, only the procedure with the greatest base units shall be used. Time units applicable for the entire period of anesthesia for the multiple procedures performed shall be used.

### Qualifying Circumstances

Anesthesia services may be provided under particularly difficult circumstances depending on factors such as the extraordinary condition of the patient, notable operative conditions, or unusual risk factors. These circumstances may significantly impact the nature of the anesthetic service provided. In these cases, additional services may be billed and reported under CPT codes 99100, 99116, 99135 or 99140. These procedures would be reported in addition to the code for the primary anesthesia procedure. The maximum fee for these additional qualifying anesthesia procedures are listed in Table O of the MFS.

### Surgery

The CPT codes listed in Tables P and Q of the MFS represent professional surgical services subject to the MFS. The maximum fees for these services for surgeons and physician non-surgeons for each region are also listed in Tables P and Q of the MFS, respectively. The maximum fee is the same, regardless of the location where the service is provided.

When multiple surgeries are performed on the same patient during the same session by the same physician and are subject to multiple procedure reduction rules, the primary procedure may be reported as listed and additional procedures should be identified by appending modifier 51 to the additional procedure codes. All procedures shall be reimbursed based on the applicable maximum fee, after applying reimbursement adjustments as outlined in the General Information section, as applicable.

### Radiology

The CPT codes listed in Tables R and S of the MFS represent professional radiology services subject to the MFS. The maximum fees for these services for surgeons and physician non-surgeons for each region are also listed in Tables R and S of the MFS, respectively.

## Lab/Pathology

The CPT codes listed in Table T of the MFS represent professional lab and pathology services subject to the MFS. The maximum fees for these services, which do not vary for surgeons and physician non-surgeons but do vary for each region, are also listed in Table T of the MFS.

## Evaluation and Management

The CPT codes listed in Tables U and V of the MFS represent professional evaluation and management services subject to the MFS. The maximum fees for these services for surgeons and physician non-surgeons for each region are also listed in Tables U and V of the MFS, respectively.

## Other Professional Services Billed with CPT Codes

The CPT codes listed in Tables W and X of the MFS represent other professional services billed with a CPT code that are not listed above and are subject to the MFS. The services included in these fee schedules generally include items such as medicine, wound care management, and medical nutritional therapy. The maximum fees for these services for surgeons and physician non-surgeons for each region are also listed in Tables W and X of the MFS, respectively.

## Other Professional Services Billed with HCPCS Codes

The HCPCS codes listed in Table Y of the MFS represent other services and items billed by a physician with a HCPCS code that are not listed above and are subject to the MFS. The services included in this fee schedule generally include items such as medical/surgical supplies, DME, orthotics and prosthetics, vision and hearing services, and other temporary procedures and miscellaneous services. Note that the maximum fees in this fee schedule for DME, orthotic and prosthetic devices only apply when these items are dispensed in a physician's office. The fee scheduled amounts for these services, which do not vary for surgeons and physician non-surgeons but do vary for each region, are also listed in Table Y of the MFS.

# Other Providers of Outpatient Medical Services

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This section addresses maximum fees for other providers of outpatient medical services (defined as Provider Group 6 in the law) that are not covered by the fee schedules that apply to surgeons, non-surgeons or ambulatory care centers. Services shall be reimbursed as set forth in a contract under which the provider has agreed to accept a specified amount in payment for the service provided. In the absence of such a contract, services subject to these MFS shall be reimbursed as either a fixed amount per service or per unit, as outlined below.

## Services Reimbursed as a Percentage of Billed Charges

The following services, when billed by other providers of medical services, shall have a maximum fee established as a percentage of billed charges.

1. Injectable Drugs as defined by specific CPT/HCPCS codes in the Definitions section
2. Unlisted procedures and services, identified with "BR" as the maximum fee amount in the MFS

To be eligible for reimbursement, injectable drugs must be billed with the appropriate CPT/HCPCS code.

The applicable percentage of billed charges shall vary by region, in accordance with the following table. These percentages are also presented in Table M of the MFS.

### Applicable Percentage of Billed Charges – Surgeons, Physician Non-surgeons, and Other Providers of Professional Medical Services

Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
78%	79%	85%	79%	86%	77%

## Physical Medicine and Rehabilitation Services

The CPT and HCPCS codes listed in Table Z of the MFS represent physical medicine and rehabilitation services subject to the MFS, and shall be reimbursed as a fixed amount per unit. The applicable measure of units that shall be reported, and upon which reimbursement shall be based, are the units referenced in the description of each code. The maximum fees apply when the services are provided in a setting other than a hospital. If the services are provided in a hospital setting, the maximum fee from the Hospital Outpatient Facility MFS applies. The maximum fees for these services for each region are also listed in Table Z of the MFS.

## Osteopathic and Chiropractic Manipulative Treatment

The CPT codes listed in Table AA of the MFS represent osteopathic and chiropractic manipulative treatment services subject to the MFS. The maximum fees for these services for each region are also listed in Table AA of the MFS.

## Acupuncture

The CPT codes listed in Table AB of the MFS represent acupuncture services subject to the MFS. The maximum fees for these services for each region are also listed in Table AB of the MFS.

## Dental Services

The HCPCS codes listed in Table AC of the MFS represent dental services subject to the MFS. The maximum fees for these services for each region are also listed in Table AC of the MFS.

## Ground Ambulance

The HCPCS codes listed in Table AD of the MFS represent ground ambulance services subject to the MFS. Note that air ambulance is not subject to the MFS. Ground ambulance services subject to the MFS shall be reimbursed as a fixed amount per trip plus a fixed amount per mile, in accordance with the definition of each code. The maximum fees for these services for each region are also listed in Table AD of the MFS.

## Private Payer Codes

HCPCS codes beginning with the letter "S" are private payer codes that represent a wide variety of items and services, and they are used in cases where existing CPT and HCPCS codes are deemed inadequate to describe an item or services. The CPT codes listed in Table AE of the MFS represent payer codes that are subject to the MFS. These codes shall be reimbursed as either a fixed amount per service or a fixed amount per unit. For those services which are to be reimbursed as a fixed amount per unit, the applicable measure of units that shall be reported and upon which reimbursement shall be based are the units referenced in the description of each code. The maximum fees for these services for each region are also listed in Table AE of the MFS.

## Contact Us

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For questions regarding the medical fee schedules, please contact us at 877-664-2566, or via e-mail at [questions@workcomp.virginia.gov](mailto:questions@workcomp.virginia.gov).