MFS Calculator Tool

Key Terms and FAQs

Disclaimer

The MFS Calculator is intended to be a tool to assist in the application and understanding of the Medical Fee Schedules and the Ground Rules Document. The results are based solely on the information provided and do not constitute the Commission's formal administrative determination or judicial ruling for the final fee schedule maximum assigned amount.

Table of Contents

Overview

The MFS Calculator will replace the MFS Reference Tool that currently searches each schedule and returns the max fee value at the code level. The MFS Calculator is a convenient resource that determines regional classifications and maximum rates of payments, incorporating applicable Ground Rules adjustments at the bill level to return the combined fee scheduled maximum assigned amount.

Boost! **The New MFS Calculator Includes These Great New Features:**

- Contains a list of applicable provider categories based on the billing code.
- Allows the user to edit and remove values.
- Data can be exported out of the calculator tool into Microsoft Excel.
- The user can enter multiple modifiers and will receive an adjusted maximum fee based on an appropriate Ground Rules adjustment.
- Identifies the lesser of logic and can modify the resulting maximum fee.

Reference Terms

Adjusted Max Fee – The total reimbursable maximum fee after all applicable Ground Rule Adjustments.

Billing code – As applicable, CPT codes, HCPCS codes, Revenue codes, CMG classifications, or DRG classifications.

Clear Bill – Click to start over with a new Region and JCN.

Clear Billing Code – Click to enter a new Date of Service or Billing Code.

Confirm - Click the Red Box to confirm the bill deletion.

Create Bill – Click to create a new bill once the Zip code and JCN are entered.

Find Code – Click to search for the entered Billing Code.

Edit – Click to change input values.

Export – Click to export the results (.csv file format).

Inpatient Duration – Admission and Discharge Date and Time

JCN – The Jurisdiction Claim Number assigned to the Date of Injury or other alpha/numeric value up to 12 characters long.

Max Fee – The maximum fee for the service, as outlined in the applicable medical fee schedule.

Place of Service – Classification of providers for which unique fee schedules will apply, as listed below:

- Outpatient Hospital
- Inpatient Hospital
- Ambulatory Surgical Center
- Professional
- Other Place of Service (Ground Ambulance)

Provider – Classification of provider types for which unique fee schedules will apply, as listed below:

- Surgeon
- Non-Surgeon (Physicians, exclusive of surgeons)
- Type One Teaching Hospital
- Other than Type One Teaching Hospital

Secondary Code – Hospital Outpatient services, implantable devices, and injectable drugs may require a companion billing code such as REV/CPT or REV/HCPCS. These code combinations are required to determine the maximum fee as applicable.

Zip Code – The place of service where medical services is provided.

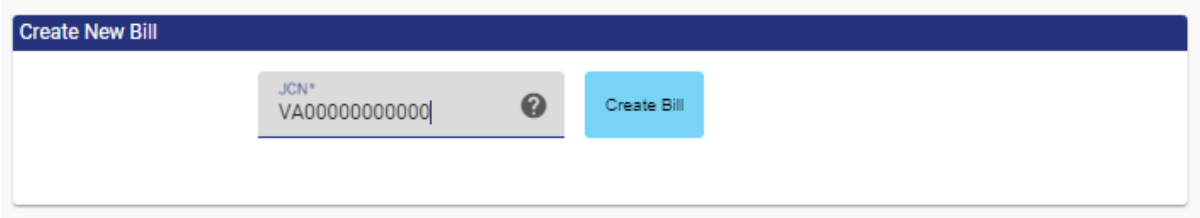
Frequently Asked Questions

Why did the MFS Calculator return the error message "Region not found" for the entered zip code?

The MFS Calculator requires the entry of one of six regions of the Commonwealth defined by three-digit Zip code prefixes. Any health care provider located outside of the Commonwealth of Virginia who provides health care services under the Act to an injured worker shall be reimbursed based on the zip code applicable to the principal place of business of the employer if located in the Commonwealth or, if no such location exists, then the zip code for the location where the Commission hearing regarding a dispute is conducted. Please contact the Medical Fee Services Department for further assistance.

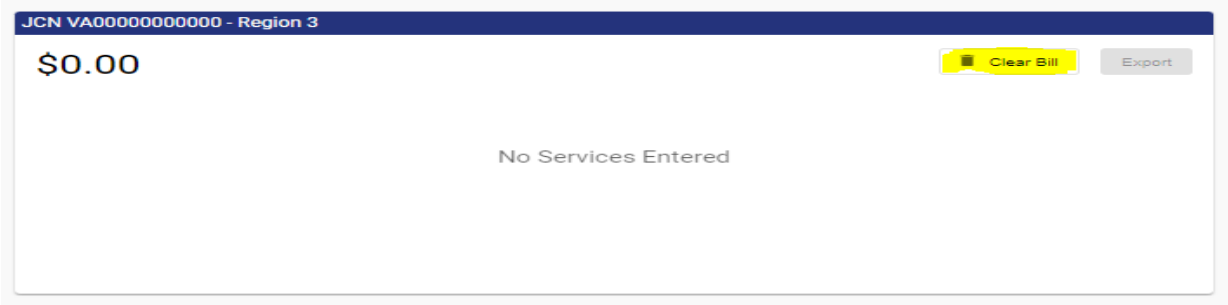
What should be entered if the JCN is unknown?

The MFS Calculator requires the entry of the JCN or an entry of up to 12 alpha/numeric characters in this field to create a new bill.



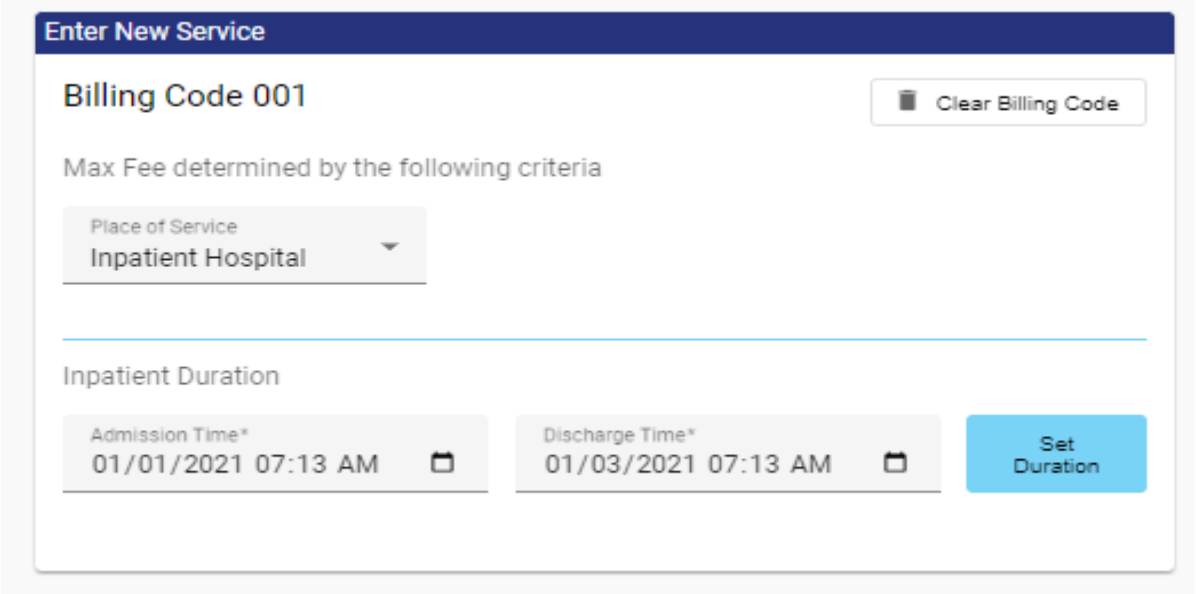
The incorrect Zip code or JCN was entered, how can these values be edited?

Once the Zip Code and JCN fields are entered and the "Create Bill" button is depressed, the calculator will not allow further edits. Depress the "Clear Bill" button to start over.



Why does the calculator require the Admission/Discharge date and time?

The MFS Calculator requires the user to input the admission and discharge date and time to calculate the inpatient duration. The inpatient duration is entered to verify the hospital stay meets the requirements for an inpatient stay and is required to calculate the per diem fee schedule maximum amount.



Note: The Inpatient Duration cannot be changed once the Set Duration button is depressed. To change the date/time press "Clear Billing Code"

Why did the calculator return a successful result but the data shows N/A?

The data from the calculator comes directly from the Medical Fee Schedule. Type One Teaching Hospitals exist only in regions 2 and 3 and have assigned fees for applicable billing codes. Therefore, if your region of service is in any region other than 2, or 3, or the billing code is not applicable, and you select a Type One teaching hospital, the result will be N/ A as it is a legitimate value in the fee schedule. See Table A for an example.

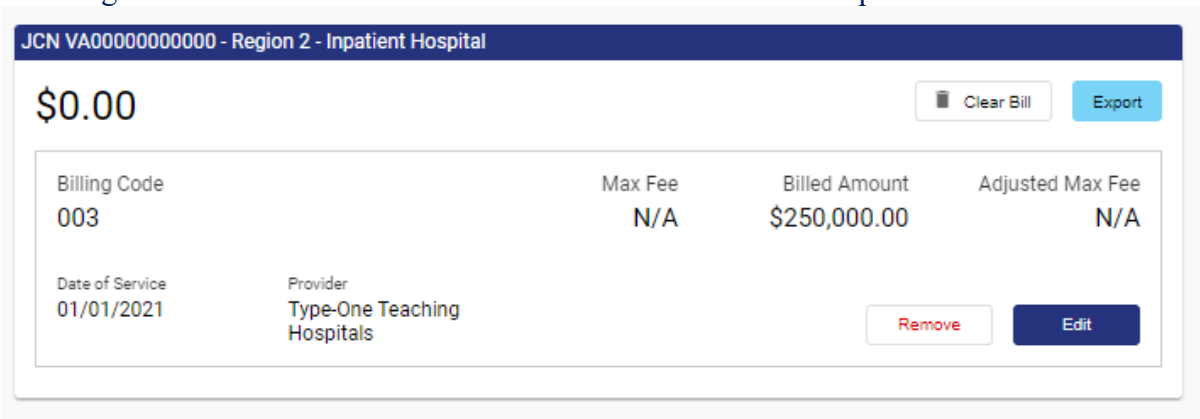


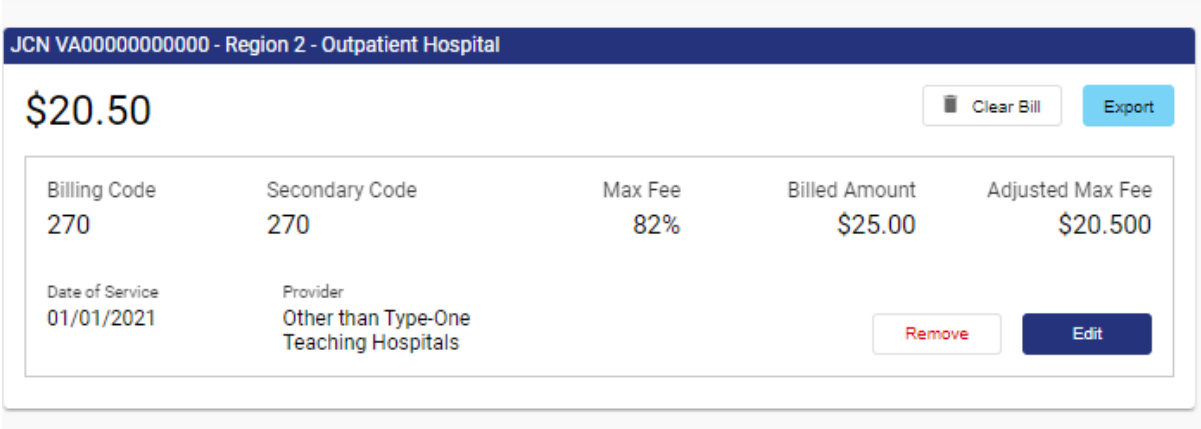
Table A

Type-One Teaching Hospitals (Table A)

	Maximum Fee Per Admission					
MS-DRG	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6
001	N/A	$746,243	$898,746	N/A	N/A	N/A
002	N/A	$460,877	$555,062	N/A	N/A	N/A
003	N/A	N/A	N/A	N/A	N/A	N/A

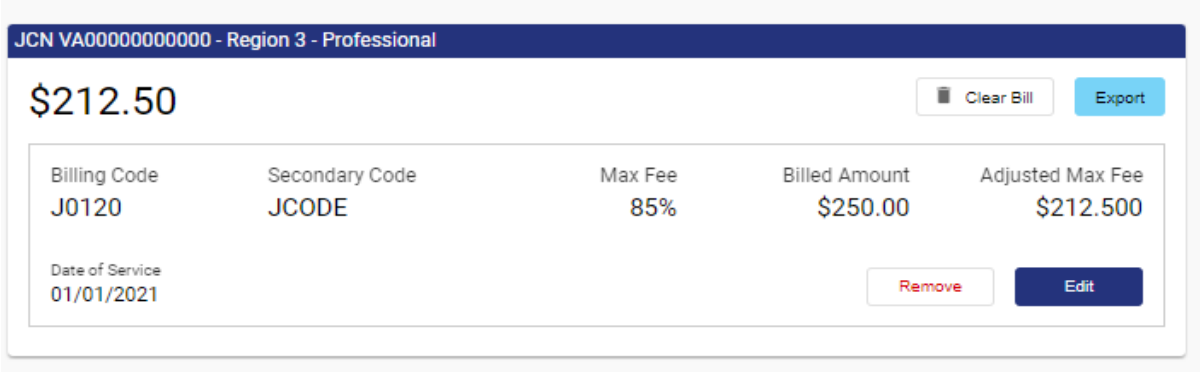
What Secondary Code should be entered for services other than implantable devices and injectable drugs?

If the calculator prompts the entry of a Secondary Code for services other than implantable devices or injectable drugs, and a valid CPT/HCPCS is not listed re-enter the Billing Code to obtain the maximum fee.



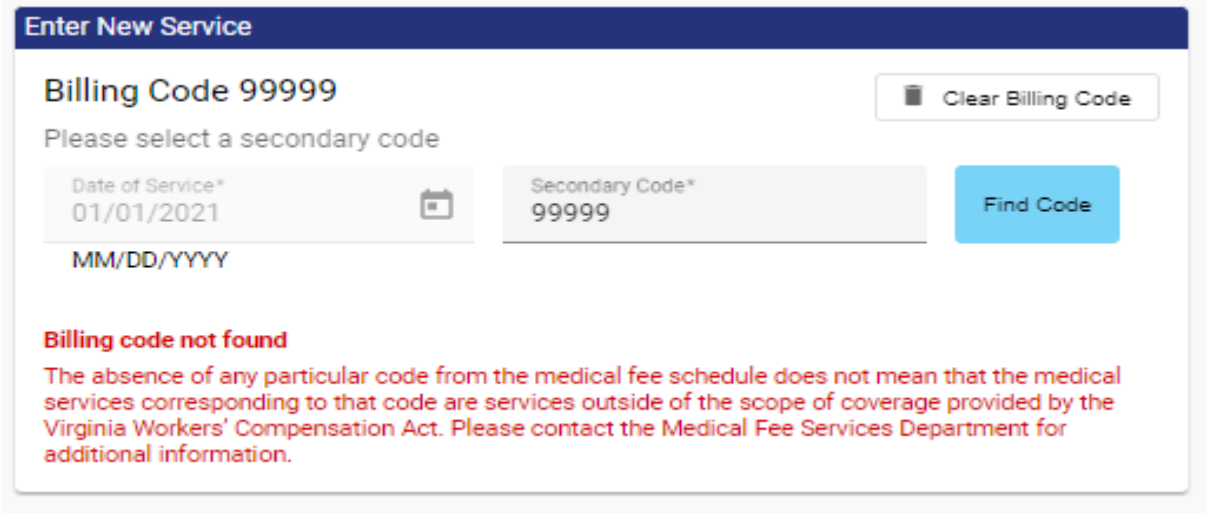
Why did I receive the error message "Billing code not found" after entering a valid HCPCS "J" code?

J codes are not expressly listed in the schedules, the calculator will return "Billing code not found". The user must click the "Enter Secondary CPT or HCPCS button and enter the J code again to obtain the adjusted max fee. The calculator will return a generic JCODE value and the adjusted max fee.



What if the billing code is not found after re-entering the code in the Secondary code field as prompted?

The MFS Calculator will only return an Adjusted Max Fee value for codes that are currently listed in the schedules. Please contact the Medical Fee Services department for further assistance.



What if the code is listed in the fee schedule as By Report (BR)?

The MFS Calculator includes the BR codes listed in the fee schedule as "BR" and will calculate reimbursement by the determined percentage of billed charge or fixed amount per service.

21499		N/A	BR	BR	N/A	N/A	N/A	Yes	No

Note: Surgical codes listed as "BR" are not primary procedures and are subject to multiple procedure reduction rules where applicable.

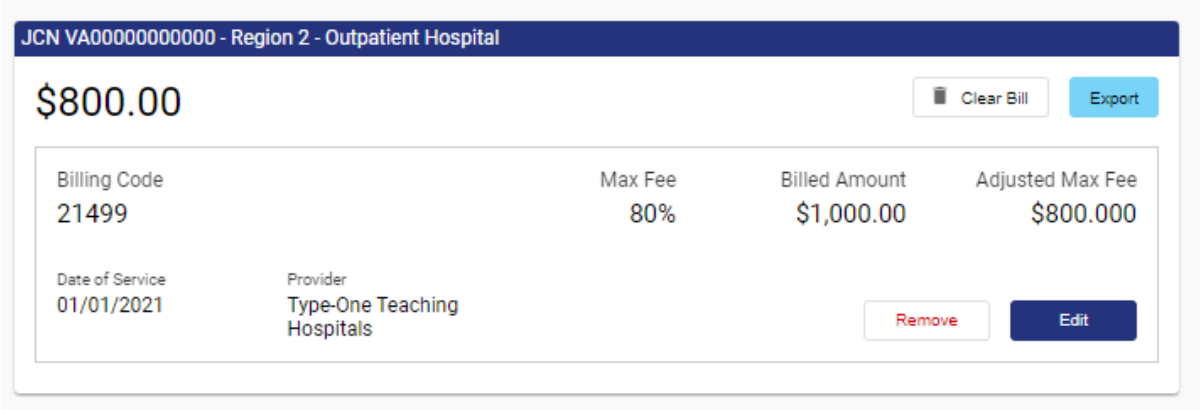
What are the frequently used Ground Rule adjustments that are included in the calculator?

Multiple Procedure Reduction (MPR)

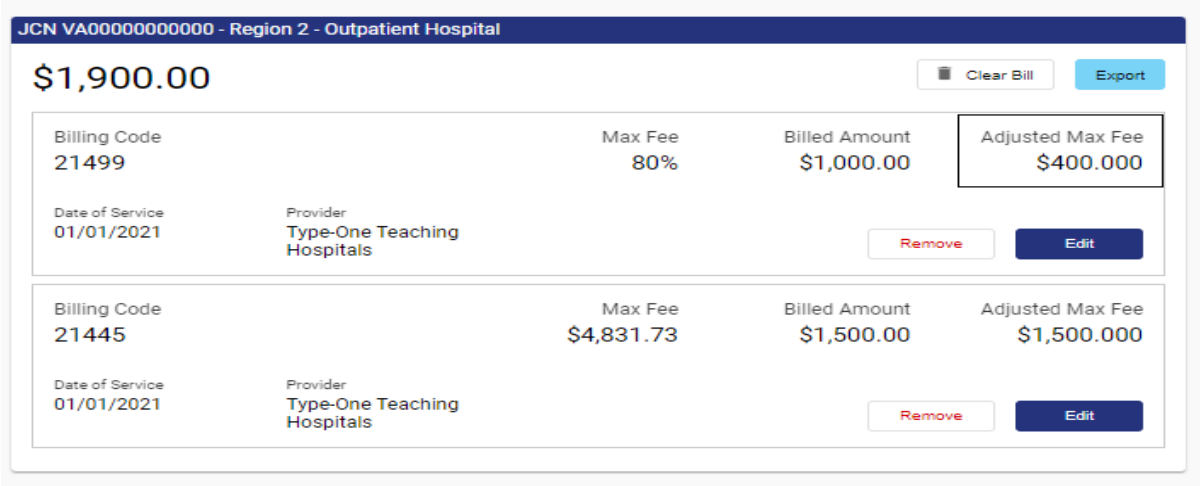
Payment reductions may apply when multiple surgeries are performed on the same patient during the same session by the same physician. Procedures that may be subjected to multiple procedure reduction rules are identified with "Yes" in the "MultSurg" column of the applicable fee schedule. Multiple procedure 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.

The MFS Calculator will automatically determine the primary procedure for each date of service and apply the 50% reduction as applicable.



(MPR)

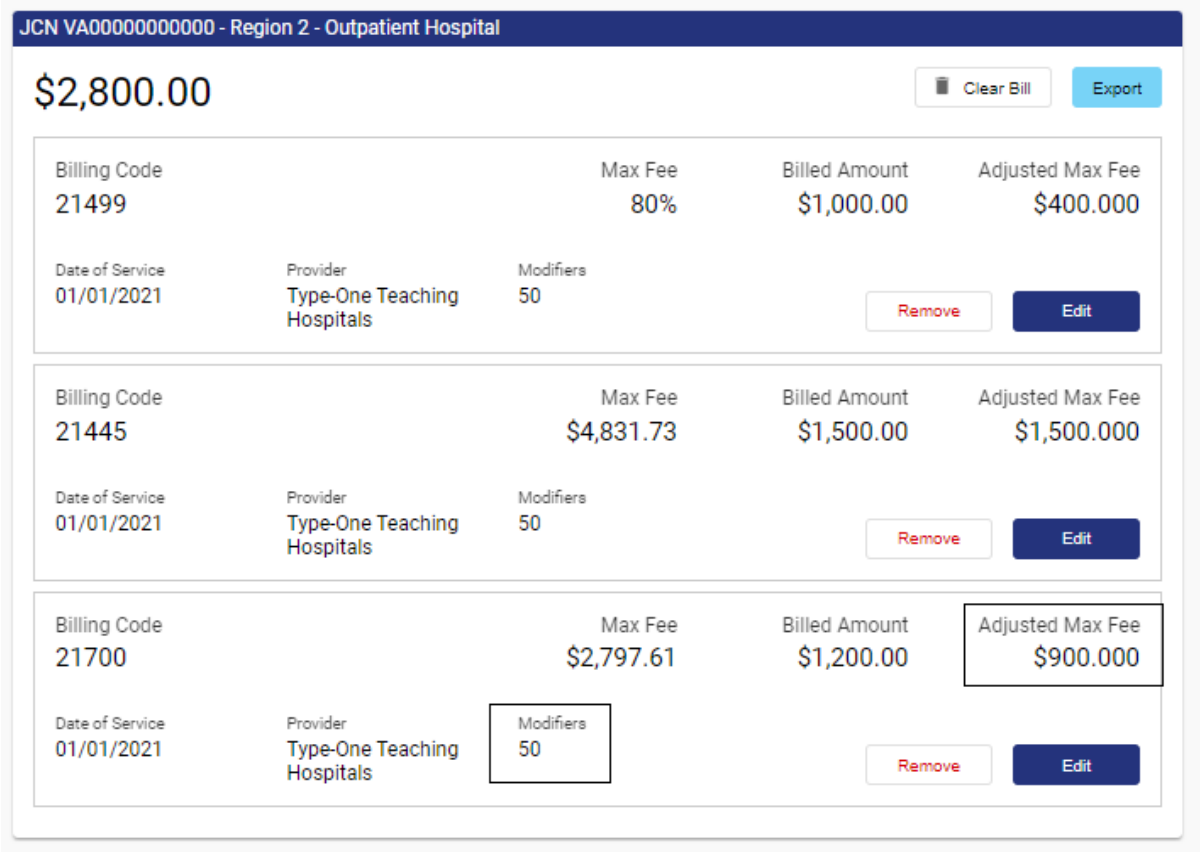


Bilateral Surgery Reduction (Bilat Surg)

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.

The MFS Calculator will automatically determine if the Bilateral Surgery 150% payment adjustment applies, contingent on the user entering modifier 50 at the claim level.

(Bilat Surg)



Lesser than Logic (LOL)

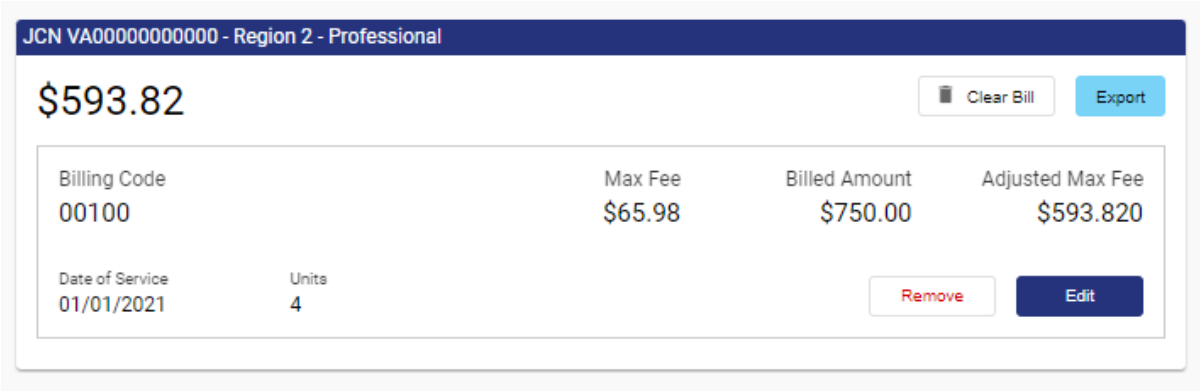
The fee schedule maximum amount is the lesser of billed charges and the maximum fee shown in the applicable fee schedule. The calculation will automatically adjust to the LOL when returning the adjusted maximum fee.

(LOL)

CPT/HCPCS Modifiers

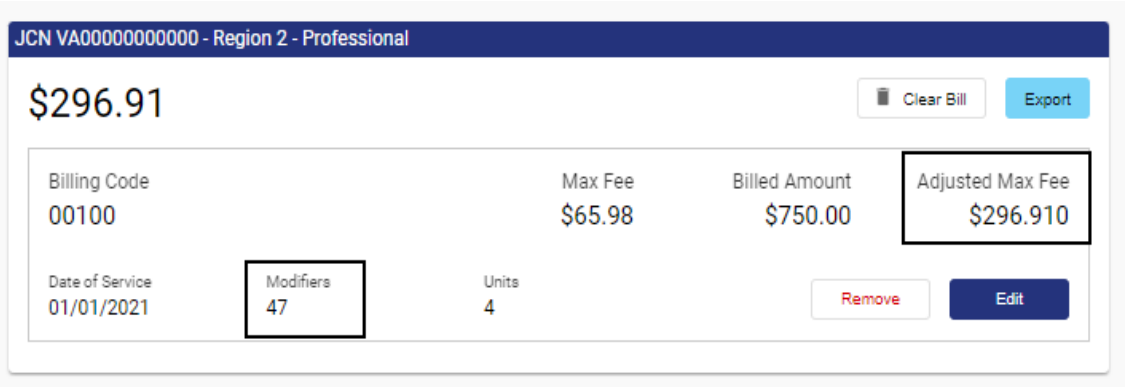
Modifiers indicate that a service or procedure performed has been altered by some specific circumstances. The applicable modifiers and reimbursement adjustments are

listed in the CPT/HCPCS Modifiers section of the Ground Rules that are included in the calculator.



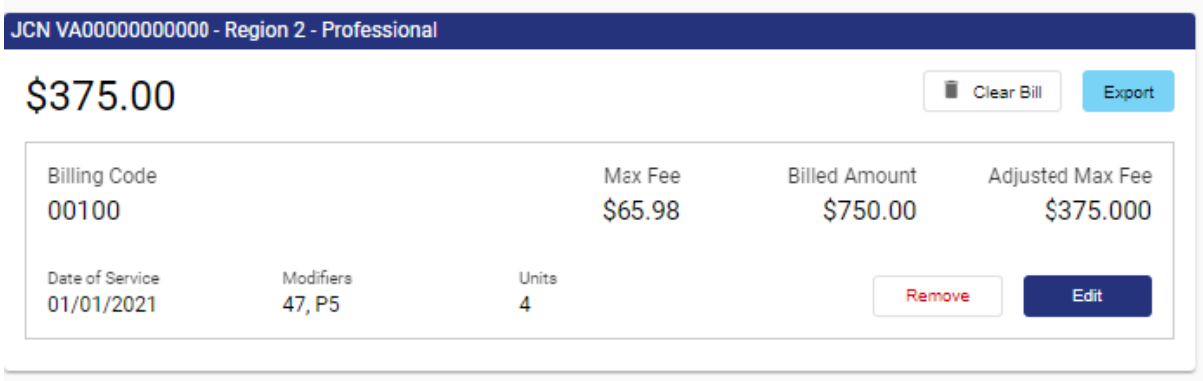
Ground Rule Modifier

- 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 2020 MFS.



What if the bill has multiple modifiers, do I have to list them in any order?

The MFS Calculator will determine the order of applicable modifiers to calculate the adjusted max fee. In the example below *(Max Fee x (Base units + Time Units + Physical Status Units))Modifier 47 = $2,441.26;* however, the billed amount is $750.00. As a result, the calculator applies modifier 47 to the billed amount.

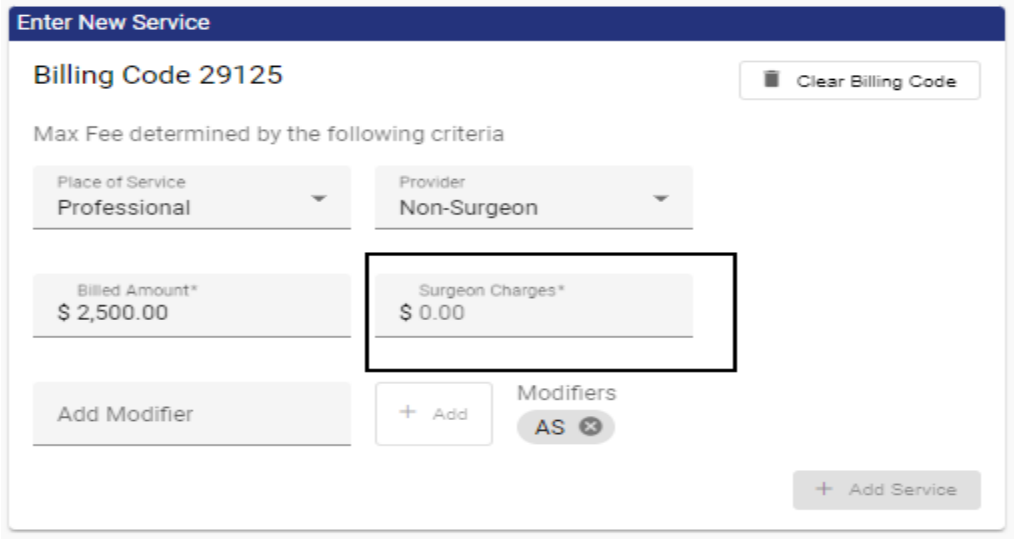


Why is the modifier I entered not listed in the calculator result?

The MFS Calculator requires the user to enter the applicable modifier and press the "Add" button to enable the modifier(s) and applicable adjustments to the maximum fee.

Why is the Surgeon's charge required for codes with modifiers AS, 80, 81, and 82?

Services provided by any assistant for the surgery are calculated based on a percentage of the amount due to the primary surgeon. The calculator determines the maximum fee due to the surgeon and then applies the applicable percentage for the entered modifier.



Contact the Commission

Virginia Workers' Compensation Commission, 333 E. Franklin St., Richmond, VA 23219

Contact Us by Phone

Please contact the Medical Fee Services Department for additional information or if you have questions, concerns, or need assistance with the MFS Calculator at 877-664-2566 from 8:30 a.m. to 4:45 p.m.

Contact Us by Email

Questions may be emailed to medicalfeeservices@workcomp.virginia.gov.

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