IDAPA 17 - INDUSTRIAL COMMISSION

17.02.09 - MEDICAL FEES

DOCKET NO. 17-0209-1201

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Section(s) 72-508, 72-720, 72-721, 72-722, 72-723, and 72-803, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be held as follows:

Monday – October 22, 2012 **2:00 p.m. to 4:00 p.m. (MDT)**
Industrial Commission Office **700 South Clearwater Lane** **Boise, Idaho 83712**

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking: Reduces the number of conversion factors and provides the annual adjustment of the medical fee schedule for physician reimbursement in accordance with Section 72-803, Idaho Code; creates a pharmaceutical fee schedule for pharmacies and dispensing physicians; standardizes the required coding sets used by providers for billing medical services.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: N/A

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year as a result of this rulemaking: N/A

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking for the pharmaceutical fee schedule was not conducted due to time constraints and the need to implement cost containment for drugs as soon as possible. The changes to the physician fee schedule and the changes to standardize the billing requirements were developed in collaboration with industry representatives.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: No documents have been incorporated by reference into this rule.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Patti Vaughn, Medical Fee Schedule Analyst 208-334-6084 or 1-800-950-2110.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 24, 2012.

DATED this 30th Day of August, 2012.

Mindy Montgomery, Director
Industrial Commission
700 S. Clearwater Lane
PO Box 83720
Boise, ID 83720-0041
Phone: 208-334-6000
Fax: 208-334-5145

THE FOLLOWING IS THE PROPOSED TEXT FOR DOCKET NO. 17-0209-1201

030. DEFINITIONS.
Words and terms used in this rule are defined in the subsections which follow. (4-7-11)

01. Charge. Expense or cost. For hospitals and ASCs, "charge" shall mean the total charge. (4-7-11)

a. "Acceptable charge." The charge for medical services calculated in accordance with this rule or as billed by the provider, whichever is lower, or the charge agreed to pursuant to a written contract. (4-7-11)

b. "Customary charge." A charge which shall have an upper limit no higher than the 90th percentile, as determined by the Commission, of usual charges made by Idaho Providers for a given medical service. (4-7-11)

c. "Reasonable charge." A charge that does not exceed the Provider's "usual" charge and does not exceed the "customary" charge, as defined in this rule. (4-7-11)

d. "Usual charge." The most frequent charge made by an individual Provider for a given medical service to non-industrially injured patients. (4-7-11)

02. Ambulatory Payment Classification (APC). A payment system adopted by the Center for Medicare and Medicaid Services (CMS) for outpatient services. (4-7-11)

03. Ambulatory Surgery Center (ASC). A facility providing medical services on an outpatient basis only. (4-7-11)

04. Average Wholesale Price (AWP). The average wholesale price for medicine obtained from pricing data provided by the original manufacturer of that medicine to industry-wide compilers of drug prices, e.g., Red Book and Medi-Span. ( )

0~~4~~5. Critical Access Hospital. A hospital currently designated as a critical access hospital by the Centers for Medicare and Medicaid Services (CMS). (4-7-11)

0~~5~~6. Hospital. An acute care facility providing medical services on an inpatient and outpatient basis. (4-7-11)

0~~6~~7. Implantable Hardware. Objects or devices that are made to support, replace or act as a missing anatomical structure or to support or manage proper biological functions or disease processes and where surgical or medical procedures are needed to insert or apply such devices and surgical or medical procedures are required to remove such devices. The term also includes equipment necessary for the proper operation of the implantable hardware, even if not implanted in the body. (4-7-11)

0~~7~~8. Medical Service. Medical, surgical, dental or other attendance or treatment, nurse and hospital service, medicine, apparatus, appliance, prostheses, and related service, facility, equipment and supply, as set forth in Section 72-102, Idaho Code. (4-7-11)

0~~8~~9. Medicare Severity - Diagnosis Related Group (MS-DRG). A system adopted by the Centers for Medicare and Medicaid Services (CMS) that groups hospital admissions based on diagnosis codes, surgical procedures and patient demographics. (4-7-11)

~~09~~10. **Payor**. The legal entity responsible for paying medical benefits under Idaho's Workers' Compensation Law. (4-7-11)

11. **Pharmacy**. A business licensed to compound or dispense prescription medicine. ( )

1~~0~~2. **Physician**. A member of any healing profession licensed or authorized to provide medical services by the statutes of this state, as set forth in Section 72-102, Idaho Code. (4-7-11)

1~~1~~3. **Provider**. Any person, firm, corporation, partnership, association, agency, institution or other legal entity providing any kind of medical service related to the treatment of an industrially injured patient which is compensable under the Idaho's Workers' Compensation Law, as set forth in Section 72-102, Idaho Code. (4-7-11)

1~~2~~4. **Rehabilitation Hospital**. A facility operated for the primary purpose of assisting with the rehabilitation of disabled persons through an integrated program of medical, psychological, social, and vocational evaluation and services under competent professional supervision. (4-7-11)

031. ACCEPTABLE CHARGES FOR MEDICAL SERVICES PROVIDED BY PHYSICIANS UNDER THE IDAHO WORKERS' COMPENSATION LAW.
Pursuant to Section 72-508 and Section 72-803, Idaho Code, the Industrial Commission (hereinafter "the Commission") hereby adopts the following rule for determining acceptable charges for medical services provided by physicians under the Idaho Workers' Compensation Law. (4-7-11)

01. Acceptable Charge. Payors shall pay providers the acceptable charge for medical services provided by physicians. (4-7-11)

02. Adoption of Standard for Physicians. The Commission hereby adopts the Resource-Based Relative Value Scale (RBRVS), published by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services, as amended, as the standard to be used for determining the acceptable charge for medical services provided under the Idaho Workers' Compensation Law by physicians. (4-7-11)

03. Conversion Factors. The following conversion factors shall be applied to the fully-implemented facility or non-facility Relative Value Unit (RVU) as determined by place of service found in the latest RBRVS, as amended, that was published before December 31 of the previous calendar year for a medical service identified by a code assigned to that service in the latest edition of the Physicians' Current Procedural Terminology (CPT), published by the American Medical Association, as amended:

~~MEDICAL FEE SCHEDULE~~			
~~SERVICE CATEGORY~~	~~CODE RANGE(S)~~	~~DESCRIPTION~~	~~CONVERSION FACTOR~~
~~Anesthesia~~	~~00000 - 09999~~	~~Anesthesia~~	~~$60.33~~
~~Surgery - Group One~~	~~22000 - 22999~~ ~~23000 - 24999~~ ~~25000 - 27299~~ ~~27300 - 27999~~ ~~29800 - 29999~~ ~~61000 - 61999~~ ~~62000 - 62259~~ ~~63000 - 63999~~	~~Spine~~ ~~Shoulder, Upper Arm, & Elbow~~ ~~Forearm, Wrist, Hand, Pelvis & Hip~~ ~~Leg, Knee, & Ankle~~ ~~Endoscopy & Arthroscopy~~ ~~Skull, Meninges & Brain~~ ~~Repair, Neuroendoscopy & Shunts~~ ~~Spine & Spinal Cord~~	~~$140.00~~
~~Surgery - Group Two~~	~~28000 - 28999~~ ~~64550 - 64999~~	~~Foot & Toes~~ ~~Nerves & Nervous System~~	~~$129.00~~

MEDICAL FEE SCHEDULE			
SERVICE CATEGORY	CODE RANGE(S)	DESCRIPTION	CONVERSION FACTOR
Surgery - Group Three	13000 - 19999 20650 - 21999	Integumentary System Musculoskeletal System	$113.52
Surgery - Group Four	10000 - 12999 20000 - 20615 29000 - 29799 30000 - 39999 40000 - 49999 50000 - 59999 60000 - 60999 62260 - 62999 64000 - 64549 65000 - 69999	Integumentary System Musculoskeletal System Casts & Strapping Respiratory & Cardiovascular Digestive System Urinary System Endocrine System Spine & Spinal Cord Nerves & Nervous System Eye & Ear	$87.72
Radiology	70000 - 79999	Radiology	$88.54
Pathology & Laboratory	80000 - 89999	Pathology & Laboratory	To Be Determined
Medicine - Group One	90000 - 90799 94000 - 94999 97000 - 97799 97800 - 98999	Immunization, Injections, & Infusions Pulmonary / Pulse Oximetry Physical Medicine & Rehabilitation Acupuncture, Osteopathy, & Chiropractic	$47.00
Medicine - Group Two	90800 - 92999 93000 - 93999 95000 - 96020 96040 - 96999 99000 - 99607	Psychiatry & Medicine Cardiography, Catheterization, & Vascular Studies Allergy / Neuromuscular Procedures Assessments & Special Procedures E / M & Miscellaneous Services	$68.50

MEDICAL FEE SCHEDULE			
SERVICE CATEGORY	CODE RANGE(S)	DESCRIPTION	CONVERSION FACTOR
Anesthesia	00000 - 09999	Anesthesia	$60.33
Surgery - Group One	22000 - 22999 23000 - 24999 25000 - 27299 27300 - 27999 29800 - 29999 61000 - 61999 62000 - 62259 63000 - 63999	Spine Shoulder, Upper Arm, & Elbow Forearm, Wrist, Hand, Pelvis & Hip Leg, Knee, & Ankle Endoscopy & Arthroscopy Skull, Meninges & Brain Repair, Neuroendoscopy & Shunts Spine & Spinal Cord	$135.00

MEDICAL FEE SCHEDULE			
SERVICE CATEGORY	CODE RANGE(S)	DESCRIPTION	CONVERSION FACTOR
Surgery - Group Two	10000 - 19999 20000 - 21999 28000 - 28999 29000 - 29799 30000 - 39999 40000 - 49999 50000 - 59999 60000 - 60999 62260 - 62999 64000 - 64999 65000 - 69999	Integumentary System Musculoskeletal System Foot & Toes Casts & Strapping Respiratory & Cardiovascular Digestive System Urinary System Endocrine System Spine & Spinal Cord Nerves & Nervous System Eye & Ear	$88.54
Radiology	70000 - 79999	Radiology	$88.54
Pathology & Laboratory	80000 - 89999	Pathology & Laboratory	To Be Determined
Medicine - Group One	90000 - 90799 94000 - 94999 97000 - 97799 97800 - 98999	Immunization, Injections, & Infusions Pulmonary / Pulse Oximetry Physical Medicine & Rehabilitation Acupuncture, Osteopathy, & Chiropractic	$49.65
Medicine - Group Two	90800 - 92999 93000 - 93999 95000 - 96020 96040 - 96999 99000 - 99607	Psychiatry & Medicine Cardiography, Catheterization, Vascular Studies Allergy / Neuromuscular Procedures Assessments & Special Procedures E / M & Miscellaneous Services	$70.00

~~(7-1-12)~~( )

04. Anesthesiology. The Conversion Factor for the Anesthesiology CPT Codes shall be multiplied by the Anesthesia Base Units assigned to that CPT Code by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services as of December 31 of the previous calendar year, plus the allowable time units reported for the procedure. Time units are computed by dividing reported time by fifteen (15) minutes. Time units will not be used for CPT Code 01996. (4-7-11)

05. Adjustment of Conversion Factors. The conversion factors set out in this rule shall be adjusted each fiscal year (FY) by the Commission to reflect changes in inflation or market conditions in accordance with Section 72-803, Idaho Code. (4-7-11)

06. Services Without CPT Code, RVU or Conversion Factor. The acceptable charge for medical services that do not have a current CPT code, a currently assigned RVU, or a conversion factor will be the reasonable charge for that service, based upon the usual and customary charge and other relevant evidence, as determined by the Commission. Where a service with a CPT Code, RVU, and conversion factor is, nonetheless, claimed to be exceptional or unusual, the Commission may, notwithstanding the conversion factor for that service set out in Subsection 031.03, above, determine the acceptable charge for that service, based on all relevant evidence in accordance with the procedures set out in Section 034, below. (4-7-11)

07. Coding. The Commission will generally follow the coding guidelines published by the Centers for Medicare and Medicaid Services and by the American Medical Association, including the use of modifiers. The

procedure with the largest RVU will be the primary procedure and will be listed first on the claim form. Modifiers will be reimbursed as follows: (4-7-11)

a. Modifier 50: Additional fifty percent (50%) for bilateral procedure. (4-7-11)

b. Modifier 51: Fifty percent (50%) of secondary procedure. This modifier will be applied to each medical or surgical procedure rendered during the same session as the primary procedure. (4-7-11)

c. Modifier 80: Twenty-five percent (25%) of coded procedure. (4-7-11)

d. Modifier 81: Fifteen percent (15%) of coded procedure. This modifier applies to MD and non-MD assistants. (4-7-11)

08. Medicine Dispensed By Physicians. Reimbursement to physicians for any medicine shall not exceed the acceptable charge calculated for that medicine as if provided by a pharmacy under Section 033, of this rule, less any dispensing or compounding fee. Reimbursement to physicians for repackaged medicine shall be the Average Wholesale Price (AWP) for the medicine prior to repackaging, identified by the National Drug Code (NDC) reported by the original manufacturer. ( )

(BREAK IN CONTINUITY OF SECTIONS)

033. ACCEPTABLE CHARGES FOR MEDICINE PROVIDED BY PHARMACIES.
Pursuant to Section 72-508 and Section 72-803, Idaho Code, the Commission hereby adopts the following rule for determining acceptable charges for medicine provided by a pharmacy under the Idaho Workers' Compensation Law. ( )

01. Acceptable Charge. Payors shall pay providers the acceptable charge for medicine provided by a pharmacy. ( )

02. Adoption of Standards for Pharmacies. The following standards shall be used to determine the acceptable charge for medicine provided by pharmacies. ( )

a. Brand/Trade Name Medicine. The standard for determining the acceptable charge for brand/trade name medicine shall be the Average Wholesale Price (AWP), plus a $2.00 dispensing fee. ( )

b. Generic Medicine. The standard for determining the acceptable charge for generic medicine shall be the Average Wholesale Price (AWP), plus a $5.00 dispensing fee. ( )

c. Compound Medicine. The standard for determining the acceptable charge for compound medicine shall be the sum of the Average Wholesale Price (AWP) for each drug included in the compound medicine, plus a $5.00 dispensing fee and a $2.00 compounding fee. ( )

d. Over-The Counter (OTC) Medicine. The standard for determining the acceptable charge for over-the-counter (OTC) medicine shall be the reasonable charge, but no dispensing fee. ( )

03. Disputes. The Commission shall determine the acceptable charge for medicine provided by a pharmacy that is disputed based on all relevant evidence in accordance with the procedures set out in Section 035 of this rule. ( )

033~~3~~4. ACCEPTABLE CHARGES FOR MEDICAL SERVICES PROVIDED BY OTHER PROVIDERS UNDER THE IDAHO WORKERS' COMPENSATION LAW.
Pursuant to Section 72-508 and Section 72-803, Idaho Code, the Commission hereby adopts the following rule for determining acceptable charges for medical services provided by providers other than physicians, hospitals or ASCs under the Idaho Workers' Compensation Law. (4-7-11)

01. Acceptable Charge. Payors shall pay providers the acceptable charge for medical services provided by providers other than physicians, hospitals or ASCs. (4-7-11)

02. Adoption of Standard. The standard for determining the acceptable charge for providers other than physicians, hospitals or ambulatory surgery centers (ASCs) shall be the reasonable charge. (4-7-11)

03. Disputes. The Commission shall determine the acceptable charge for medical services provided by providers other than physicians, hospitals and ASCs that are disputed based on all relevant evidence in accordance with the procedures set out in Section 03~~4~~5 of this rule. ~~(4-7-11)~~( )

03~~4~~5. BILLING AND PAYMENT REQUIREMENTS FOR MEDICAL SERVICES AND PROCEDURES PRELIMINARY TO DISPUTE RESOLUTION.

01. Authority. Pursuant to Section 72-508 and Section 72-803, Idaho Code, the Industrial Commission hereby promulgates this rule governing billing and payment requirements for medical services provided under the Workers' Compensation Law and the procedures for resolving disputes between payors and providers over those bills or payments. (4-7-11)

02. Time Periods. None of the periods herein shall begin to run before the Notice of Injury/Claim for Benefits has been filed with the Employer as required by law. (4-7-11)

03. Provider to Furnish Information. A Provider, when submitting a bill to a Payor, shall inform the Payor of the nature and extent of medical services furnished and for which the bill is submitted. This information shall include, but is not limited to, the patient's name, the employer's name, the date the medical service was provided, the diagnosis, if any, and the amount of the charge or charges. Failure to submit a bill complying with this Subsection 03~~4~~5.03 to the Payor within one hundred twenty (120) days of the date of service will result in the ineligibility of the Provider to utilize the dispute resolution procedures of the Commission set out in Subsection 03~~4~~5.10 for that service. ~~(4-7-11)~~( )

a. A Provider's bill shall, whenever possible, describe the Medical Service provided, using the American Medical Association's appropriate Current Procedural Terminology (CPT) coding, including modifiers, the appropriate Healthcare Common Procedure Coding System (HCPCS) code, the diagnostic and procedure code set version required by the Centers for Medicare and Medicaid Services (CMS) and the original National Drug Code (NDC for the year in which the service was performed ~~and using current International Classification of Diseases (ICD) diagnostic coding, as well~~. ~~(4-7-11)~~( )

b. The bill shall also contain the name, address and telephone number of the individual the Payor may contact in the event the Payor seeks additional information regarding the Provider's bill. (4-7-11)

c. If requested by the Payor, the bill shall be accompanied by a written report as defined by IDAPA 17.02.04, "Administrative Rules of the Industrial Commission Under the Workers' Compensation Law -- Benefits." Subsection 322.01.f. Where a bill is not accompanied by such Report, the periods expressed in Subsections 03~~4~~5.04 and 03~~4~~5.06, below, shall not begin to run until the Payor receives the Report. ~~(4-7-11)~~( )

04. Prompt Payment. Unless the Payor denies liability for the claim or, pursuant to Subsection 03~~4~~5.06, below, sends a Preliminary Objection, a Request for Clarification, or both, as to any charge, the Payor shall pay the charge within thirty (30) calendar days of receipt of the bill. ~~(4-7-11)~~( )

05. Partial Payment. If the Payor acknowledges liability for the claim and, pursuant to Subsection 03~~4~~5.06, below, sends a Preliminary Objection, a Request for Clarification, or both, as to only part of a Provider's bill, the Payor must pay the charge or charges, or portion thereof, as to which no Preliminary Objection or Request for Clarification has been made, within thirty (30) calendar days of receipt of the bill. ~~(4-7-11)~~( )

06. Preliminary Objections and Requests for Clarification. (4-7-11)

a. Whenever a Payor objects to all or any part of a Provider's bill on the ground that such bill contains

a charge or charges that do not comport with the applicable administrative rule, the Payor shall send a written Preliminary Objection to the Provider within thirty (30) calendar days of the Payor's receipt of the bill explaining the basis for each of the Payor's objections. (4-7-11)

b. Where the Payor requires additional information, the Payor shall send a written Request for Clarification to the Provider within thirty (30) calendar days of the Payor's receipt of the bill, and shall specifically describe the information sought. (4-7-11)

c. Each Preliminary Objection and Request for Clarification shall contain the name, address and phone number of the individual located within the state of Idaho that the Provider may contact regarding the Preliminary Objection or Request for Clarification. (4-7-11)

d. Where a Payor does not send a Preliminary Objection to a charge set forth in a bill or a Request for Clarification within thirty (30) calendar days of receipt of the bill, or provide an in-state contact in accord with Subsection 03~~4~~5.06.c., it shall be precluded from objecting to such charge as failing to comport with the applicable administrative rule. ~~(4-7-11)~~( )

07. Provider Reply to Preliminary Objection or Request for Clarification. (4-7-11)

a. Where a Payor has timely sent a Preliminary Objection, Request for Clarification, or both, the Provider shall send to the Payor a written Reply, if any it has, within thirty (30) calendar days of the Provider's receipt of each Preliminary Objection or Request for Clarification. (4-7-11)

b. If a Provider fails to timely reply to a Preliminary Objection, the Provider shall be deemed to have acquiesced in the Payor's objection. (4-7-11)

c. If a Provider fails to timely reply to a Request for Clarification, the period in which the Payor shall pay or issue a Final Objection shall not begin to run until such clarification is received. (4-7-11)

08. Payor Shall Pay or Issue Final Objection. The Payor shall pay the Provider's bill in whole or in part or shall send to the Provider a written Final Objection, if any it has, to all or part of the bill within thirty (30) calendar days of the Payor's receipt of the Reply. (4-7-11)

09. Failure of Payor to Finally Object. Where the Payor does not timely send a Final Objection to any charge or portion thereof to which it continues to have an objection, it shall be precluded from further objecting to such charge as unacceptable. (4-7-11)

10. Dispute Resolution Process. If, after completing the applicable steps set forth above, a Payor and Provider are unable to agree on the appropriate charge for any Medical Service, a Provider which has complied with the applicable requirements of this rule may move the Commission to resolve the dispute as provided in the Judicial Rule Re: Disputes Between Providers and Payors, as referenced in Sections 031, 032, ~~and~~ 033, and 034 of this rule. If Provider's motion disputing CPT or MS-DRG coded items prevails, Payor shall pay the amount found by the Commission to be owed, plus an additional thirty percent (30%) of that amount to compensate Provider for costs and expenses associated with using the dispute resolution process. For motions filed by a Provider disputing items without CPT or MS-DRG codes, the additional thirty percent (30%) shall be due only if the Payor does not pay the amount found due within thirty (30) days of the administrative order. ~~(4-7-11)~~( )

03~~5~~6. -- 999. (RESERVED)