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**IDAPA 17
TITLE 02
CHAPTER 08**

17.02.08 - MISCELLANEOUS PROVISIONS

000. LEGAL AUTHORITY.

These rules are adopted and promulgated by the Industrial Commission pursuant to the provision of Section 72-508, Idaho Code. (7-6-94)

001. TITLE AND SCOPE.

These rules shall be cited as IDAPA 17.02.08, "Miscellaneous Provisions." (7-6-94)

002. WRITTEN INTERPRETATIONS.

No written interpretations of these rules exist. (7-6-94)

003. ADMINISTRATIVE APPEALS.

There is no administrative appeal from decisions of the Industrial Commission in workers' compensation matters, as the Commission is exempted from contested-cases provisions of the Administrative Procedure Act. (7-6-94)

004. INCORPORATION BY REFERENCE.

No documents have been incorporated by reference into these rules. (3-14-07)

005. OFFICE -- OFFICE HOURS -- MAILING ADDRESS AND STREET ADDRESS.

This office is open from 8:00 a.m. to 5:00 p.m., except Saturday, Sunday, and legal holidays. The department's mailing address is: P.O. Box 83720, Boise, ID 83720-0041. The principal place of business is 317 Main Street, 2nd Floor, Boise, ID 83702-7274. (3-14-07)

006. PUBLIC RECORDS ACT COMPLIANCE.

Any records associated with these rules are subject to the provisions of the Idaho Public Records Act Title 9, Chapter 3, and Title 41, Idaho Code. (3-14-07)

007. -- 030. (RESERVED).

031. ACCEPTABLE CHARGES FOR MEDICAL SERVICES 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 under the Idaho Workers' Compensation Law: (3-15-07)T

01. Definitions. Words and terms used in this rule are defined in the subsections which follow. (6-1-92)

a. "Acceptable charge" means the lower of the charge for medical services calculated in accordance with this rule or as billed by the provider, or the charge agreed to pursuant to written contract. (3-15-07)T

b. "Ambulatory Surgery Center (ASC)" means a facility providing surgical services on an outpatient basis only. (3-15-07)T

c. "Hospital" is any acute care facility providing medical or hospital services and which bills using a medicare universal hospital billing form. (3-15-07)T

i. Large hospital is any hospital with more than one hundred (100) acute care beds. (3-15-07)T

ii. Small Hospital is any hospital with one hundred (100) acute care beds or less. (3-15-07)T

d. "Provider" means 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 are compensable under Idaho’s Workers’ Compensation Law. (3-15-07)T

e. “Payor” means the legal entity responsible for paying medical benefits under Idaho’s Workers’ Compensation Law. (6-1-92)

f. “Medical Service” means medical, surgical, dental or other attendance or treatment, nurse and hospital service, medicine, apparatus, appliance, prostheses, and related service, facility, equipment and supply. (3-15-07)T

g. “Reasonable,” means a charge does not exceed the Provider’s “usual” charge and does not exceed the “customary” charge, as defined below. (3-15-07)T

h. “Usual” means the most frequent charge made by an individual Provider for a given medical service to non-industrially injured patients. (3-15-07)T

i. “Customary” means 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. (3-15-07)T

02. Acceptable Charge. Payors shall pay providers the acceptable charge for medical services. (3-15-07)T

a. Adoption of Standard. 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 providers other than hospitals and ASCs. The standard for determining the acceptable charge for hospitals and ASCs shall be: (3-15-07)T

i. For large hospitals: Eighty-five Percent (85%) of the appropriate inpatient charge. (3-15-07)T

ii. For small hospitals: Ninety percent (90%) of the appropriate inpatient charge. (3-15-07)T

iii. For ambulatory surgery centers (ASCs) and hospital outpatient charges: Eighty percent (80%) of the appropriate charge. (3-15-07)T

iv. Surgically implanted hardware shall be reimbursed at the rate of actual cost plus fifty percent (50%). (3-15-07)T

v. Paragraph 031.02.e., shall not apply to hospitals or ASCs. The Commission shall determine the appropriate charge for hospital and ASC services that are disputed based on all relevant evidence in accordance with the procedures set out in Subsection 032.10. (3-15-07)T

b. Conversion Factors. The following conversion factors shall be applied to the Relative Value Unit (RVU) 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:

CPT CODE:	DESCRIPTION:	CONVERSION FACTOR:
00000 - 09999	Anesthesia	\$ 58.19
10000 - 69999	Surgery:	
10000 - 12999	Integumentary System	\$ 67.00
13000 - 19999	Integumentary System	\$ 105.00
20000 - 20615	Musculoskeletal System	\$ 88.00

CPT CODE:	DESCRIPTION:	CONVERSION FACTOR:
20650 - 21935	Musculoskeletal System	\$ 110.00
22100 - 22999	Spine	\$ 142.00
23000 - 24999	Shoulder, Upper Arm & Elbow	\$ 142.00
25000 - 27299	Forearm, Hand, Pelvis & Hip	\$ 142.00
27300 - 27899	Leg	\$ 142.00
28000 - 28999	Foot and Toes	\$ 142.00
29000 - 29750	Casts and Strapping	\$ 60.00
29800 - 29899	Endoscopy and Arthroscopy	\$ 142.00
30000 - 39999	Respiratory and Cardiovascular	\$ 88.00
40000 - 49999	Digestive System	\$ 88.00
50000 - 59999	Urinary System	\$ 80.00
60000 - 60999	Endocrine System	\$ 88.00
61000 - 61999	Skull, Meninges and Brain	\$ 142.00
62000 - 62258	Repair, Neuroendoscopy and Shunts	\$ 142.00
62263 - 62368	Spine and Spinal Cord	\$ 88.00
63000 - 63999	Spine and Spinal Cord	\$ 155.00
64400 - 64530	Nerves and Nervous System	\$ 88.00
64550 - 64999	Nerves and Nervous System	\$ 125.00
65000 - 69990	Eye and Ear	\$ 88.00
70000 - 79999	Radiology	\$ 85.00
80000 - 89999	Pathology and Laboratory	To be Determined
90465 - 90749	Immunization	\$ 35.00
90760 - 90779	Infusions and Injections	\$ 59.00
90801 - 92998	Psychiatry and Medicine	\$ 60.00
93000 - 93999	Cardiography and Studies	\$ 70.00
94000 - 94750	Pulmonary	\$ 60.00
94760 - 94762	Pulse Oximetry	\$ 40.00
94770 - 95999	Allergies; Testing	\$ 70.00
96000 - 96999	Assessments and Special Procedures	\$ 60.00
97000 - 97799	Physical Medicine and Rehabilitation	\$ 44.00
97800 - 98999	Acupuncture, Osteopathy, Chiropractic	\$ 43.00
99000 - 99499	Miscellaneous Services	\$ 63.00

(3-15-07)T

c. 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 Codes 01995 and 01996. (3-15-07)T

d. Adjustment of Conversion Factors. The conversion factors set out in this rule shall be adjusted prior to the beginning of each state fiscal year (FY), starting with FY 2009. The Commission shall determine the adjustment, which shall equal the percent change in the all item consumer price index for the west urban area, as published by the U.S. Department of Labor, for the twelve-month (12) month period ending with December of the prior year. (3-15-07)T

e. Services Without CPT Code, RVU or Conversion Factor. The acceptable charge for medical services that do not have a 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 031.02.b., determine the acceptable charge for that service, based on all relevant evidence in accordance with the procedures set out in Subsection 032.10. (3-15-07)T

f. 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: (3-15-07)T

- i. Modifier 50: Additional fifty percent (50%) for bilateral procedure. (3-15-07)T
- ii. 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. (3-15-07)T
- iii. Modifier 80: Twenty-five percent (25%) of coded procedure. (3-15-07)T
- iv. Modifier 81: Fifteen percent (15%) of coded procedure. This modifier applies to MD and non-MD assistants. (3-15-07)T

032. BILLING AND PAYMENT REQUIREMENTS FOR MEDICAL SERVICES AND PROCEDURES PRELIMINARY TO DISPUTE RESOLUTION.

01. Authority and Definitions. Pursuant to Section 72-508 and Section 72-803, Idaho Code, the Industrial Commission hereby promulgates this rule augmenting IDAPA 17.02.08.031. The definitions set forth in IDAPA 17.02.08.031 are incorporated by reference as if fully set forth herein. (3-14-07)

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. (1-1-93)

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 Subsection 032.03 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 032.10 for that service. (3-14-07)

a. CPT and ICD Coding. 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, for the year in which the service was performed and using current International Classification of Diseases (ICD) diagnostic coding, as well. (7-1-95)

b. Contact Person. 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. (1-1-93)

c. Report to Accompany Bill. If requested by the Payor, the bill shall be accompanied by a written report as defined by IDAPA 17.02.04.322.01.f. Where a bill is not accompanied by such Report, the periods expressed in Subsections 032.04 and 032.06, below, shall not begin to run until the Payor receives the Report. (3-14-07)

04. Prompt Payment. Unless the Payor denies liability for the claim or, pursuant to Subsection 032.06, sends a Preliminary Objection 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. (3-14-07)

05. Partial Payment. If the Payor acknowledges liability for the claim and, pursuant to Subsection 032.06 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 and/or Request for Clarification has been made, within thirty (30) calendar days of receipt of the bill. (3-14-07)

06. Preliminary Objections and Requests for Clarification. (1-1-93)

a. Preliminary Objection. 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. (1-1-93)

b. Request for Clarification. 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. (1-1-93)

c. Provider Contact. 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. (3-14-07)

d. Failure of Payor to Object or Request or Provide Contact. Where a Payor does not send a Preliminary Objection to a charge set forth in a bill and/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 032.06.c., it shall be precluded from objecting to such charge as failing to comport with the applicable administrative rule. (3-14-07)

07. Provider Reply to Preliminary Objection and/or Request for Clarification. (1-1-93)

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 and/or Request for Clarification. (1-1-93)

b. Failure of Provider to Reply to Preliminary Objection. If a Provider fails to timely reply to a Preliminary Objection, the Provider shall be deemed to have acquiesced in the Payor's objection. (1-1-93)

c. Failure of Provider to Reply to Request for Clarification. 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. (1-1-93)

08. Payor Shall Pay or Issue Final Objection. The Payor shall pay the Provider's bill in whole or in part and/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. (1-1-93)

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. (1-1-93)

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 and 032 of this rule. If Provider's motion disputing CPT 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 hospital or ambulatory surgical center, under section 031.02.a.v., or by a provider under 031.02.e, 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. (3-14-07)

033. RULE GOVERNING APPROVAL OF ATTORNEY FEES IN WORKERS' COMPENSATION CASES.

01. Authority and Definitions. Pursuant to Sections 72-404, 72-508, 72-707, 72-735 and 72-803, Idaho Code, the Commission promulgates this rule to govern the approval of attorney fees. (7-1-94)

a. "Available funds" means a sum of money to which a charging lien may attach. It shall not include any compensation paid or not disputed to be owed prior to claimant's agreement to retain the attorney. (7-1-94)

b. "Approval by Commission" means the Commission has approved the attorney fees in conjunction with an award of compensation or a lump sum settlement or otherwise in accordance with this rule upon a proper showing by the attorney seeking to have the fees approved. (7-1-94)

c. "Charging lien" means a lien, against a claimant's right to any compensation under the Workers' Compensation laws, which may be asserted by an attorney who is able to demonstrate that: (7-1-94)

i. There are compensation benefits available for distribution on equitable principles; (7-1-94)

ii. The services of the attorney operated primarily or substantially to secure the fund out of which the attorney seeks to be paid; (7-1-94)

iii. It was agreed that counsel anticipated payment from compensation funds rather than from the client; (7-1-94)

iv. The claim is limited to costs, fees, or other disbursements incurred in the case through which the fund was raised; and (7-1-94)

v. There are equitable considerations that necessitate the recognition and application of the charging lien. (7-1-94)

d. "Fee agreement" means a written document evidencing an agreement between a claimant and counsel, in conformity with Rule 1.5, Idaho Rules of Professional Conduct (IRPC). (7-1-94)

e. "Reasonable" means that an attorney's fees are consistent with the fee agreement and are to be satisfied from available funds, subject to the element of reasonableness contained in IRPC 1.5. (7-1-94)

i. In a case in which no hearing on the merits has been held, twenty-five percent (25%) of available funds shall be presumed reasonable; or (7-1-94)

ii. In a case in which a hearing has been held and briefs submitted (or waived) under Judicial Rules of Practice and Procedure (JRP), Rules X and XI, thirty percent (30%) of available funds shall be presumed reasonable; or (7-1-94)

iii. In any case in which compensation is paid for total permanent disability, fifteen percent (15%) of

such disability compensation after ten (10) years from date such total permanent disability payments commenced. (7-1-94)

02. Statement of Charging Lien. (7-1-94)

a. All requests for approval of fees shall be deemed requests for approval of a charging lien. (7-1-94)

b. An attorney representing a claimant in a Workers' Compensation matter shall in any proposed lump sum settlement, or upon request of the Commission, file with the Commission, and serve the claimant with a copy of the fee agreement, and an affidavit or memorandum containing: (7-1-94)

i. The date upon which the attorney became involved in the matter; (7-1-94)

ii. Any issues which were undisputed at the time the attorney became involved; (7-1-94)

iii. The total dollar value of all compensation paid or admitted as owed by employer immediately prior to the attorney's involvement; (7-1-94)

iv. Disputed issues that arose subsequent to the date the attorney was hired; (7-1-94)

v. Counsel's itemization of compensation that constitutes available funds; (7-1-94)

vi. Counsel's itemization of costs and calculation of fees; and (7-1-94)

vii. The statement of the attorney identifying with reasonable detail his or her fulfillment of each element of the charging lien. (7-1-94)

c. Upon receipt and a determination of compliance with this Rule by the Commission by reference to its staff, the Commission may issue an Order Approving Fees without a hearing. (7-1-94)

03. Procedure if Fees Are Determined Not to Be Reasonable. (7-1-94)

a. Upon receipt of the affidavit or memorandum, the Commission will designate staff members to determine reasonableness of the fee. The Commission staff will notify counsel in writing of the staff's informal determination, which shall state the reasons for the determination that the requested fee is not reasonable. Omission of any information required by Subsection 033.02 may constitute grounds for an informal determination that the fee requested is not reasonable. (7-1-94)

b. If counsel disagrees with the Commission staff's informal determination, counsel may file, within fourteen (14) days of the date of the determination, a Request for Hearing for the purpose of presenting evidence and argument on the matter. Upon receipt of the Request for Hearing, the Commission shall schedule a hearing on the matter. A Request for Hearing shall be treated as a motion under Rule III(e), JRP. (7-1-94)

c. The Commission shall order an employer to release any available funds in excess of those subject to the requested charging lien and may order payment of fees subject to the charging lien which have been determined to be reasonable. (7-1-94)

d. The proponent of a fee which is greater than the percentage of recovery stated in Subsections 033.01.e.i., 033.01.e.ii., or 033.01.e.iii. shall have the burden of establishing by clear and convincing evidence entitlement to the greater fee. The attorney shall always bear the burden of proving by a preponderance of the evidence his or her assertion of a charging lien and reasonableness of his or her fee. (7-1-94)

04. Disclosure. Upon retention, the attorney shall provide to claimant a copy of a disclosure statement. No fee may be taken from a claimant by an attorney on a contingency fee basis unless the claimant acknowledges receipt of the disclosure by signing it. Upon request by the Commission, an attorney shall provide a copy of the signed disclosure statement to the Commission. The terms of the disclosure may be contained in the fee agreement, so long as it contains the text of the numbered paragraphs one (1) and two (2) of the disclosure. A copy of the agreement

must be given to the client. The disclosure statement shall be in a format substantially similar to the following:

State of Idaho
Industrial Commission

Client's name printed or typed
Attorney's name and address
printed or typed

DISCLOSURE STATEMENT

1. In workers' compensation matters, attorney's fees normally do not exceed twenty-five percent (25%) of the benefits your attorney obtains for you in a case in which no hearing on the merits has been completed. In a case in which a hearing on the merits has been completed, attorney's fees normally do not exceed thirty percent (30%) of the benefits your attorney obtains for you.

2. Depending upon the circumstances of your case, you and your attorney may agree to a higher or lower percentage which would be subject to Commission approval. Further, if you and your attorney have a dispute regarding attorney fees, either of you may petition the Commission to resolve the dispute.

I certify that I have read and understand this disclosure statement.

Client's Signature Date

Attorney's Signature Date

(7-1-94)

05. Effective Dates. Subparagraphs i., ii., and iii. of Subsection 033.01.e. are effective as to fee agreements entered into on and after December 1, 1992. All other provisions shall be effective on and after December 20, 1993. (7-1-94)

034. -- 060. (RESERVED).

061. RULE GOVERNING NOTICE TO CLAIMANTS OF STATUS CHANGE PURSUANT TO SECTION 72-806, IDAHO CODE.

01. Notice of Change of Status. As required and defined by Idaho Code, Section 72-806, a worker shall receive written notice within fifteen (15) days of any change of status or condition. (1-6-92)

02. By Whom Given. Any notice to a worker required by Idaho Code, Section 72-806 shall be given by: the surety if the employer has secured Workers' Compensation Insurance; or the employer if the employer is self-insured; or the employer if the employer carries no Workers' Compensation Insurance. (1-6-92)

03. Form of Notice. Any notice to a worker required by Idaho Code, Section 72-806 shall be mailed within ten (10) days by regular United States Mail to the last known address of the worker, as shown in the records of the party required to give notice as set forth above. The Notice shall be given on IC Form 8, as prescribed by the Commission for this purpose, as substantially set forth below:

IC Form 8:

NOTICE OF CLAIM STATUS

Injured Worker

SSN

Date of Injury

Employer

Insurance Company

Address State Zip

This is to notify you of the denial or change of status of your workers' compensation claim as indicated in the statement checked below.

Your claim is denied.
Reason

Your benefit payments will be reduced increased
Effective date
Reason

Your benefit payments will be stopped. Effective date
Reason

Your claim is being investigated.
A decision should be made by

Other Effective date
Explanation

See attached medical reports

Signature of insurance company adjuster/examiner date
Name (typed or printed)

A sample copy of IC Form 8 is available from the;

Industrial Commission
317 Main Street
P. O. Box 83720, Boise, Idaho 83720-0041
telephone (208) 334-6000. (1-6-92)

04. Medical Reports. As required by Idaho Code, Section 72-806, if the change is based on a medical report, the party giving notice shall attach a copy of the report to the notice. (1-6-92)

05. Copies of Notice. The party giving notice pursuant to Idaho Code, Section 72-806 shall send a copy of any such notice to the Industrial Commission, the employer, and the worker's attorney, if the worker is represented, at the same time notice is sent to the worker. (1-6-92)

062. -- 999. (RESERVED).

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