

IDAPA 17 – INDUSTRIAL COMMISSION

17.0209 – MEDICAL FEES

NOTICE OF RULE CHANGE

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
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

(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)

032. ACCEPTABLE CHARGES FOR MEDICAL SERVICES PROVIDED BY HOSPITALS AND AMBULATORY SURGERY CENTERS 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 hospitals and ambulatory surgery centers under the Idaho Workers' Compensation Law. (1-1-12)

01. Acceptable Charge. Payors shall pay providers the acceptable charge for medical services provided by hospitals and ambulatory surgery centers. (1-1-12)

02. Adoption of Standards for Hospitals and ASCs. The following standards shall be used to determine the acceptable charge for hospitals and ambulatory surgery centers. (1-1-12)

a. Critical Access and Rehabilitation Hospitals. The standard for determining the acceptable charge for inpatient and outpatient services provided by a critical access or rehabilitation hospital is ninety percent (90%) of the reasonable charge. Implantable hardware charges shall be reimbursed at the rate of the actual cost plus fifty percent (50%). (1-1-12)

b. Hospital Inpatient Services. The standard for determining the acceptable charge for inpatient services provided by hospitals, other than critical access and rehabilitation hospitals, is calculated by multiplying the base rate by the current MS-DRG weight for that service. The base rate for inpatient services is ten thousand dollars (\$10,000). Inpatient services that do not have a relative weight shall be paid at eighty-five percent (85%) of the reasonable charge; however, implantable hardware charges billed for services without an MS-DRG weight shall be reimbursed at the rate of actual cost plus fifty percent (50%). (1-1-12)

c. Hospital Outpatient and Ambulatory Surgical Center (ASC) Services. The standard for determining the acceptable charge for outpatient services provided by hospitals (other than critical access and rehabilitation hospitals) and for services provided by ambulatory surgical centers is calculated by multiplying the base rate by the Medicare Hospital Outpatient Prospective Payment System (OPPS) APC weight in effect on the first day of January of the current calendar year. The base rate for hospital outpatient services is one hundred and thirty eight dollars (\$138). The base rate for ASC services is ninety dollars (\$90). (1-1-12)

i. Medical services for which there is no APC weight listed shall be reimbursed at seventy-five percent (75%) of the reasonable charge. (3/29/12)

ii. Status code N items (other than implantable hardware) or items with no CPT or Healthcare Common Procedure Coding System (HCPCS) code shall receive no payment. (1-1-12)

iii. Two or more medical procedures with a status code T on the same claim shall be reimbursed with the highest weighted code paid at one hundred percent (100%) of the APC calculated amount and all other status code T items paid at fifty percent (50%). (1-1-12)

iv. Status code Q items with an assigned APC weight will not be discounted. (1-1-12)

d. Hospitals Outside of Idaho. Reimbursement for services provided by hospitals outside the state of Idaho may be based upon the agreement of the parties. If there is no agreement, services shall be paid in accordance with the workers' compensation fee schedule in effect in the state in which services are rendered. If there is no hospital

fee schedule in effect in such state, or if the fee schedule in that state does not allow reimbursement for the services rendered, reimbursement shall be paid in accordance with these rules. (1-1-12)

e. Additional Hospital Payments. When the charge for a medical service provided by a hospital (other than a critical access or rehabilitation hospital) meets the following standards, additional payment shall be made for that service, as indicated. (1-1-12)

i. Inpatient Threshold Exceeded. When the charge for a hospital inpatient MS-DRG coded service exceeds the sum of thirty thousand dollars (\$30,000) plus the payment calculated under the provisions of Subparagraph 032.02.b. of this rule, then the total payment for that service shall be the sum of the MS-DRG payment and the amount charged above that threshold multiplied by seventy-five percent (75%). Implantable charges shall be excluded from the calculation for an additional inpatient payment under this Subparagraph. (1-1-12)

ii. Inpatient Implantable Hardware. Hospitals may seek additional reimbursement beyond the MS-DRG payment for invoiced implantable hardware where the aggregate invoice cost is greater than ten thousand dollars (\$10,000). Additional reimbursement shall be the invoice cost plus an amount which is equal to ten percent (10%) of the invoice cost, but which does not exceed three thousand dollars (\$3,000). Handling and freight charges shall be included in invoice cost. (1-1-12)

iii. Outpatient Implantable Hardware. Hospitals and ASCs may seek additional reimbursement beyond the APC payment for invoiced implantable hardware where the aggregate invoice cost is greater than five hundred dollars (\$500). Additional reimbursement shall be the invoice cost plus an amount which is equal to ten percent (10%) of the invoice cost, but which does not exceed one thousand dollars (\$1,000). Handling and freight charges shall be included in invoice cost. (1-1-12)

03. Disputes. The Commission shall determine the acceptable charge for hospital and ASC services that are disputed based on all relevant evidence in accordance with the procedures set out in Section 034 of this rule. (1-1-12)

04. Adjustment of Hospital and ASC Base Rates. The Commission may periodically adjust the base rates set out in Subparagraphs 032.02.b. and 032.02.c. of this rule to reflect changes in inflation or market conditions. (1-1-12)