

IDAPA 17 - INDUSTRIAL COMMISSION

17.02.09 - MEDICAL FEES

DOCKET NO. 17-0209-1301

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 Sections 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 scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 16, 2013.

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:

This Rule adjusts the dispensing fees for pharmacies allowed under the pharmaceutical fee schedule. These fees were determined in collaboration with interested stakeholders. Under the physician fee schedule, a correction is made to a range of CPT codes in the conversion factor table that had been improperly included in Surgery Group 2. This Rule seeks to make permanent the changes already in effect by the Temporary Rule.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: There is no fiscal impact.

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 resulting from this rulemaking: There is no negative fiscal impact.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the rule complies with the requirements of Section 72-803, Idaho Code, requiring the Commission to adopt, and adjust as necessary each year, rules governing the approval of fees for medical services in workers' compensation cases.

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.

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 23, 2013.

DATED this 26th day of August, 2013.

Mindy Montgomery, Director
Industrial Commission
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PO Box 83720
Boise, Idaho 83720-0041
Phone: 208-334-6000
Fax: 208-334-5145

Pursuant to Section 67-5221(1), Idaho Code, this docket is being published as a proposed rule.

This docket has been previously published as a temporary rule.
 The temporary effective date is July 1, 2013.

The original text of the temporary rule was published in the Idaho Administrative Bulletin,
 Volume 13-7, July 3, 2013, pages 60 through 63.

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO 17-0209-1301
(Only those Sections being amended are shown.)

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 total* 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	Spine	\$135.00
	23000 - 24999	Shoulder, Upper Arm, & Elbow	
	25000 - 27299	Forearm, Wrist, Hand, Pelvis & Hip	
	27300 - 27999	Leg, Knee, & Ankle	
	29800 - 29999	Endoscopy & Arthroscopy	
	61000 - 61999	Skull, Meninges & Brain	
	62000 - 62259	Repair, Neuroendoscopy & Shunts	
Surgery - Group Two	63000 - 63999	Spine & Spinal Cord	\$124.00
	28000 - 28999	Foot & Toes	
	64000 00 550 - 64999	Nerves & Nervous System	

MEDICAL FEE SCHEDULE			
SERVICE CATEGORY	CODE RANGE(S)	DESCRIPTION	CONVERSION FACTOR
Surgery - Group Three	10000 - 19999	Integumentary System	\$88.54
	20000 - 21999	Musculoskeletal System	
	29000 - 29799	Casts & Strapping	
	30000 - 39999	Respiratory & Cardiovascular	
	40000 - 49999	Digestive System	
	50000 - 59999	Urinary System	
	60000 - 60999	Endocrine System	
	62260 - 62999	Spine & Spinal Cord	
	<u>64000 - 64549</u>	<u>Nerves & Nervous System</u>	
	65000 - 69999	Eye & Ear	
Radiology	70000 - 79999	Radiology	\$88.54
Pathology & Laboratory	80000 - 89999	Pathology & Laboratory	To Be Determined
Medicine - Group One	90000 - 90799	Immunization, Injections, & Infusions	\$49.00
	94000 - 94999	Pulmonary / Pulse Oximetry	
	97000 - 97799	Physical Medicine & Rehabilitation	
	97800 - 98999	Acupuncture, Osteopathy, & Chiropractic	
Medicine - Group Two	90800 - 92999	Psychiatry & Medicine	\$70.00
	93000 - 93999	Cardiography, Catheterization, Vascular Studies	
	95000 - 96020	Allergy / Neuromuscular Procedures	
	96040 - 96999	Assessments & Special Procedures	
	99000 - 99607	E / M & Miscellaneous Services	

(7-1-13)()

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 0345, 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 without a 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. Reimbursement may be withheld until the original manufacturer's National Drug Code (NDC) is provided by the physician. (7-1-13)

(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. (7-1-13)

01. Acceptable Charge. Payors shall pay providers the acceptable charge for medicine provided by a pharmacy. (7-1-13)

02. Adoption of Standards for Pharmacies. The following standards shall be used to determine the acceptable charge for medicine provided by pharmacies. (7-1-13)

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 ~~two~~ five dollar (~~\$2~~\$5) dispensing fee. (7-1-13)()

b. Generic Medicine. The standard for determining the acceptable charge for generic medicine shall be the Average Wholesale Price (AWP), plus an five ~~eight~~ dollar (~~\$8~~\$5) dispensing fee. (7-1-13)()

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 five dollar (\$5) dispensing fee and a two dollar (\$2) compounding fee. All components of the compound medicine shall be identified by their original manufacturer's National Drug Code (NDC) when submitted for reimbursement. Payors may withhold reimbursement until the original manufacturer's NDC assigned to each component of the compound medicine is provided by the pharmacy. Components of a compound medicine without an NDC may require medical necessity confirmation by the treating physician prior to reimbursement. (7-1-13)

d. Prescribed Over-The Counter (OTC) Medicine. The standard for determining the acceptable charge for prescribed over-the-counter (OTC) medicine filled by a pharmacy shall be the reasonable charge, ~~but no plus a two dollar (\$2)~~ dispensing fee. (7-1-13)()

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. (7-1-13)