

Notice of Adoption of Temporary Rulemaking

IDAPA 17 – INDUSTRIAL COMMISSION

17.02.08 – MISCELLANEOUS PROVISIONS

DOCKET NO. 17-0208-0901

NOTICE OF RULEMAKING - ADOPTION OF TEMPORARY RULE

EFFECTIVE DATE: The effective date of the temporary rule is May 8, 2009.

AUTHORITY: In compliance with Sections 67-5226, Idaho Code, notice is hereby given this agency has adopted a temporary rule. The action is authorized pursuant to Section(s) 72-508, 72-720, 72-721, 72-722, 72-723, and 72-803, Idaho Code.

DESCRIPTIVE SUMMARY: The following is the required finding and concise statement of its supporting reasons for adopting a temporary rule: The temporary rule containing physician fee updates effective July 1, 2008, as required by 72-803, Idaho Code, will no longer be in effect upon *sine die* adjournment of the 2009 legislature, May 8, 2009. This temporary rule will provide the same fee schedule updates as the previous temporary rule until a new proposed rule can be submitted for legislative approval in 2010.

TEMPORARY RULE JUSTIFICATION: Pursuant to Section(s) 67-5226(1) b, Idaho Code, the Governor has found that temporary adoption of the rule is appropriate for the following reasons: Compliance with deadlines in amendments to governing law. The proposed rules were rejected by the 2009 legislature due to problems in one section, causing the entire rule to be rejected. The rejected rule contained the new fee structure of a required annual adjustment that provided a 3% increase for providers. This temporary rule will extend those fees until a proposed rule can be presented to the 2010 legislature.

FEE SUMMARY: Pursuant to Section 67-5226(2), the Governor has found that the fee or charge being imposed or increased is justified and necessary to avoid immediate danger and the fee is described herein:

N/A

ASSISTANCE ON TECHNICAL QUESTIONS: For assistance on technical questions concerning the temporary rule, contact Patti Vaughn at 208-334-6084.

DATED this 8th day of May, 2009.

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**IDAPA 17
TITLE 02
CHAPTER 08**

17.02.08 - MISCELLANEOUS PROVISIONS

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: (3-12-07)

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. (3-12-07)

b. "Ambulatory Surgery Center (ASC)" means a facility providing surgical services on an outpatient basis only. (4-2-08)

c. "Hospital" is any acute care facility providing medical or hospital services and which bills using a Medicare universal hospital billing form. (4-2-08)

i. Large hospital is any hospital with more than one hundred (100) acute care beds. (4-2-08)

ii. Small Hospital is any hospital with one hundred (100) acute care beds or less. (4-2-08)

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. (3-12-07)

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. (3-12-07)

g. "Reasonable," means a charge does not exceed the Provider's "usual" charge and does not exceed the "customary" charge, as defined below. (3-12-07)

h. "Usual" means the most frequent charge made by an individual Provider for a given medical service to non-industrially injured patients. (3-12-07)

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. (3-12-07)

02. Acceptable Charge. Payors shall pay providers the acceptable charge for medical services. (3-12-07)

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: (4-2-08)

- i. For large hospitals: Eighty-five percent (85%) of the appropriate inpatient charge. (4-2-08)
- ii. For small hospitals: Ninety percent (90%) of the appropriate inpatient charge. (4-2-08)
- iii. For ambulatory surgery centers (ASCs) and hospital outpatient charges: Eighty percent (80%) of the appropriate charge. (4-2-08)
- iv. Surgically implanted hardware shall be reimbursed at the rate of actual cost plus fifty percent (50%). (4-2-08)
- 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. (4-2-08)

b. 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 | \$60.05 |
| 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 | \$144.48 |
| 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 | 20000 - 20615 30000 - 39999 40000 - 49999 50000 - 59999 60000 - 60999 62260 - 62999 64000 - 64549 65000 - 69999 | Musculoskeletal System Respiratory & Cardiovascular Digestive System Urinary System Endocrine System Spine & Spinal Cord Nerves & Nervous System Eye & Ear | \$87.72 |

| | | | |
|------------------------|------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|
| Surgery - Group Five | 10000 - 12999 29000 - 29799 | Integumentary System Casts & Strapping | \$69.14 |
| Radiology | 70000 - 79999 | Radiology | \$87.72 |
| 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 | \$46.44 |
| Medicine - Group Two | 90800 - 92999 96040 - 96999 99000 - 99607 | Psychiatry & Medicine Assessments & Special Procedures E / M & Miscellaneous Services | \$66.56 |
| Medicine - Group Three | 93000 - 93999 95000 - 96020 | Cardiography, Catheterization, & Vascular Studies Allergy / Neuromuscular Procedures | \$72.24 |

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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 Code 01996. (4-2-08)

d. Adjustment of Conversion Factors. The conversion factors set out in this rule shall be adjusted each fiscal year (FY), starting with FY 2009, as determined by the director of the Department of Health and Welfare using the methodology set forth in section 56-136, Idaho Code, pursuant to Section 72-803, Idaho Code. (4-2-08)

e. 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 031.02.b., determine the acceptable charge for that service, based on all relevant evidence in accordance with the procedures set out in Subsection 032.10. (4-2-08)

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: (3-12-07)

i. Modifier 50: Additional fifty percent (50%) for bilateral procedure. (3-12-07)

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. (3-12-07)

- iii. Modifier 80: Twenty-five percent (25%) of coded procedure. (3-12-07)
- iv. Modifier 81: Fifteen percent (15%) of coded procedure. This modifier applies to MD and non-MD assistants. (3-12-07)