

vii. Counsel's itemization of medical bills for which Claim was made in the underlying action, but which remain unpaid by employer/surety at the time of LSS, along with counsel's explanation of the treatment to be given such bills/claims following approval of the LSS. (3-20-20)T

viii. The statement of the attorney identifying with reasonable detail his or her fulfillment of each element of the Charging Lien. (3-20-20)T

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. (3-20-20)T

**04. Procedure if Fees Are Determined Not to Be Reasonable. (3-20-20)T**

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 Paragraph 802.02.b may constitute grounds for an informal determination that the fee requested is not reasonable. (3-20-20)T

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. (3-20-20)T

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. (3-20-20)T

d. The proponent of a fee which is greater than the percentage of recovery stated in Subsection 802.02 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. (3-20-20)T

**05. Disclosure Statement.** 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 following text: (3-20-20)T

a. In worker's 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. (3-20-20)T

b. 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 Industrial Commission, PO Box 83720, Boise, ID 83720-0041, to resolve the dispute. (3-20-20)T

**803. MEDICAL FEES.**

**01. General Provisions for Medical Fees.** The following provisions shall apply to Commission approval of claims for medical benefits. (3-20-20)T

a. Acceptable Charge. Payors shall pay Providers the acceptable charge for medical services. (3-20-20)T

b. Coding. The Commission will generally follow the coding guidelines published by CMS and by the

American Medical Association, including the use of modifiers. (3-20-20)T

**c.** Disputes. Disputes between Providers and Payors are governed by Subsection 803.06 of this rule and JRP 19. (3-20-20)T

**d.** Outside of Idaho. Reimbursement for medical services provided 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 worker's compensation fee schedule in effect in the state in which services are rendered. If there is no 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. (3-20-20)T

**02. Acceptable Charges For Medical Services Provided By Physicians Under The Idaho Worker's Compensation Law.** (3-20-20)T

**a.** The Commission adopts the RBRVS, published by CMS, as amended, as the standard to be used to determine acceptable charges by physicians. (3-20-20)T

**b.** Modifiers. Modifiers for physicians will be reimbursed as follows: (3-20-20)T

**i.** Modifier 50: Additional fifty percent (50%) for bilateral procedure. (3-20-20)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. (3-20-20)T

**iii.** Modifier 80: Twenty-five percent (25%) of coded procedure. (3-20-20)T

**iv.** Modifier 81: Fifteen percent (15%) of coded procedure. This modifier applies to MD and non-MD assistants. (3-20-20)T

**c.** Conversion Factors. The standard for determining the acceptable charge for a medical service, identified by a code assigned to that service in the latest edition of the Physician's CPT, published by the American Medical Association, as amended, is calculated by the application of the total facility or non-facility RVU for services as determined by place of service in the latest RBRVS in effect on the first day of January of the current calendar year, to the following corresponding conversion factors. The procedure with the largest RVU will be the primary procedure and will be listed first on the claim form. (3-20-20)T

<b>MEDICAL FEE SCHEDULE</b>			
<b>SERVICE CATEGORY</b>	<b>CODE RANGE(S)</b>	<b>DESCRIPTION</b>	<b>CONVERSION FACTOR</b>
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	
	64550 - 64999	Nerves & Nervous System	

<b>MEDICAL FEE SCHEDULE</b>			
<b>SERVICE CATEGORY</b>	<b>CODE RANGE(S)</b>	<b>DESCRIPTION</b>	<b>CONVERSION FACTOR</b>
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	
	64000 - 64549	Nerves & Nervous System	
	65000 - 69999	Eye & Ear	
Radiology	70000 - 79999	Radiology	\$88.54
Pathology & Laboratory	80000 - 89999	Pathology & Laboratory	To Be Determined
Medicine - Group One	90000 - 90749	Immunization, Injections, & Infusions	\$49.00
	94000 - 94999	Pulmonary / Pulse Oximetry	
	97000 - 97799	Physical Medicine & Rehabilitation	
	97800 - 98999	Acupuncture, Osteopathy, & Chiropractic	
Medicine - Group Two	90750 - 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	

(3-20-20)T

**d.** Anesthesiology. The Conversion Factor for the Anesthesiology CPT Codes shall be multiplied by the current Anesthesia Base Units assigned to that CPT Code by CMS, 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. (3-20-20)T

**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 Paragraph 02.c, above, determine the acceptable charge for that service, based on all relevant evidence in accordance with the procedures set out in Subsection 06, below. (3-20-20)T

**f.** 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 Subsection 04 of this rule without a dispensing or compounding fee. Reimbursement to physicians for repackaged medicine shall be the AWP for the medicine prior to repackaging, identified by the NDC reported by the original manufacturer. Reimbursement may be withheld until the original manufacturer's NDC is provided by the physician. (3-20-20)T

**g.** Adjustment of Conversion Factors. The conversion factors set out in this rule may 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. (3-20-20)T

**03. Acceptable Charges For Medical Services Provided By Hospitals And Ambulatory Surgery Centers Under The Idaho Worker's Compensation Law.** The following standards shall be used to determine the acceptable charge for Hospitals and ASCs. (3-20-20)T

**a. Critical Access Hospitals.** The standard for determining the acceptable charge for inpatient and outpatient services provided by a Critical Access 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%). (3-20-20)T

**b. Hospital Inpatient Services.** The standard for determining the acceptable charge for inpatient services provided by Hospitals, other than Critical Access 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 two hundred dollars (\$10,200). 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%). (3-20-20)T

**c. Hospital Outpatient and ASC Services.** The standard for determining the acceptable charge for outpatient services provided by Hospitals (other than Critical Access Hospitals) and for services provided by ASCs is calculated by multiplying the base rate by the Medicare Hospital Outpatient Prospective Payment System 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 forty dollars and seventy-five cents (\$140.75). The base rate for ASC services is ninety-one dollars fifty cents (\$91.50). (3-20-20)T

**i. Medical services for which there is no APC weight listed shall be reimbursed at seventy-five percent (75%) of the reasonable charge.** (3-20-20)T

**ii. Status code N items or items with no CPT or HCPCS code shall receive no payment except as provided in Subparagraph 803.03.c.ii.(1) or 803.03.c.ii.(2) of this rule.** (3-20-20)T

**(1) Implantable Hardware may be eligible for separate payment under Subparagraph 03.d.iii. of this rule.** (3-20-20)T

**(2) Outpatient laboratory tests provided with no other Hospital outpatient service on the same date, or outpatient laboratory tests provided on the same date of service as other Hospital outpatient services that are clinically unrelated may be paid separately if billed with modifier L1. Payment shall be made in the same manner that services with no APC weight are paid under Subparagraph 803.03.c.i. of this rule.** (3-20-20)T

**iii. When no medical services with a status code J1 appears on the same Claim, two (2) 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%). When a medical service with a status code J1 appears on the same Claim, all medical services with a status code T shall be paid at fifty percent (50%).** (3-20-20)T

**iv. When no medical services with a status code J1 appears on the same Claim, status code Q items with an assigned APC weight will not be discounted. When a medical service with a status code J1 appears on the same Claim, status code Q items shall be paid at fifty percent (50%).** (3-20-20)T

**d. Additional Hospital Payments.** When the charge for a medical service provided by a Hospital (other than a Critical Access Hospital) meets the following standards, additional payment shall be made for that service, as indicated. (3-20-20)T

**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 Paragraph 03.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. (3-20-20)T

**ii. Inpatient Implantable Hardware.** Hospitals may seek additional reimbursement beyond the

MSDRG 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. (3-20-20)T

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. (3-20-20)T

e. Adjustment of Hospital and ASC Base Rates. The Commission may periodically adjust the base rates set out in Paragraphs 803.03.b. and 803.03.c. of this rule to reflect changes in inflation or market conditions. (3-20-20)T

**04. Acceptable Charges For Medicine Provided By Pharmacies.** The following standards shall be used to determine the acceptable charge for medicine provided by pharmacies. (3-20-20)T

a. Brand/Trade Name Medicine. The standard for determining the acceptable charge for brand/trade name medicine shall be the AWP, plus a five dollar (\$5) dispensing fee. (3-20-20)T

b. Generic Medicine. The standard for determining the acceptable charge for generic medicine shall be the AWP, plus an eight dollar (\$8) dispensing fee. (3-20-20)T

c. Compound Medicine. The standard for determining the acceptable charge for compound medicine shall be the sum of the 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 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. (3-20-20)T

d. Prescribed Over-the Counter Medicine. The standard for determining the acceptable charge for prescribed over-the-counter medicine filled by a Pharmacy shall be the reasonable charge plus a two dollar (\$2) dispensing fee. (3-20-20)T

**05. Acceptable Charges For Medical Services Provided By Other Providers Under The Idaho Worker's Compensation Law.** The standard for determining the acceptable charge for Providers other than physicians, Hospitals or ASCs shall be the reasonable charge. (3-20-20)T

**06. Billing And Payment Requirements For Medical Services And Procedures Preliminary To Dispute Resolution.** This rule governs billing and payment requirements for medical services provided under the Worker's Compensation Law and the procedures for resolving disputes between Payors and Providers over those bills or payments. (3-20-20)T

a. 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. (3-20-20)T

b. 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 Paragraph 06.b 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 Paragraph 803.06.i. of this rule for that service. (3-20-20)T

i. A Provider's bill shall, whenever possible, describe the Medical Service provided, using the

American Medical Association's appropriate CPT coding, including modifiers, the appropriate HCPCS code, the diagnostic and procedure code set version required by CMS and the original NDC for the year in which the service was performed. (3-20-20)T

ii. 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. (3-20-20)T

iii. If requested by the Payor, the bill shall be accompanied by a written report as defined by Subsection 010.31 and required by Section 404 of these rules. Where a bill is not accompanied by such Report, the periods expressed in Paragraphs 803.06.c and 803.06.e. of this rule, shall not begin to run until the Payor receives the Report. (3-20-20)T

**c. Prompt Payment.** Unless the Payor denies liability for the Claim or, pursuant to Paragraph 803.06.e. of this rule, 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 or upon acceptance of liability, if made after bill is received from Provider. (3-20-20)T

**d. Partial Payment.** If the Payor acknowledges liability for the Claim and, pursuant to Paragraph 803.06.e. of this rule, 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. (3-20-20)T

**e. Preliminary Objections and Requests for Clarification.** (3-20-20)T

i. 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. (3-20-20)T

ii. 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. (3-20-20)T

iii. 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. (3-20-20)T

iv. 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 Subparagraph 06.e.iii., it shall be precluded from objecting to such charge as failing to comport with the applicable administrative rule. (3-20-20)T

**f. Provider Reply to Preliminary Objection or Request for Clarification.** (3-20-20)T

i. 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. (3-20-20)T

ii. If a Provider fails to timely reply to a Preliminary Objection, the Provider shall be deemed to have acquiesced in the Payor's objection. (3-20-20)T

iii. 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. (3-20-20)T

**g. Payor Shall Pay or Issue Final Objection.** The Payor shall pay the Provider's bill in whole or in part or 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. (3-20-20)T

**h.** 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. (3-20-20)T

**i.** 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 Paragraph 803.01.c. 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. (3-20-20)T

**804. – 999. (RESERVED)**