IDAPA 17 – INDUSTRIAL COMMISSION

17.01.01 – ADMINISTRATIVE RULES UNDER THE WORKER'S COMPENSATION LAW

**010. DEFINITIONS.**

The definitions set forth in Chapter 72, Idaho Code apply to these rules. In addition, the following terms have the meaning set forth below: (3-23-22)

## Edited or Deleted Definitions:

07. Charge. ~~Means the expense or cost. For hospitals and ASCs, "charge" Means the total~~
IS ANY DOLLARS BILLED BY A HEALTH CARE PROVIDER OR FACILITY. ~~charge~~.

~~a. Acceptable charge. Means a charge calculated in compliance with Section 803 of this rule or as billed by the Provider, whichever is lower, or the charge agreed to pursuant to a written contract. (3-23-22)~~

~~b. Customary charge. Means a charge that has 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. (3-23-22)~~

~~c. Reasonable charge. Means a charge that does not exceed the Provider's "usual" charge and does not exceed the "customary" charge. (3-23-22) d. Usual charge. Means the most frequent charge made by an individual Provider for a given medical service to non-industrially injured patients~~

## Added definitions

22. HEALTHCARE PROVIDER: ANY AUTHORIZED TREATING HEALTHCARE PROFESSIONAL PROVIDER (MD,DC, PT, OT, MT, ETC) OR FACILITY (HOSPITAL OR ASC) OR VENDOR (DMEPOS, TRANSLATOR, PHARMACY, ETC).

30. MAXIMUM ALLOWED FEES: EITHER THE CALCULATED FEES AS OUTLINED UNDER SECTION 803 OF THIS RULE OR AS BILLED BY THE PROVIDER, WHICHEVER IS LOWER, OR THE CHARGE AGREED TO PURSUANT TO A WRITTEN CONTRACT OR AS DETERMINED BY THE ID COMMISSION.

**42. USUAL AND Customary charge:** Means a charge no higher than the 75TH PERCENTILE FOR ALL PROVIDERS IN A GIVEN ZIP CODE OR DURABLE MEDICAL EQUIPMENT (DME) AND OR SUPPLIES DELIVERED, IN AN INJURED WORKERS GIVEN ZIP CODE AREA -(3-23-22)

**803. MEDICAL FEES.**

**01. General Provisions for Medical Fees.** The following provisions shall apply to Commission approval of claims for medical benefits. (3-23-22)

a. Payors shall pay providers the lessor of the calculated maximum fees under this rule 803 or billed charges for health care services, procedures or use of facilities or as directed by the Commission under 06 of this rule.(3-23-22)

b. Coding. The Commission will ~~**generally**~~ follow the coding guidelines published by CMS and by the American Medical Association, including the use of modifiers. (3-23-22)

c. Disputes. Disputes between Providers and Payors are governed by Subsection 803.05 of this rule and JRP 19. (3-23-22)

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. (3-23-22)

**02. Acceptable Charges For Medical Services Provided By Physicians Under The Idaho Worker's Compensation Law.** (3-23-22)

A. As amended by this rule and as published by and annually released by CMS in January, the Commission hereby adopts the following to be used as the standard to determine the maximum health care providers and facilities fees:

1. Resource-Based Relative value Scale (RBRVS); and
2. Anesthesia Base Relative Value Units
3. Clinical Laboratory Fee Schedule (CLFS); and
4. ID Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS); and
5. Average Sale Price (ASP); and
6. Ambulance Fee Schedules
7. MSDRG Table 5 as released for October
8. OPPS Addendum B, Addendum A, and Addendum J.

b. Modifiers. Modifiers for physicians will be reimbursed as follows: (3-23-22)

i. Modifier 50: Additional fifty percent (50%) for bilateral procedure. (3-23-22)

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. (3-23-22)

iii. Modifier 80: Twenty-five percent (25%) of coded procedure. (3-23-22)

iv. Modifier 81: Fifteen percent (15%) of coded procedure. This modifier applies to MD and non-MD assistants. (3-23-22)

v. Modifier 62: Surgical code values are in increased to 125% of the maximum fees allowed and split between the Co-Surgeons, when the surgical code is allowed to be paid with the 62 modifier under the RBRVS indicator

vi. QX – Certified Registered Nurse Anesthetist (CRNA) service with medical direction by a physician

vii. QY – Medical direction of one CRNA/AA by an anesthesiologist

viii. QZ - CRNA service without medical direction by a physician

c. Added Relative weights for services without RVU in RBRVS:

Work Hardening/Conditioning -

97545 = 4 RVU Initial 2 hrs

97546 = 2 RVU each additional hour

Impairment rating fees performed by the treating physician – all-inclusive fee (office visit, measurements, and report etc)

99455 = 10 RVU x E&M conversion factor

Impairment rating fees performed by a non-treating physician – all-inclusive fee (office visit, measurements, and report etc)

99456 = 15 RVU x E&M conversion factor

0232T Platelet Rich Plasma (PRP) – all inclusive fees and is not reportable

| Conversion Factors | | |
|---|---|---|
| **Service Category** | **Code Ranges and or any applicable HCPC Level II Codes in the RBRVS** | **Conversion Factor** |
| Anesthesia | 00000 - 09999 | $37.50 |
| Surgery, Radiology Pathology x RBRVS RVU Medicine | 10000-89999<br>90785-96999<br>98966-99607 | $88.54 |
| Clinical Laboratory | 80000 – 89999 | CLFS fees x 200% |
| Immune Globulin & Vaccine Administration | 90281-90474<br>97010-98968 | $49.00 |

| PM&R, Acupuncture, &Manipulation | | |
|---|---|---|
| E&M | 99202-99484 | $70.00 |

RVU = 7 RVU x Surgery conversion factor

c. Calculated Maximum Fees. The latest edition of the Physician's Current Procedural Terminology (CPT), as published by the American Medical Association and as amended, is calculated by the application of the total facility or non-facility RVU for services as determined by place of service (POS) 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. (3-23-22)

CHAPTER 26 OF *MEDICARE'S CLAIM PROCESSING MANUAL* list which POS codes allow payment under the total facility or non-facility RVU.

Conversion factors 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. (3-23-22)

d. Anesthesiology. ANESTHESIA SERVICES ARE ONLY REIMBURSABLE IF THE ANESTHESIA IS ADMINISTERED BY A PHYSICIAN, A CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA), OR AN ANESTHESIOLOGIST ASSISTANT (AA) WHO REMAINS IN CONSTANT ATTENDANCE DURING THE PROCEDURE FOR THE SOLE PURPOSE OF RENDERING ANESTHESIA. 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. (3-23-22)

WHEN A CRNA OR AA ADMINISTERS ANESTHESIA:

(A)CRNAS NOT UNDER THE MEDICAL DIRECTION OF AN ANESTHESIOLOGIST SHALL BE REIMBURSED 90% OF THE MAXIMUM ANESTHESIA VALUE;

(B)IF BILLED SEPARATELY, CRNAS AND AAS UNDER THE MEDICAL DIRECTION OF AN ANESTHESIOLOGIST SHALL BE REIMBURSED 50% OF THE MAXIMUM ANESTHESIA VALUE. THE OTHER 50% IS PAYABLE TO THE ANESTHESIOLOGIST PROVIDING THE MEDICAL DIRECTION TO THE CRNA OR AA;

(C)MEDICAL DIRECTION FOR ADMINISTERING ANESTHESIA MEANS THE ANESTHESIOLOGIST PERFORMS THE FOLLOWING:

(I) EXAMINES AND EVALUATES THE INJURED WORKER BEFORE ADMINISTERING ANESTHESIA;

(II) PRESCRIBES THE ANESTHESIA PLAN;

(III) PERSONALLY PARTICIPATES IN THE MOST DEMANDING PROCEDURES IN THE ANESTHESIA PLAN INCLUDING, IF APPLICABLE, INDUCTION AND EMERGENCE;

(IV) ENSURES THAT ANY PROCEDURE IN THE ANESTHESIA PLAN IS PERFORMED BY A QUALIFIED ANESTHETIST;

(V) MONITORS ANESTHESIA ADMINISTRATION AT FREQUENT INTERVALS;

(VI) REMAINS PHYSICALLY PRESENT AND AVAILABLE FOR IMMEDIATE DIAGNOSIS AND TREATMENT OF EMERGENCIES; AND

(VII) PROVIDES INDICATED POST-ANESTHESIA CARE.

PHYSICAL STATUS MODIFIERS ARE REIMBURSED AS FOLLOWS, USING THE ANESTHESIA CF:

| | | |
|---|---|---|
| P-1 | HEALTHY PATIENT | 0 RVUS |
| P-2 | PATIENT WITH MILD SYSTEMIC DISEASE | 0 RVUS |
| P-3 | PATIENT WITH SEVERE SYSTEMIC DISEASE | 1 RVU |
| P-4 | PATIENT WITH SEVERE SYSTEMIC DISEASE THAT IS A CONSTANT THREAT TO LIFE | 2 RVUS |
| P-5 | A MORIBUND PATIENT WHO IS NOT EXPECTED TO SURVIVE WITHOUT THE OPERATION | 3 RVUS |
| P-6 | A DECLARED BRAIN-DEAD PATIENT WHOSE ORGANS ARE BEING REMOVED FOR DONOR PURPOSES | 0 RVUS |

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. (3-23-22)

F. CLINICAL LABORATORY. MEDICARE'S CLINICAL LABORATORY FEE SCHEDULE MULTIPLIED BY 200% REPRESENTS THE MAXIMUM FEES FOR THESE SERVICES. ALL CLINICAL LABORATORY CODES THAT FALL UNDER MEDICARE'S CLINICAL LABORATORY FEE SCHEDULE REPRESENTS THE TOTAL COMPONENT OF THE CLINICAL LAB FEE. ONLY ONE FEE IS PAYABLE UNDER MEDICARE CLINICAL LABORATORY FEE SCHEDULE. THE FIRST PROVIDER WHO BILLS (PROFESSIONAL OR TECHNICAL) WILL BE ALLOWED PAYMENT. ANY SUBSEQUENT PROVIDERS BILLING FOR THE SAME CLINICAL LABORATORY CODE WILL BE DENIED PAYMENT OR THE PROVIDER MAY SEEK PARTIAL PAYMENT FROM THE PAID PROVIDER. .

G. DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS AND SUPPLIES (DMEPOS). MEDICARE'S CURRENT DMEPOS FEES FOR IDAHO SHALL DETERMINE THE MAXIMUM ALLOWED DOLLARS, UNLESS NO FEE HAS BEEN ESTABLISHED FOR THAT ITEM. ANY DMEPOS

ITEM WITHOUT AN ESTABLISHED VALUE SHALL BE DETERMINED USING THE COST OF THE ITEM TO THE BILLING PROVIDER+20%.

i. ALL DMEPOS ITEMS SHALL IDENTIFY WHETHER THE ITEM DISPENSED IS BEING RENTED WITH THE MODIFIER -RR APPENDED TO THE BILLED CODE OR -NU IF THE ITEM IS NEW OR -EU IF ITEM IS USED.

ii. ANY ELECTROSTIMULATION DEVICES (TENS, IF ETC) SHALL HAVE A PHYSICIAN PRESCRIPTION IDENTIFYING MEDICAL NECESSITY AND LENGTH OF TIME THE ITEM IS MEDICALLY NECESSARY.

1. ALL TENS/IF OR ANY COMBINATION OF ELECTRICAL STIMULATION DEVICES SHALL BE BILLED UNDER HCPC CODES:
   a. E0720 FOR A TWO LEAD DEVICE
   b. E0730 FOR A FOUR LEAD DEVICE
   c. E0744 FOR SCOLIOSIS
   d. E0745 FOR NEUROMUSCULAR STIMULATOR, ELECTRIC SHOCK UNIT
   e. E0747-E0760 FOR OSTEOGENESIS ELECTRICAL STIMULATORS
   f. REPLACEMENT SUPPLIES ARE LIMITED TO ONCE PER MONTH AND ARE NOT ELIGIBLE WITH THE FIRST MONTH RENTAL.
      i. A4595 FOR ELECTRICAL STIMULATOR SUPPLIES, TWO LEADS.
      ii. A4557 =LEAD WIRES, PAIR (REIMBURSABLE EVERY 12 MONTHS).
2. MONTHLY RENTAL FEES CANNOT EXCEED THE PURCHASE PRICE OF THE DEVICE.
3. IF THE DEVICE IS RENTED, THEN PURCHASED THE RENTAL FEES SHALL BE DEDUCTED FROM THE PURCHASED PRICE OF THE FEES.

iii. CONTINUOUS PASSIVE MOTION DEVICES SHALL BE BILLED UNDER E0935 OR E0936

iv. INTERMITTENT PNEUMATIC DEVICES WITH OR WITHOUT THERMAL CAPABILITIES SHALL BE BILLED USING HCPC CODES E0650-E0676. THE ASSOCIATED WRAPS/GARMENTS ARE ALLOWED AT COST +10%.

v. ANY INTERMITTENT PNEUMATIC DEVICES USED FOR DVT PREVENTION USED DURING THE COURSE OF AN OUTPATIENT SURGICAL PROCEDURE IS CONSIDERED INCLUSIVE TO THE FACILITY FEES AND NOT SEPARATELY PAYABLE UNLESS THE DEVICE IS SENT HOME WITH THE PATIENT AS MEDICALLY NECESSARY.

vi. PROVIDER OFFICE DISPENSED SUPPLIES: ANY SUPPLY AND OR PHYSICAL MEDICINE AND REHABILITATION ITEMS DISPENSED BY A PROVIDER'S OFFICE SHALL BE LIMITED TO THE COST OF THE ITEM +10%.

H. AMBULANCE. ALL AMBULANCE SERVICES FEES SHALL BE DETERMINED BY USING MEDICARE'S AMBULANCE FEE SCHEDULE FOR IDAHO MULTIPLIED BY 200%; EXCEPT AIR AMBULANCE, WHICH MAY BE NEGOTIATED. GROUND AMBULANCE FEES ARE BASED UPON A BASE RATE AND

A MILEAGE RATE AND ALL SUPPLIES AND OTHER ITEMS/SERVICES ARE CONSIDERED INCLUDED IN THE ESTABLISHED BASE RATE AND MILEAGE FEES.

a. AMBULANCE RATES ARE DETERMINED BY THE ZIP CODE OF WHERE THE INJURED WORKER WAS PICKED UP.

b. RURAL AND SUPER RURAL RATES ARE DETERMINED BASED "R" IS RURAL AND "B" IS SUPER RURAL AS LISTED IN MEDICARE'S ZIP CODE GEOGRAPHIC AREA DEFINITIONS.

**03. Hospitals And Ambulatory Surgery Centers Maximum Fee Calculations**

a. Critical Access Hospitals. The standard for determining the acceptable charge for inpatient ~~and outpatient~~ services provided by a Critical Access Hospital is eighty percent (80%) of the BILLED charge. Implantable hardware charges shall be reimbursed at the rate of the actual cost plus ten percent (10%). (3-23-22)

b. Hospital Inpatient Services. The standard for determining the maximum fees 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 percent (80%) of the billed charges. Implantable hardware is considered bundled unless separately reimbursable under Medicare's MSDRG payment rate system.

i Inpatient Outlier 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 hardware charges shall be excluded from the calculation for an additional inpatient payment under this Subparagraph. (3-23-22)

b. Hospital Outpatient and ASC Services. The standard for determining the maximum fees 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 from Addendum B in effect on the first day of January of the current calendar year. The base rate for CAH is $172.28 and acute care hospital outpatient services is ~~one hundred forty dollars and seventy-five cents~~ $143.57. The base rate for ASC services is ~~ninety-one dollars fifty cents~~ $93.33 (3-23-22) THE FOLLOWING SERVICES AND ITEMS ARE CONSIDERED INCLUSIVE TO THE APC DOLLAR VALUE CALCULATION:

i NURSING, TECHNICIAN, AND RELATED SERVICES;

ii USE OF THE FACILITY WHERE THE SURGICAL PROCEDURE(S) WAS PERFORMED;

iii DRUGS AND BIOLOGICALS FOR WHICH SEPARATE PAYMENT IS NOT ALLOWED;

iv MEDICAL AND SURGICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT AND ORTHOTICS NOT LISTED AS A "PASS THROUGH";

v SURGICAL DRESSINGS;

vi EQUIPMENT;

vii SPLINTS, CASTS AND RELATED DEVICES;

viii RADIOLOGY SERVICES FOR WHICH SEPARATE PAYMENT IS NOT ALLOWED;

ix ADMINISTRATIVE, RECORD KEEPING, AND HOUSEKEEPING ITEMS AND SERVICES;

x MATERIALS, INCLUDING SUPPLIES AND EQUIPMENT FOR THE ADMINISTRATION AND MONITORING OF ANESTHESIA;

xi SUPERVISION OF THE SERVICES OF AN ANESTHETIST BY THE OPERATING SURGEON;

C. STATUS INDICATORS FROM MEDICARE'S ADDENDUM B APPLY AS FOLLOWS:

| INDICATOR | MEANING |
|---|---|
| A | USE ANOTHER FEE SCHEDULE INSTEAD OF ADDENDUM B, SUCH AS RBRVS RVUS, AMBULANCE FEE SCHEDULE, CLINICAL LABORATORY OR DMEPOS. |
| B & N | IS NOT RECOGNIZED FOR OUTPATIENT HOSPITAL SERVICES BILL TYPE (12X AND 13X) OR PACKAGED |
| C | ARE INPATIENT ONLY PROCEDURES; HOWEVER, THE COMMISSION RECOGNIZES THESE PROCEDURES ON AN OUTPATIENT BASIS IF AUTHORIZED BY INSURER. SIMILAR CODES WITH AN ESTABLISHED APC $ ABOVE ZERO SHALL ESTABLISH THE FEES. |
| E | NOT GENERALLY REIMBURSABLE WHEN SUBMITTED ON ANY OUTPATIENT BILL TYPE. |
| F | CORNEAL TISSUE ACQUISITION, CERTAIN CRNA SERVICES, AND HEPATITIS B VACCINES ARE ALLOWED AT A REASONABLE COST TO THE FACILITY. THE FACILITY MUST PROVIDE A SEPARATE INVOICE IDENTIFYING ITS COST. |
| G & H | "PASS-THROUGH DRUGS AND BIOLOGICALS" AND "DEVICE" SEPARATE APC PAYMENT. |
| J1 | A COMPREHENSIVE APC TREATS ALL INDIVIDUALLY REPORTED CODES AS REPRESENTING COMPONENTS OF THE COMPREHENSIVE SERVICE, RESULTING IN A SINGLE PROSPECTIVE PAYMENT. AS DEFINED BY STATUS INDICATOR J1, ALL COVERED OUTPATIENT SERVICES ON THE CLAIM ARE PACKAGED WITH THE PRIMARY J1 SERVICE FOR PAYMENT, EXCEPT SERVICES WITH A STATUS INDICATOR OF F, G, H, L, OR U; AMBULANCE SERVICES; DIAGNOSTIC AND SCREENING MAMMOGRAPHY; REHABILITATION THERAPY SERVICES (PT/OT AND SPEECH THERAPY) REPORTED ON A SEPARATE CLAIM; NEW TECHNOLOGY SERVICES; AND SELF-ADMINISTERED DRUGS.<br><br>WHEN MULTIPLE CODES WITH J1 STATUS INDICATORS ARE INCLUDED ON THE CLAIM, SERVICES ARE PACKAGED WITH THE PRIMARY (HIGHEST APC VALUE) J1 CODE. CERTAIN J1 CODES, WHEN BILLED TOGETHER, MAY BE ELIGIBLE FOR A COMPLEXITY ADJUSTED APC PAYMENT LISTED ON MEDICARE'S ADDENDUM J. |

<table>
<tr><td>J2</td><td>Services with a status indicator J2 are assigned to a comprehensive APC (8011) when specific combinations of services are reported on the claim. All levels of emergency department (ED) and clinic visits, if billed in combination with observation time, can trigger this comprehensive composite rate. Payment of APC 8011 requires:<br><br>• A minimum of eight units of G0378 hospital observation service, per hour;<br>• No status T procedure on the claim; and<br>• Either an E&M visit on the same day or day before the G0378 date of service; or G0379 direct admit to observation.<br>All covered services on the claim shall be considered adjunct to APC 8011 and packaged into a single payment, except those items excluded. Excluded services include:<br><br>• Covered screening procedures,<br>• Preventative services,<br>• Pass-through drugs and devices (status indicator G or H),<br>• PT, OT, and SLP services reported on a separate claim,<br>• Certain vaccines (status indicator L or F),<br>• Cornea tissue acquisition, and<br>• New technology APCs with status indicator S.<br>If the claim contains a J1 primary service, the J1 C-APC will be the composite under which the services will be paid. There is no complexity adjustment for J2 occurring on the same claim as J1.<br><br>If services with a J2 status indicator are provided during an extended assessment and management encounter, including observation care, and do not meet all the requirements for APC 8011 listed above, the usual APC logic will apply.</td></tr>
<tr><td>K</td><td>“Nonpass-Through Drug or Biological or Device” for therapeutic radiopharmaceuticals, brachytherapy sources, blood and blood products; separate APC payment.</td></tr>
<tr><td>L</td><td>Influenza Vaccine/Pneumococcal Pneumonia Vaccine and therefore is generally considered to be unrelated to work injuries.</td></tr>
<tr><td>M</td><td>Are measurement codes and not separately payable.</td></tr>
<tr><td>P</td><td>Partial hospitalization paid based on observation fees outlined in this section.</td></tr>
<tr><td>Q1, Q2, Q3, & Q4</td><td>Composites are not recognized. Payment is made through a separate APC, unless billed with HCPC codes with a J1 or J2.</td></tr>
<tr><td>R</td><td>Blood and blood products; separate APC payment.</td></tr>
<tr><td>S</td><td>Significant procedure, not discounted when multiple.</td></tr>
</table>

| T | SIGNIFICANT PROCEDURE, MULTIPLE PROCEDURE REDUCTION APPLIES. THE MAXIMUM ALLOWANCE FOR MULTIPLE PROCEDURES WITH A T STATUS INDICATOR IS LIMITED TO FOUR PROCEDURE CODES PER EPISODE. THE HIGHEST VALUED APC CODE IS ALLOWED AT 100% OF THE MAXIMUM ALLOWANCE, PLUS 50% OF THE MAXIMUM ALLOWANCE FOR THE FOLLOWING THREE HIGHEST VALUED CODES.<br><br>THE USE OF MODIFIER 51 IS NOT A FACTOR IN DETERMINING WHICH CODES ARE SUBJECT TO MULTIPLE PROCEDURE REDUCTIONS.<br><br>BILATERAL PROCEDURES REQUIRE EACH PROCEDURE TO BE BILLED ON SEPARATE LINES USING RT AND LT MODIFIER(S).<br><br>WHEN A CODE IS BILLED WITH MULTIPLE UNITS, MULTIPLE PROCEDURE REDUCTIONS APPLY TO THE SECOND THROUGH FOURTH UNITS AS APPROPRIATE. UNITS MAY ALSO BE SUBJECT TO OTHER MAXIMUM FREQUENCY PER DAY POLICIES. |
|---|---|
| U | BRACHYTHERAPY SOURCE; SEPARATE APC PAYMENT. |
| V | CLINIC OR AN ED VISIT; SEPARATE APC PAYMENT AS ALLOWED BY THESE RULES; ERD CODES 99281-99285 OR G0380-G0384 ARE BUNDLED IF J2 COMPREHENSIVE CRITERIA IS MET; OTHERWISE SEPARATE APC DOLLAR IS PAYABLE PER CODE. |
| Y | NON-IMPLANTABLE DURABLE MEDICAL EQUIPMENT PAID PURSUANT TO MEDICARE'S DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER FEE SCHEDULE FOR IDAHO. |

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. (3-23-22)

Urgent Care/Clinic facility fees are payable under CPT code G0463 at $75.00 for CAH and ACH facilities.

**04. Prescriptions, Over the Counter and Compounded Medications.** The following standards shall be all providers who are legally eligible to dispense medicines: (3-23-22)

a. Prescription Medications. The generic brand is the benefit unless DAW is indicated by the prescribing physician as being reasonable and necessary. The standard for determining the acceptable charge for medicine shall be the AWP, plus a five dollar ($5) dispensing fee. (3-23-22) IDAHO ADMINISTRATIVE CODE IDAPA 17.01.01 – Administrative Rules Industrial Commission Under the Worker's Compensation Law Section 803 Page 30

~~b. Generic Medicine. The standard for determining the acceptable charge for generic medicine shall be the AWP, plus an eight dollar ($8) dispensing fee. (3-23-22)~~

c. Compound Medicine. 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. (3-23-22)

d. Over-the Counter Medicine. Prescribed over-the-counter medicine shall be the cost of the item to the dispensing provider or injured worker. (3-23-22)

E. INJECTABLE DRUGS ADMINISTERED BY PROVIDERS DURING THE COURSE OF TREATMENT. INJECTABLES SHALL BE BILLED EITHER AS A HCPC LEVEL I OR II CODE AS LISTED UNDER MEDICARE'S ASP FEES AND ALLOWED AT MEDICARE'S AVERAGE SALE PRICE (ASP) OR AT COST TO THE PROVIDER IF THE COST OF THAT DRUG IS GREATER THAN THE ASP VALUE.

~~**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. (3-23-22)~~

**05. Provider Billing and Payor Payment Requirements**

Provider Billing Form(s), Supporting Documentation and timeline requirements:

- CMS 1500 billing form shall be completed with appropriate ICD-10 CM codes, CPT codes and modifiers as outlined by CPT/CMS for services supported by the providers documentation. All healthcare professionals (MD, DO, DC, PT, OT, LAc, MT, Independent Radiology and Labs, DMEPOS providers) shall use the CMS 1500 billing form to bill for their services/procedure. ASC's may bill on the CMS 1500 billing form or the UB04 billing form. Documentation to support their billed services must accompany the bill when submitted for payment.
- UB04 billing form shall be completed with the appropriate ICD-10 CM & PCS codes, CPT codes and modifiers as outlined by CPT/CMS for services supported by the providers documentation. All hospitals shall use the UB 04 billing form to bill for inpatient and outpatient services and ASCs(ERD, outpatient surgery etc). Payor must request the specific records required for reviewing their billed services.
- American Dental Association Dental Claim Form shall be completed with appropriate dental codes and modifiers. Dentist shall submit their services for payment on the ADA Dental claim form along with their documentation that supports the services billed. .
- Electronic versions of these forms may be submitted through the ASC X12N or NCPDP for pharmacy transactions and as accepted by the payer agreement and electronic capabilities exist and within HIPAA privacy and security regulations and business agreement requirements.
- All healthcare providers/facility documentation for billed services must be medically reasonable and necessary and support the services being billed in accordance with this Rule and AMA/CMS billing requirements.
- Bills must be submitted within 120 days from the date of service, unless extenuating circumstances exist. Extenuating circumstances includes but is not limited to the provider:

- Not did not know the workers compensation claim existed; and or
  - Did not know where to submit the bill for payment; and or
  - Claim recently became compensable
- Any bill not received within 12 months from date of injury and the provider did not contact the payor to seek payment is considered final and is not payable.

Payor Timeline and Requirements:

- The Payor shall pay and submit an Explanation of Review (EOR) to the billing provider within thirty (30) calendar days of receipt of the providers bill or upon acceptance of liability, if made after bill is received from Provider. Receipt of the providers bill maybe determined as 3 days from the date it was mailed to the correct payors mailing address.
- The EOR shall identify each line of service billed by the provider and explain any nonpaid lines and how any paid lines were determined. Any line on the bill not paid must be supported with a valid CPT/CMS or administrative rule explanation of why the line was not paid. Any line identified as paid shall be paid and forwarded to the provider along with the EOR.
- Each EOR shall contain the name, address, and phone number of the organization located within the state of Idaho that the Provider may contact regarding any questions or disputes. (3-23-22)
- Where a Payor does not send a EOR and or payment 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. (3-23-22)

Provider and Payor Appeal Process

- Within 60 days from receipt of the payor EOR/payment the provider must submit an appeal to the payor. The payor must respond to the provider written dispute within thirty (30) calendar days from receipt of the provider's appeal.
- If a provider fails to timely reply to payors EOR/payment the provider shall be deemed to have agreed to payors payment and the dispute is resolved.
- After the first appeal and the parties still have not agreed to a payment solution either party may request resolution from the Commission as outlined in subsection 6. of this rule.

6. Commission 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. (3-23-22)

**804. – 999 (RESERVED)**