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).

42. USUAL AND Customary charge: Means a charge no higher than the 80TH 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. Acceptable Charge. Payors shall pay Providers THE LESSOR OF THE CALCULATED FEES UNDER THIS RULE 803. OR USUAL AND CUSTOMARY CHARGE OR AS CONTRACTED WITH THE PROVIDER OR AS DIRECTED BY THE COMMISSION UNDER 06. J. OF THIS RULE. ~~acceptable charge for medical services~~. (3-23-22)

b. Coding. The Commission will generally follow the coding guidelines published by CMS and by the American Medical Association (AMA) CPT publication. This includes~~ing~~ the use of modifiers and RBRVS PAYMENT ADJUSTMENTS UNDER MEDICARE. (3-23-22)

c. Disputes. Disputes between Providers and Payors are governed by Subsection 803.06 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. The Commission adopts the Resource-Based Relative Value Scale (RBRVS), published by CMS, as amended, as the standard to be used to determine acceptable charges by physicians. (3-23-22)

b. Modifiers. Modifiers for physicians will be reimbursed AS OUTLINED BY MEDICARE. ~~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)~~

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 Relative Value Unit (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 and CHAPTER 26 OF *MEDICARE'S CLAIM PROCESSING MANUAL* , 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)

Medical Fee Schedule Conversion Factors

Service Category	*Code Ranges*	*ID WC 2024 MFS Conversion Factor*
Anesthesia	00000-09999	$ 60.33
Surgery #1	22000-22999, 23000-24999, 25000-27299, 27300-27999, 29800-29999, 61000-61999, 62000-62259, 63000-63999	$ 135.00
Surgery #2	28000-28999, 64550-64999	$ 124.00
Surgery #3	1000-19999, 20000-21999, 29000-29799, 30000-59999,60000-60999,62260-62999, 64000-64549, 65000-69999	$ 88.54
Radiology	70000-79999	$ 88.54
Pathology & Clinical Laboratory	80000-89999	
Medicine #1	90000-90749, 94000-94999, 97000-97799,97800-98999	$ 49.00
Medicine #2	90750-92999,93000-93999, 95000-96020, 96040-96999, 99000-99607	$ 70.00

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. (3-23-22)

F. CLINICAL LABORATORY. MEDICARE'S CLINICAL LABORATORY FEE SCHEDULE MULTIPLIED BY 170% 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. MONTHLY RENTAL FEES CANNOT EXCEED THE PURCHASE PRICE OF THE DEVICE AND CANNOT BE NO MORE THAN TEN PERCENT

(10%) OF THE DEVICES PURCHASED PRICE TO THE RENTAL COMPANY.

iii. THE RENTAL FEES SHALL BE DEDUCTED FROM THE PURCHASED PRICE OF ANY RENTED ITEM.

h.~~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)

if. 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 National Drug Code (NDC) reported by the original manufacturer. Reimbursement may be withheld until the original manufacturer's NDC is provided by the physician. (3-23-22)

jg. 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. (3-23-22)

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. (3-23-22)

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 TEN ~~fifty~~ percent (150%). (3-23-22)

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 TEN ~~fifty~~ percent (150%). (3-23-22)

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). ALL STATUS INDICATORS AS LISTED BY MEDICARE ARE ACCEPTED FOR PAYMENT ADJUSTMENTS EXCEPT THE COMPOSITE "Q" STATUS CODES AND IMPLANTS. (3-23-22)

i. Medical services for which there is no APC weight listed shall be reimbursed at seventy-five percent (75%) of the reasonable charge, EXCEPT WHEN THE ADDENDUM B STATUS INDICATORS INDICATE THE CODE IS BUNDLED/PACKAGED OR REFERS TO A DIFFERENT FEE SCHEDULE FOR A DEFINED FEE ALLOWANCE, OR SHOULD NOT BE BILLED ON A UB 04 FOR FACILITY FEES. ~~IS A SERVICE DEFINED IN 803.03.C.III OF THIS RULE.~~ (3-23-22)

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

~~III. OUTPATIENT PHYSICAL, OCCUPATIONAL, AND SPEECH THERAPY SERVICES WILL BE REIMBURSED ACCORDING TO THE ALLOWABLE PROFESSIONAL CHARGE UNDER SUBSECTION 803.02 OF THIS RULE.~~

~~(1) Implantable Hardware may be eligible for separate payment under Subparagraph 03.d.iii. of this rule. (3-23-22)~~

(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. (3-23-22)~~

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

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

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. (3-23-22)

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. (3-23-22)

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. (3-23-22)

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. (3-23-22)

IV. OUTPATIENT FACILITY URGENT CARE OR CLINIC FACILITY FEES ARE ONLY PAYABLE UNDER CPT CODE G0463 AT $75.00 FOR CAH AND ACH'S ON THE INITIAL VISIT AFTER THE INJURY. NO ADDITIONAL CLINIC VISITS ARE SEPARATELY PAYABLE.

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)

04. Acceptable Charges For Medicine Provided By Pharmacies. The following standards shall be used to determine the acceptable charge for medicine provided by pharmacies. (3-23-22)

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. (3-23-22)

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. 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. (3-23-22)

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. (3-23-22)

e. Any non-steroidal anti-inflammatory drug (NSAID), muscle relaxant, or topical agent for which a significantly lower-cost therapeutic equivalent is available, including commercially or over-the-counter (OTC), even in a different strength/dosage. Significantly lower cost means the therapeutic equivalent costs at least $100 less, for the same number of days' supply. For example, prior authorization would be required to dispense diclofenac gel 1.5% at an average wholesale price (AWP) of $689 when diclofenac 1% is available OTC for $10, or to dispense more than one unit of lidocaine 4.5%-menthol 5% patch at an AWP of $49 when a lidocaine 4%-menthol 5% patch can be obtained OTC for $2.

f. Over-the-Counter Medications:

i Medications that are available for purchase by the general public without a prescription and listed as over-the-counter in publications such as RedBook Online or Medispan, are reimbursed at NDC/AWP and are not eligible for dispensing fees. If drugs have been repackaged, use the original AWP and NDC that was assigned by the source of the repackaged drugs to determine reimbursement.

ii. The maximum allowance for any topical agent containing only active ingredients available without a prescription shall be at cost to the billing provider up to $30.60 per 30 day supply for any application (excludes patches). The maximum allowance for a patch is cost to the billing provider up to $71.40 per 30 day supply. When less than a 30 day supply is prescribed, these allowances shall be pro-rated to the amount dispensed to the injured worker.

Idaho WC Z0794 per 30 day supply for any application (excludes patches) $30.60.
Idaho WC Z0795 per 30 day supply for patches $71.40.

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)

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. (3-23-22)

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. (3-23-22)

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. *THE COMMISSION CONSIDERERS ALL INITIAL OR /CORRECTED BILLS OR SUBSEQUENT APPEALS RECEIVED WITHIN ONE YEAR FROM THE DATE OF SERVICE ARE CONSIDERED PAYABLE; BUT AFTER 120 DAYS FROM THE DATE OF SERVICE THEY ARE NOT ELIGIBLE TO GO THROUGH THE COMMISSION'S DISPUTE RESOLUTION PROCESS UNDER 803.06.I.* (3-23-22)

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. (3-23-22)

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. (3-23-22)

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. (3-23-22)

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. (3-23-22)

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. (3-23-22)

e. Preliminary Objections and Requests for Clarification. (3-23-22)

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. (3-23-22)

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. (3-23-22)

iii. Each Preliminary Objection and Request for Clarification shall contain the name, address, and phone number of the Claims Administrator ~~individual~~ located within the state of Idaho that the Provider may contact regarding the Preliminary Objection or Request for Clarification. (3-23-22)

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. (3-23-22)

f. Provider Reply to Preliminary Objection or Request for Clarification. (3-23-22)

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. (3-23-22)

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. (3-23-22)

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. (3-23-22)

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. (3-23-22)

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. (3-23-22)

i. All medical bill disputes must be finalized within one year from the date of service; otherwise they are not considered payable.

~~i.~~ j. 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