prohibited. (3-23-22)

a. The Commission may, upon receipt of a written Application for Waiver, grant a waiver from the provisions of Subsections 305.06 and [this subsection]305.09 of this rule to permit an insurance carrier or a self-insured employer to sign and issue checks outside the state of Idaho. (3-23-22)

b. An Application for Waiver must be accompanied by an affidavit signed by an officer or principal of the insurance carrier or self-insured employer, attesting to the fact that the insurance carrier or self-insured employer is prepared to comply with all statutes and rules pertaining to prompt payments of compensation. (3-23-22)

c. All waivers shall be effective from the date the Commission issues the order granting the waiver. A waiver shall remain in effect until revoked by the Industrial Commission. At least annually, staff of the Industrial Commission may review the performance of any insurance carrier or self-insured employer for which a waiver under this rule has been granted to assure that the insurance carrier or self-insured employer is complying with all statutes and rules pertaining to prompt payments of compensation. (3-23-22)

d. If at any time after the Commission has granted a waiver, the Commission receives information permitting the inference that the insurance carrier or self-insured employer has failed to provide timely benefits to any Claimant, the Commission may issue an order to show cause why the Commission should not revoke the waiver; and, after affording the insurance carrier or self-insured employer an opportunity to be heard, may revoke the waiver and order the insurance carrier or self-insured employer to comply with the requirements of Subsections 305.06 and [this subsection] 305.09 of this rule. (3-23-22)

10. Copies of Checks. Copies of checks and/or electronically reproducible copies of the information contained on the checks must be maintained in the in-state files for Industrial Commission audit purposes. ~~A copy~~Notice of the first income benefit check shall be sent to the Industrial Commission electronically on the same day of issuance.

(3-23-22)

11. Prompt Claim Servicing. Prompt claim servicing includes, but is not limited to: (3-23-22)

a. Making an initial decision to accept or deny a Claim for an injury or occupational disease within thirty (30) days of the date the Claims Administrator receives knowledge of the same. The worker shall be given notice of that initial decision in accordance with Section 72-806, Idaho Code. ~~Nothing in this rule shall be construed as amending the requirement to start payment of income benefits no later than four (4) weeks or twenty-eight (28) days from the date of disability under the provisions of Section 72-402, Idaho Code.~~ (3-23-22)

b. Payment of medical bills in accordance with the provisions of Section 803 of these rules. (3-23-22)

c. Payment of income benefits on a weekly basis, unless otherwise approved by the Commission. (3-23-22)

i. The first payment of income benefits under Section 72-408, Idaho Code, shall constitute application by the insurance carrier or self-insured employer for a waiver to pay Temporary Total Disability (TTD) benefits on a bi-weekly basis, Temporary Partial Disability (TPD) benefits on other than a weekly basis, Permanent Partial Disability (PPD) benefits based on permanent impairment and Permanent Total Disability (PTD) benefits every twenty-eight (28) days, rather than on a weekly basis. (3-23-22)

ii. Such waiver application shall be granted upon receipt and remain in effect unless revoked by the Industrial Commission in accordance with Subparagraph 305.11.c.iii. (3-23-22)

iii. If at any time after a waiver has been granted pursuant to this section the Commission receives information permitting the inference that the insurance carrier or self-insured employer has failed to service claims in accordance with Idaho law, or that such waiver has created an undue hardship on a Claimant, the Commission may issue an order to show cause why the Commission should not revoke that waiver, and after affording the insurance carrier or employer an opportunity to be heard, may revoke the waiver with respect to all or certain Claimants and

order the insurance carrier or self-insured employer to comply with the requirements of Subsection 305.11.c. of this rule. (3-23-22)

d. Payment of the first Permanent Partial Disability (PPD) benefit based on permanent impairment no later than fourteen (14) days after receipt of the Medical Report providing the impairment rating. The first payment shall include payment of benefits retroactive to the date of medical stability. (3-23-22)

e. Temporary Partial Disability (TPD) payments shall be calculated using the employee's pay period, whether weekly, bi-weekly, or semi-monthly. ~~For employees paid pursuant to any other schedule, TPD benefits shall be calculated semi-monthly.~~ TPD payments owed for a particular pay period shall issue no later than seven (7) days following the date on which employee is ordinarily paid for that pay period. (3-23-22)

12. Audits. The Industrial Commission ~~will~~may perform ~~periodic~~ audits consistent with the Industrial Commission's Audit Guidelines. ~~to ensure compliance with the above requirements.~~ (3-23-22)

13. Non-Compliance. Non-compliance with the above requirements may result in the revocation of the authority of an insurance carrier to write worker's compensation insurance or self-insured employer to self-insure its worker's compensation insurance obligations in the state of Idaho, or such lesser sanctions as the Industrial Commission may impose. (3-23-22)

306. RULE PROHIBITING USE OF SICK LEAVE OR OTHER ALTERNATIVE COMPENSATION.

01. Employee Not Required to Take Sick Leave in Lieu of Compensation. No employer obligated to pay worker's compensation benefits to an employee as provided by the Worker's Compensation Law may require an employee to accept "sick leave" or other comparable benefit in lieu of the worker's compensation benefits provided by law. ~~Section 72-318(2), Idaho Code, specifically provides that no agreement by an employee to waive his rights to compensation under the Worker's Compensation Law shall be valid.~~ (3-23-22)

02. Election of Sick Leave or Alternative Compensation Prohibited. Further, an employee may not elect to accept "sick leave" or other comparable benefit from an employer in lieu of worker's compensation benefits to which the employee is entitled under the Worker's Compensation Law. (3-23-22)

307. RULE GOVERNING REPORTING INDEMNITY AND MEDICAL PAYMENTS AND MAKING PAYMENT OF INDUSTRIAL SPECIAL INDEMNITY FUND (ISIF) ASSESSMENT.

Pursuant to Section 72-327, Idaho Code, the state insurance fund, every authorized insurance carrier, and self-insured employer in Idaho shall report annually to the Industrial Commission the total gross amount of medical only and Indemnity Benefits paid on Idaho worker's compensation claims during the applicable reporting period. ~~This report is~~ The reported indemnity payments only are used to calculate the pro rata share of the annual assessment for the ISIF, under Section 72-327, Idaho Code.
(3-23-22)

01. Filing. The report of indemnity and medical payments shall be filed with the Industrial Commission simultaneously with the first Semi-Annual Premium Tax Report; which, pursuant to Section 72-523, Idaho Code, is due each year on March 3rd. (3-23-22)

02. Form. The report of indemnity and medical payments shall be submitted on Form IC2-327 in the manner prescribed by the Industrial Commission. ~~in writing on, or in a format substantially the same as the current Form IC2-327, available on the Commission's website.~~ (3-23-22)

03. Report Required When No Indemnity Paid. If an entity required to report under this rule has no claims against which indemnity or medical payments have been made during the reporting period, a report shall be filed so indicating. (3-23-22)

04. Penalty for Late Filing. A penalty shall be assessed by the Commission for filing the report of indemnity and medical payments later than March 3rd each year. (3-23-22)

a. A penalty of two hundred dollars ($200) for late filing of seven (7) days or less. (3-23-22)

b. A penalty of one hundred dollars ($100) per day for late filing of more than seven (7) days. (3-23-22)

c. A penalty assessed by the Commission shall be payable to the Industrial Commission and be submitted with the April 1 payment of the ISIF assessment, following notice by the Commission of the penalty assessment. (3-23-22)

05. Estimating Indemnity Payments for Entities That Fail to Report Timely. If an entity required to report indemnity payments under these rules fails to report within the time allowed in these rules, the Commission will estimate the indemnity payments for that entity by using the indemnity amount reported for the preceding reporting period and adding twenty percent (20%). (3-23-22)

06. Adjustment for Overpayments or Underpayments. Overpayments or underpayments, including those resulting from estimating the indemnity payments of entities that fail to report timely, will be adjusted on the billing for the subsequent period. (3-23-22)

308. – 400. (RESERVED)

401. RULE GOVERNING COMPUTATION OF AVERAGE WEEKLY WAGE.

01. Amounts Paid over Base Rate. Sums paid by an employer to an employee, over and above the base rate of compensation agreed upon by the employer and the employee in a contract of hire, which are contingent and dependent upon the employee's increased physical exertion and/or efficiency shall be included in computing the employee's average weekly wage pursuant to Section 72-419(4)(a), Idaho Code. Said sums shall not be considered premium pay. (3-23-22)

02. Fringe Benefits. Also, in computing the average weekly wage, it shall be presumed that wages include, but are not limited to, cost of living increases, vacation pay, holiday pay, and sick leave. (3-23-22)

03. Premium Pay. Further, in computing the average weekly wage, it shall be presumed that premium pay includes, but is not limited to, shift differential pay and overtime pay. (3-23-22)

~~04.~~ **Examples Not Exclusive**. The above-listed examples are not ~~shall not be taken as~~ exclusive in computing the average weekly wage. (3-23-22)

402. RULE GOVERNING CONVERSION OF IMPAIRMENT RATINGS TO "WHOLE MAN" STANDARD.

~~**01. Converting Single Rating of Body Part to Whole Person Rating**. Impairment ratings shall be converted in accordance with the Industrial Commission Schedule, Section 72-428, Idaho Code, with the base of five hundred (500) weeks for the whole man. (3-23-22)~~

02. Averaging Multiple Ratings. Where more than one (1) evaluating physician has given ratings, these shall be converted to the statutory percentage of the whole man, and averaged for the applicable rating. (3-23-22)

03. Correcting Manifest Injustice. The Commission may take steps to correct a manifest injustice resulting from averaging multiple ratings. ~~In the event that the Commission deems a manifest injustice would result from the above ruling, it may at its discretion take steps necessary to correct such injustice.~~ (3-23-22)

403. RULE GOVERNING COMPENSATION FOR DISABILITY DUE TO LOSS OF TEETH.

01. Compensation for Disability. A Claimant under the Worker's Compensation Law shall be entitled to compensation for permanent disability for the loss of each tooth other than wisdom teeth at the rate of one tenth of

one percent (.1%) of the whole man. The loss of wisdom teeth shall not constitute any permanent disability. Compensation hereunder shall be in addition to payments for medical services including dental appliances and bridgework necessitated by the injury and any income benefits during the period of Claimant's recovery to which the Claimant be entitled. (3-23-22)

02. Prima Facie Evidence. This rule and schedule shall be prima facie evidence of the percentage of permanent disability to be attributed to the loss of teeth. (3-23-22)

404. SUBMISSION OF MEDICAL REPORTS FROM PROVIDERS

~~This procedure applies to all open worker's compensation claims where medical services are provided and which have not been denied by the Payor. (3-23-22)~~

01. Procedure. In all cases in which a particular injury or occupational disease results in a worker's compensation Claim, the Provider shall submit written Medical Reports for each medical visit to the Payor. A medical authorization for release of records signed by Claimant shall remain in effect ~~for a period of twelve months, or~~ until revoked. Payo~~e~~rs and Providers may contract with one another to identify specific records that will be provided in support of billings. The Provider shall also submit the same written Medical Reports to the Claimant upon request. These reports shall be submitted within fourteen (14) days following each evaluation, examination, and/or treatment. The first copy of any such reports shall be provided to the Payor and the Claimant, or their attorney, at no charge. If duplicate copies of reports already provided are requested by either the Payor or the Claimant, the Provider may charge the requesting party a reasonable charge to provide the additional reports. Whenever possible, billing information shall be coded using CPT. In the case of Hospitals, reports shall include a Uniform Billing Form 04. In the case of physicians and other Providers supplying outpatient services, this reporting requirement shall include a CMS 1500 form. (3-23-22)

a. If an injury or occupational disease results in a Claim, the Employer/Surety or Provider shall submit written reports to the Commission upon request. Such request may either be in writing or telephonic. If a Claim is referred to the Rehabilitation Division, Medical Reports shall be furnished by the Payor or Provider directly to the office that requests such reports. The Payor or Provider shall consider this an on-going request until notice is received that the reports are no longer required. (3-23-22)

b. If the injury or occupational disease results in a time-loss Claim, the Payor shall submit copies of medical records containing information regarding the beginning and ending of disability, releases to work whether light duty or regular duty, impairment ratings, physical restrictions to the Commission. Other Medical Reports shall be submitted to the Commission only upon request. (3-23-22)

c. ISIF shall receive all copies of Medical Reports, without charge, from either the Claimant or the Payor, depending upon who seeks to join it as a party to a worker's compensation Claim. (3-23-22)

d. If the Commission requests Medical Reports from the Payor or Provider, the information shall be provided within a reasonable time period without charge. If information is received for which the Commission has no need, the information may be discarded or destroyed. (3-23-22)

02. Report Form and Content. Upon approval of the Commission, Medical Reports may be submitted in electronic or other machine-readable form usable to all parties. (3-23-22)

03. Timely Response Requirement. When the Commission requests a Medical Report from a Payor or Provider for use in monitoring a worker's compensation Claim, the Payor or Provider shall provide the requested information promptly. (3-23-22)

04. Forfeiture of Payment. If a Provider fails to give records to the Payor or Claimant, the Payor or Claimant may petition the Commission for an order requiring the Provider to provide the requested information. The petition shall set forth the Petitioner's efforts to obtain the information, the responses to those efforts, and why the Petitioner believes that the Provider has the information. In response to the petition, the Commission may enter an order requiring the Provider to furnish the requested records or demonstrate that the records are not available. If a Provider fails to provide records when ordered by the Commission, the Commission may enter an Order of Forfeiture.

In the event such an order is entered, the Provider will forfeit its right to payment from both the Payor and Claimant, until such time as the records are provided. (3-23-22)

405. RULE GOVERNING REIMBURSEMENT FOR TRAVEL EXPENSES.

~~**01. Mileage Rate**. If Claimant has access to, and is able to operate, a vehicle for transportation covered by Sections 72-432(13) or 72-433(3), Idaho Code, employer shall reimburse Claimant at the mileage rate then allowed by the State Board of Examiners for State employees. Such rate shall be published annually by the Industrial Commission, together with the average state wage for the upcoming period. All such miles shall be reimbursed, with fractions of a mile greater than one-half (1/2) mile rounded to the next higher mile and fractions of a mile below one-half (1/2) mile disregarded.~~ ~~(3-23-22)~~

0~~2~~1. **Commercial Transportation**. If Claimant has no vehicle, or has access to a vehicle and is reasonably unable to utilize the vehicle for transportation covered by Sections 72-432(13) or 72-433(3), Idaho Code, Claimant's employer shall reimburse Claimant the actual cost of commercial transportation as evidenced by actual receipts. ~~Notwithstanding the above provision, no Claimant shall be eligible for reimbursement of the actual cost of commercial transportation where such Claimant is unable to operate a motor vehicle due to the revocation or suspension of driving privileges because Claimant was under the influence of alcohol and/or drugs.~~ (3-23-22)

0~~3~~2. **Request for Reimbursement**. It shall be Claimant's responsibility to submit a travel reimbursement request to the employer. Such request shall be made on a form substantially the same as Industrial Commission Form IC 432(1), posted on the Commission's website. The Claimant must attach to the form a copy of a bill or receipt showing that the visit occurred. The employer shall furnish the Claimant with copies of this form.

(3-23-22)

0~~4~~3. **Frequency of Requests**. Claimant shall not request transportation reimbursement more frequently than once every thirty (30) days. However, notwithstanding this provision, should a Claimant request transportation reimbursement more frequently than every thirty (30) days, employer need not issue more than one reimbursement check in any thirty-day (30) period. (3-23-22)

406. -- 500. (RESERVED)

501. RULE GOVERNING PROTECTION AND DISCLOSURE OF REHABILITATION DIVISION RECORDS.

~~**01. Request for Disclosure**. Pursuant to Section 74-105(10), Idaho Code, a party requesting rehabilitation records shall do so in writing and identify which provision of 74-105(10), Idaho Code, authorizes their request.~~ ~~(3-23-22)~~

0~~1~~2. **Requests from Other Agencies**. If records are in the possession of the Rehabilitation Division by reason of an agreement to comply with valid confidentiality regulations of any agency of the state of Idaho, or agency of the United States, then disclosure shall be requested from the source agency, and not from the Rehabilitation Division. (3-23-22)

502. RULE GOVERNING REPORTS OF ATTORNEY COSTS AND FEES IN LITIGATED CASES.
When requested by the Commission, parties to a Litigated Case shall provide the Commission the information required by Section 72-528, Idaho Code. The form for Sureties is Form 1022 and the form for Claimant's attorneys is Form 1023; both are available on the Commission's website. (3-23-22)

503. -- 600. (RESERVED)

601. SUBMISSION OF FROI AND SROI.

~~**01. Purpose**. Pursuant to Sections 72-602(1) (2), Idaho Code, employers must submit a FROI and/or SROI in accordance with these rules.~~ ~~(3-23-22)~~

02. EDI Reporting. The Commission adopts the ~~requires electronic submission of FROIs and SROIs in accordance with the most current versions of the~~ IAIABC's electronic claims record layout and transaction standards as the required reporting mechanism for all initial claim filings and subsequent reports ~~EDI Claims Release 3.0, or release 3.1 after September 14, 2023, and the Commission's EDI Guides and Tables~~ from any employer not otherwise exempt by these rules. The Commission's EDI Claims Guides and Tables are available on the website. ~~Each FROI and SROI must comply with formatting requirements and must contain the information identified as mandatory or mandatory conditional, as applicable.~~ (4-6-23)

03. Trading Partner Agreements. Before commencing ~~with~~ electronic reporting, Trading Partners shall electronically submit a Trading Partner Agreement ~~with the Commission~~, which the Commission must approve prior to submitting reports. ~~This agreement must provide the effective date to send and receive electronic reports, the acceptable data to be sent and received, the method of transmission to be used, and other pertinent elements.~~ This agreement will identify the insurance carrier, the Claims Administrator, the sender of the electronic files, and the electronic filing method. To ensure the accuracy of reported data, the Trading Partner must maintain their profile to reflect changes as they occur and the Commission may make periodic audits of Trading Partner files. ~~In the event that~~ If a Trading Partner Agreement is entered into by a Claims Administrator, notice to the Trading Partner of a FROI shall be deemed to be notice to the underlying insurance carrier or self-insured employer. (3-23-22)

04. Report Form and Content for Parties Exempt from EDI Requirements. (3-23-22)

a. Individual ~~injured workers~~claimants, claimant's ~~injured worker's~~ legal counsel, and employers that are not insured are not required to comply with EDI requirements for FROIs and SROIs. (3-23-22)

b. Parties exempt from EDI requirements must submit FROIs on a form 1A-1 and SROIs on a form IC-8, or in a format substantially similar. Both forms are available on the Commission's website. (3-23-22)

05. Retaining Claims Files. Upon request of the Commission, insurance carriers, Claims Administrators, or employers shall provide to the Commission, in whole or in part according to the request, a copy of the claim file at no cost to the Commission. All insurance carriers, Claims Administrators, or employers shall retain complete copies of claims files for the life of the Claim and a minimum of five (5) years from the date of closure. (3-23-22)

06. Filing Not an Admission. Filing a FROI is not an admission of liability and is not conclusive evidence of any fact stated therein. ~~If a Claim is submitted electronically, no signatures are required.~~ (3-23-22)

07. Filing Considered Authorization. Filing of a Claim shall be considered an authorization for the release of medical records that are relevant to or bearing upon the particular injury or occupational disease for which the Claimant is seeking compensation. (3-23-22)

08. Timely Response Requirement. When the Commission requests additional information ~~in order~~ to process the Claim, the ~~Claimant or employer~~ surety or self-insured employer shall provide the requested information promptly within fifteen (15)~~three (3)~~ business days. The Commission's request may be ~~either~~ in writing or telephonic. (3-23-22)

602. FINAL REPORTS.

01. Report Requirements. An electronic filing of the Final Report as prescribed by Commission EDI requirements shall be filed for all indemnity claims or any claims resolved by ~~lump sum~~ settlement agreement within thirty (30) days from the date the surety or self-insured employer closes the claim file. In the case of medical-only claims, no Final Report need be filed. For death claims and permanent total disability claims, Annual Reports shall be filed within the first quarter of each calendar year. A Final Report shall be filed within thirty (30) days from the date the surety or self-insured employer closes the death or permanent total disability claim file. In the event the Commission is unable to reconcile the Annual Report or Final Report, a written request for additional information may be made, ~~either in writing or telephonically,~~ and the surety or self-insured employer shall submit the requested information within fifteen (15) working days of the request. If the surety or self-insured employer is unable to furnish the requested information, the surety or self-insured employer shall notify the Commission, in writing, of its inability

to respond and the reasons therefor within fifteen (15) workings days of the request. (3-23-22)

~~**02. Format**. The required format for Final Reports is contingent on the claim file date: (3-23-22)~~

~~**a.** Final Reports for legacy claims filed on paper or via EDI Claims 1.0 prior to November 4, 2017, shall be submitted in a format substantially similar to IC Form 6, available on the Commission's website, or EDI Claims Release 3.1 after September 14, 2023. (4-6-23)~~

~~**b.** Final Reports for legacy claims filed via EDI Claims 3.0 shall be submitted electronically via EDI Claims 3.0, or EDI Claims 3.1 after September 14, 2023. (4-6-23)~~

03. Change in Status of Employer. In case of any default by the Employer or in the event the Employer ~~shall~~ fails to pay any final award or awards, by reason of insolvency or because a receiver has been appointed, the receiver or successor shall continue to report to the Commission, including the submission of Annual Reports, Final Reports and schedules of outstanding awards. (3-23-22)

603. -- 800. (RESERVED)

801. RULE GOVERNING CHANGE OF STATUS NOTICE TO CLAIMANTS.

~~**01. Notice of Change of Status**. As required and defined by Section 72-806, Idaho Code, a worker shall receive written notice within fifteen (15) days of any change of status or condition, including, but not limited to, whenever there is an acceptance, commencement, denial, reduction, or cessation of medical or monetary compensation benefits to which the worker might presently or ultimately be entitled. Such notice is required when benefits are curtailed to recoup any overpayment of benefits in accordance with the provisions of Section 72-316, Idaho Code. (3-23-22)~~

02. By Whom Given. Any notice to a worker required by Section 72-806, Idaho Code, shall be given by: the surety if the employer has secured Worker's Compensation Insurance; or the employer if the employer is self-insured; or the employer if the employer carries no Worker's Compensation Insurance. (3-23-22)

03. Form of Notice. Any notice to a worker required by Section 72-806, Idaho Code, shall be mailed within ten (10) days by regular United States Mail to the last known address of the worker, as shown in the records of the party required to give notice as set forth above. If the worker has elected to receive electronic correspondence, notice may be emailed to the worker within fifteen (15) days. The Notice shall be given in a format substantially similar to IC Form 8, available on the Commission's website. (3-23-22)

~~**04. Medical Reports**. As required by Section 72-806, Idaho Code, if the change is based on a Medical Report, the party giving notice shall attach a copy of the report to the notice. (3-23-22)~~

05. Copies of Notice. The party giving notice pursuant to Section 72-806, Idaho Code, shall send a copy of any such notice to the ~~Industrial Commission, the~~ employer, and the worker's attorney, if the worker is represented, at the same time notice is sent to the worker. The party will provide notice to the Commission consistent with its policy on electronic submission of the FROI and SROI. ~~The party giving notice may supply the copy to the Industrial Commission in accordance with the Commission's rule on electronic submission of documents.~~ In the case of an overpayment recovery request made pursuant to I.C. 72-316, notice shall be contemporaneously submitted to the Commission by email or in paper format. (3-23-22)

802. RULE GOVERNING APPROVAL OF ATTORNEYS FEES.

~~**01. Purpose**. The Industrial Commission promulgates this rule to govern the approval of attorney fees. (3-23-22)~~

02. Charges Presumed Reasonable: (3-23-22)

a. In a case in which no hearing on the merits has been held, twenty-five percent (25%) of Available

Funds shall be presumed reasonable; or (3-23-22)

b. In a case in which a hearing has been held and briefs submitted (or waived) under Judicial Rules of Practice and Procedure (JRP), Rules X and XI, thirty percent (30%) of Available Funds shall be presumed reasonable; or (3-23-22)

c. In any case in which compensation is paid for total permanent disability, fifteen percent (15%) of such disability compensation after ten (10) years from date such total permanent disability payments commenced. (3-23-22)

03. Statement of Charging Lien. (3-23-22)

a. All requests for approval of fees shall be deemed requests for approval of a Charging Lien. (3-23-22)

b. An attorney representing a Claimant in a Worker's Compensation matter shall, within thirty (30) days of the Commission's dismissal of any Settlement Agreement ~~in any proposed LSS~~, or upon request of the Commission, file with the Commission, and serve the Claimant with a copy of the Fee Agreement, and an affidavit or memorandum containing: (3-23-22)

i. The date upon which the attorney became involved in the matter; (3-23-22)

ii. Any issues which were undisputed at the time the attorney became involved; (3-23-22)

iii. The total dollar value of all compensation paid or admitted as owed by employer immediately prior to the attorney's involvement; (3-23-22)

iv. Disputed issues that arose subsequent to the date the attorney was hired; (3-23-22)

v. Counsel's itemization of compensation that constitutes Available Funds; (3-23-22)

vi. Counsel's itemization of costs and calculation of fees; and (3-23-22)

vii. The statement of the attorney identifying with reasonable detail his or her fulfillment of each element of the Charging Lien. (3-23-22)

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. The thirty (30) day-time period for counsel to submit the affidavit or memorandum may be extended by the Commission upon the filing of a motion under JRP 3 demonstrating good cause for the delay. (3-23-22)

04. Procedure if Fees Are Determined Not to Be Reasonable. (3-23-22)

a. Upon receipt of the affidavit or memorandum, ~~the Commission will designate staff members to determine reasonableness of the fee.~~ ~~T~~the Commission staff will notify counsel in writing of the ~~staff's~~ Commission'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. (3-23-22)

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. (3-23-22)

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. (3-23-22)

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. (3-23-22)

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: (3-23-22)

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. (3-23-22)

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. (3-23-22)

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 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), including the use of modifiers and payment status indicators. (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 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, 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			
SERVICE CATEGORY	**CODE RANGE(S)**	**DESCRIPTION**	**CONVERSION FACTOR**
Anesthesia	00000 - 09999	Anesthesia	$60.33
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	$135.00
Surgery - Group Two	28000 - 28999 64550 - 64999	Foot & Toes Nerves & Nervous System	$124.00
Surgery - Group Three	10000 - 19999 20000 - 21999 29000 - 29799 30000 - 39999 40000 - 49999 50000 - 59999 60000 - 60999 62260 - 62999 64000 - 64549 65000 - 69999	Integumentary System Musculoskeletal System Casts & Strapping Respiratory & Cardiovascular Digestive System Urinary System Endocrine System Spine & Spinal Cord Nerves & Nervous System Eye & Ear	$88.54
Radiology	70000 - 79999	Radiology	$88.54
Pathology & Laboratory	80000 - 89999	Pathology & Laboratory	To Be Determined
Medicine - Group One	90000 - 90749 94000 - 94999 97000 - 97799 97800 - 98999	Immunization, Injections, & Infusions Pulmonary / Pulse Oximetry Physical Medicine & Rehabilitation Acupuncture, Osteopathy, & Chiropractic	$49.00
Medicine - Group Two	90750 - 92999 93000 - 93999 95000 - 96020 96040 - 96999 99000 - 99607	Psychiatry & Medicine Cardiography, Catheterization, Vascular Studies Allergy / Neuromuscular Procedures Assessments & Special Procedures E / M & Miscellaneous Services	$70.00

(3-23-22)

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)

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. 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)

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. (3-23-22)

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 fifty percent (50%). (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 fifty percent (50%). (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). (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 bundled with another service appearing on the same bill or 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)

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)

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. (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. 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)

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