Outlook

Comments for Rule Hearing on October 24,2024

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Date Fri 10/25/2024 10:31 AM
To Vaughn, Patti <Patti.Vaughn@iic.idaho.gov>; Kamerron Slay <Kamerron.Slay@iic.idaho.gov>

Idaho Industrial Commission,

Thank you for allowing me to express my recommendations and opinion on the proposed changes.

My comments will focus on outpatient hospital maximum fee allowances as covered under 803.03.c.. I respectfully request that additional status indicator be included and clarified on their appropriate use under this section. My recommended language in green underlined and italicized below:

> 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.ii - ivi of this rule*. *Routine supplies, anesthesia, recovery room use and most drugs of a hospital episode of care and are considered integral to the hospitals services and are considered included in the APC allowances paid under other HCPC Level I and II codes under Addendum B.*(3-23-22)
>
> ~~ii. Status *indicator* code N *codes* 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.~~
>
> *ii. Outpatient biofeedback, physical, occupational, and speech therapy services will be reimbursed according to the allowable professional charge under subsection 803.02 of this rule.*
> ~~*iv. Status indicator Q codes are not subject to composite APC packaging standards.*~~
>
> *iii. The following status indicators for codes listed in Adden B are allowed and adjusted as follows :*
>
> - *A – Active codes with dollars allowed in other portions of this Rule 803 (eg.,PT/OT or DME's 803.05) or at 75% of billed charges (eg, Pathology, a few Radiology, A); and*
> - *B – Alternate code exist or is a different bill type and are not payable as billed (except all dentistry codes are allowed at 75% of billed charges); and*
> - *C - Medicare inpatient only codes are allowed at a similar CPT code with an established APC dollar value or 75% of billed charges; and*
> - *D – Discontinued codes are not separately payable; and*
> - *E1- & E2 – Disallowed by Medicare, but are allowed at 75% of billed charges, and*
> - *F - Allowed at invoice cost +10% for Corneal tissue Acquistion; and*
> - *G - Pass-Through Drugs and Biologicals allowed at invoice cost +10%; and*

- *H - Pass-Through Device Categories are allowed at invoice cost +10%; and*
- *J1 - allowed at 100% for one J1 code per bill; and (alternatively allowing all other secondary J1 code on the same bill at 50%)*
- *J2 - allowed at their respective APC calculated dollar values and the Comprehensive APC criteria is not recognized, and*
- *K – Non-Pass Through Drugs and Nonimplantable Biologicals, including Radiopharmaceuticals are allowed at invoice cost +10%; and*
- *L – Vaccines Antibody therapy allowed at invoice cost +10%; and*
- *M – Measurement only codes and are not payable, and*
- *N - Packaged and are not separately payable, and*
- *P – Partial Hospitalization or Intensive Outpatient program and are allowed at 75% of billed charges; and*
- *Q1-Q4 are allowed at the APC calculated dollars as listed in Addendum B or 75% of billed charges if no APC weight in Addendum B and APC packaging standards are not applied, and*
- *R – Blood and Blood Products allowed at APC calculated dollars, and*
- *S – Service not discounted allowed at APC calculated dollars if listed in Addendum B or 75% of billed charges if no APC Relative Weight is listed in Addendum B; and,*
- *T – Multiple are allowed at 100% for the initial code and 50% of the APC dollar value for any second codes with a T status indicator or 75% of billed charges if no APC Relative Weight is listed; and,*
- *U – Brachytherapy Sources allowed at APC calculated dollars, and*
- *V – Clinic or Emergency department visit and are allowed at APC calculated dollars, and*
- *Y - allowed at this Rule 803.05. a.*

iv, Any code without a status indicator directive listed above will be allowed at 75% of billed charges or at cost + 10% for any type of new or unusual tangible durable medical device or equipment or supply or drug not listed with a HCPC I or II code.

These recommended changes will enable payors to be consistent when applying these outpatient hospital allowances to their bills and at the same time remains consistent with the Commission direction in these proposed changes.

Thank you for your time and consideration to my recommendations.

Thanks & Best

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