SIF Idaho Workers' Compensation (SIF)- Comments after 7/29/2024 Negotiated Rule Making- Medical Fee Schedule.

SIF supports the current medical fee schedule with the additions in green below.

The fee schedule allows for proper review with formal hearings. The medical fee schedule impacts the relationship between sureties/administrators and healthcare providers in every corner of Idaho. The validity of the fee schedule ensures access to all injured workers. Legislative review and oversight of the fee schedule maintains this balance and has a huge impact over the industry and related revenue.

IDAPA 17.01.01.010- Definitions- SIF supports the suggested additions and deletions of section 17.01.010 from draft 07/29/2024, including the following changes:

> ***17.01.01.010.07. b.- Customary charge.*** *Means a charge that has an upper limit no higher than the ~~90th~~ 80th percentile, as determined by the Commission, of usual charges made by Idaho Providers for a given medical service.*
>
> ***Note-*** SIF's data shows the 80th percentile to be fair and above average of community, regional and national data of customary charges and other insurance carriers reimbursement including Medicare.
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> ***17.01.01.010.25- Implantable Hardware****. Means objects or devices that are made to support, replace, or act as a missing anatomical structure or to support or manage proper biological functions or disease processes and where surgical or medical procedures are needed to insert or apply such devices and surgical or medical procedures are required to remove such devices.* ~~The term also includes equipment necessary for the proper operation of the implantable hardware, even if not implanted in the body.~~ *Instruments, tools, equipment, supplies, and kits used to perform surgical or medical procedures are not considered an implant.*
>
> ***Note-***SIF supports following the AMA guidelines, CMS Medicare inpatient, OPPS facility, physician billing, and CMS National Correct Coding Initiative (CCI). Implantable Hardware does not include staff, equipment, instruments, tools, supplies, and kits to perform a procedure. These are included in the physician and or facility fee schedule (surgical package) for the procedure. *(Reference CMS global surgical package and Medicare National Correct Coding Initiative policy chapter 1)*.

IDAPA 17.01.01.011- Abbreviations- SIF supports the suggested deletion of this section.

IDAPA 17.01.01.803- Medical Fees- SIF supports the current medical fee schedule with the additions in green below.

IDAPA 17.01.01.803.01.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 unless otherwise specified in Section 803*.

IDAPA 17.01.01.803.02.b-Modifiers. *Modifiers for physicians will be reimbursed ~~as follows~~- per CMS-Medicare Physician Fee Schedule.*

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.~~

IDAPA 17.01.01.803.02.c- Conversion Factors- SIF supports the current conversion factors. **Note**-SIF's support is based on SIF's own internal data, Milliman Report, and Idaho Commercial Reimbursement Benchmarking. SIF sees no evidence to increase the existing Medical Fee Schedule's Conversion Factors.

Medical Fee Schedule:

Pathology & Laboratory- Suggest IIC to adopt CMS annual Clinical Laboratory Fee Schedule (CLFS) and billing guidelines.

IDAPA 17.01.01.803.02.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 for any drug or topical agent for which a significantly lower-cost therapeutic equivalent is available, including over-the-counter (OTC), shall be limited to ~~50%~~ 30%above the cost of the therapeutic equivalent. 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.

IDAPA 17.01.01.803.03- 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.

a. The Commission adopts the Medicare Hospital Outpatient Prospective Payment System (OPPS), published by CMS, as amended, as the standard to be used to determine acceptable charges by Hospitals and Ambulatory Surgery Centers.

.~~a~~ b- 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%)~~ ten percent (10%). Handling and freight charges shall be included in the invoice cost.*

C. 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%)~~ cost-plus ten percent (10%).*

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. SIF supports. (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. SIF supports.

(1) Implantable Hardware may be eligible for separate payment under Subparagraph 03.d.iii. of this rule. SIF Supports (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%).~~

SIF supports removal of 2, iii and iv.

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.

HCPCS Level II Codes- Suggest IIC to adopt the current year's first Biannual (B1) CMS billing guidelines and fee schedule for HCPCS Level II Codes. HCPCS Level II codes without an established value shall be determined by actual cost plus 30% or based upon the agreement of the parties. If there are no agreements services shall be paid in accordance with these rules.
Durable Medical Equipment (DME) Providers. Within the first thirty (30) days of equipment use, the Payor shall be given the option to rent or purchase DME. Rented equipment shall be considered purchased once the rental charges exceed the purchase price, which may not exceed ten percent (10%) of the invoice cost. If purchased, the DME shall become the property of the Claimant.

Note- HCPCS Level II codes are grouped by the type of service or supply they represent and are updated annually by CMS with input from private insurance companies. HCPCS Level II codes are required for claims for supplies and devices covered by Medicare and Medicaid and by most private payers. Fees are national and per state with rental and purchase prices.

IDAPA 17.01.01.803.06 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 Idaho Worker's Compensation Law and the procedures for resolving disputes between Payors and Providers over those bills or payments. Rule does not govern disputes regarding Preferred Provider Organization (PPO) reductions. PPO reductions are between Provider of Services and their PPO Networks contracts.

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.

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. Except for the circumstances listed below, payment is forfeited when the charges are not billed within twelve (12) months from the date of service and may not be balance billed as defined in Idaho Code 72-102(2):

The industrial cause of the injury is initially unknown to the Provider;

A change in Employer's coverage or designated claims administrator is unknown to the Provider.

This list is not exhaustive, and the Commission has discretion to address disputes regarding timeliness of the billing in the dispute resolution procedures of the Commission set out in Paragraph 803.06.i of this rule.

SIF supports above additions to Time Periods.