SUMMARY OF COMMENTS ON NEGOTIATED RULEMAKING

2024 Zero-Based Regulation Review:

IDAPA 17.01.01 – Administrative Rules Under the Worker's Compensation Law

The following document contains summaries of the negotiated rulemaking comments submitted to the Idaho Industrial Commission in writing or as raised in discussion at public hearings. Selected portions of the proposed amendments those comments discuss have been included from the July 29, 2024 rule draft for context. These do not necessarily reflect the final rules which would be generated after negotiated rulemaking was completed. This document does not address amendments or sections that did not receive comments.

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§ 010 DEFINITIONS

RULE AS PROPOSED

07. **Charge**. Means the expense or cost. For hospitals and ASCs, "charge" means the total charge. (3-23-22)

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~~ 80th percentile, as determined by the Commission, of usual charges made by Idaho Providers for a given medical service. (3-23-22)

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. (3-23-22)

COMMENTS

Surety/Third Party Services Comments

- The State Insurance Fund (SIF) proposes redefining customary charge to use the 80th percentile as the upper limit. SIF proposed redefining implantable hardware to exclude certain devices, using the language "Instruments, tools, equipment, supplies, and kits used to perform surgical or medical procedures are not considered an implant." SIF would delete the sentence "The term also includes equipment necessary for the proper operation of the implantable hardware, even if not implanted in the body." SIF is in support of deleting the definition of abbreviations, which the current draft replaces with parenthetical insertion of abbreviations where the terms are used. (*Written Comment 7/31/24* - Tresa Brown, Cost Containment Manager, SIF – Idaho Worker's Compensation).

- Intermountain Claims proposes a definition of adjusting office that means "any location within the state where a Claims Administrator services workers' compensation claims." (*Written Comment 8/1/24* - Chris Wagener, Worker's Compensation Supervisor, Intermountain Claims, Inc. Boise ID).

- Debra Northrup, CorVel, proposes editing the definition of charge, adding a definition for healthcare provider, and editing the definition of customary charge to reference the 75th percentile in a zip code. Alternately, Northrup proposes using the 80th percentile. (*Written Comments 6/24/24, 6/25/24, 7/31/24* - Debra Northrup, Bill Review Manager, CorVel Corporation, Denver CO).

- Debra Northrup, CorVel, comments on difficulties related to provider billing when the schedules do not govern and the standard is through the 90th percentile rule or the usual

and customary rule. Northrup comments that the 90th percentile is unreasonable, and the 80th percentile is reasonable. Northrup agrees that using a zip code basis instead of statewide comparison is preferable. (7/11/24 Meeting).

- Tresa Brown (SIF) agrees that the 90th percentile should be lowered, and prefers the 75th percentile. (7/11/24 Meeting). Markup can be 700% for a DME; she prefers having a usual and customary standard with a percentage based on data. She recommends using a zip code basis for comparison rather than statewide. (7/11/24 Meeting).

- Debra Northrup (CorVel), proposed a number of changes to medical fee rules that would increase the number of billing terms that are defined by regulation, replace a number of current definitions, adopt a number of billing tables published by CMS. Northrup presented a draft of these proposed changes. Among other proposals, this would limit reimbursement to 75th/80th percentiles of charges in a zip code area, rather than the current 90% of customary charge. (*Written Comments 6/25/24* - Debra Northrup, Bill Review Manager, CorVel Corporation).

- Lene O'Dell (Risk Administration Services) comments that definition of claimant could be removed and replaced with injured worker. (11/8/23 Meeting)

- Shelly Martin (Traveler's Insurance) suggested consistent use of either claimant or injured worker throughout the chapter. Claimant is a broader term, whereas injured worker indicates an accepted claim. (11/8/23 Meeting).

Attorney Comments

- Jamie Arnold, claimant attorney, comments that use of "injured worker" is narrower and potentially exclusive of situations like fatalities. (11/8/23 Meeting).

Medical Provider Comments

- Changing the definition of usual and customary was opposed by the Idaho Medical Association, which stated dropping from the 90th to the 70-80th percentile could limit reimbursement rates to levels below costs of providing care and below what Medicare provides. (7/26/24, Mary Barinaga, MD, Idaho Medical Association President).

§ 301.02 RULES GOVERNING QUALIFICATIONS TO WRITE INSURANCE OR SELF-INSURE

PROPOSED RULE

02. Self-Insured Employers. In order to gain written approval from the Industrial Commission to self-insure under Section 72-301, Idaho Code, an employer shall comply with the following requirements: (3-23-22)

a. Payroll. Have an average annual Idaho Payroll over the preceding three (3) years of at least ten ~~four~~ million dollars ($10,000,000) ~~($4,000,000)~~. (3-23-22)

COMMENTS

Surety/Third Party Services Comment

- Chris Wagener (Intermountain Claims) objects to $10 million increase as it may be problematic in the event of an economic downturn and suggests $6 to $8 million instead. (*Written Comment 8/1/24* - Chris Wagener, Worker's Compensation Supervisor, Intermountain Claims, Inc. Boise ID).

Attorney Comments

- Josh Scholer (Idaho State Division of Financial Management) inquires about comparison to other states. (7/29/24 Meeting).

§ 302.01.(c) MAINTAIN RESIDENT IDAHO OFFICE

PROPOSED RULE

c. Maintain Resident Idaho Office. Each insurance carrier shall maintain a Claims Administrator employing an Idaho licensed resident adjuster or the carrier's own adjusting offices or officers residing in Idaho. (3-23-22)

i. Each authorized insurance carrier shall notify the Commission ~~Secretary~~ in writing of any change to the primary claims administrator within fifteen (15) days of such change and report the designated claims administrator ~~of the designated resident adjuster(s)~~ for every insured Idaho employer through proof of coverage (POC) ~~within fifteen (15) days of such change~~. (3-23-22)

COMMENTS

Medical Provider Comment

- Certain sureties do not have a main point of contact and fail to respond to calls or emails, making it difficult to identify whether a worker's compensation claim is filed and who the adjuster is. (*Written Comment 5/20/24* - Collected Comments from Primary Health Medical Group).

Attorney Comment

- If striking subsection (c) does not allow out of state adjusting, then it should be stricken. To the extent it has language referencing "its own adjusting offices or officers located within the state" it does not comport with statutory language that permits operating through a person or through in-state adjusting offices. (*Written Comment 7/29/24* - Josh Scholer Deputy General Counsel, Idaho State Division of Financial Management).

§ 305.01.(a) REQUIREMENTS FOR MAINTAINING IDAHO WORKER'S COMPENSATION CLAIMS FILES

PROPOSED RULE

305. REQUIREMENTS FOR MAINTAINING IDAHO WORKER'S COMPENSATION CLAIMS FILES. ~~All insurance carriers, self-insured employers, and licensed adjusters servicing Idaho worker's compensation claims shall comply with the following requirements: (3-23-22)~~

01. Idaho Office. (3-23-22)

a. All insurance carriers, self-insured employers, and licensed adjusters servicing Idaho worker's compensation claims shall maintain an office within the state of Idaho. The offices shall be staffed by adequate personnel to conduct business. (3-23-22)

02. Claim Files. All Idaho worker's compensation claim files shall be maintained within the state of Idaho in either hard copy or immediately accessible electronic format. Claim files shall include all documents relevant to the claim file:~~, but are not limited to~~:
(3-23-22)

COMMENTS

Surety/Third Party Services Comments

- Debra Northrup, CorVel, proposes striking the requirement for providing an Idaho office. Northrup also objects to the list of documents in subsection 2 including the language "but not limited to", objects to the requirement in subsection 3 to maintain records at an Idaho office, proposes adding the descriptive "electronic or paper" to the date stamp requirement, and proposes other changes to how filing is stamped or sent. (*Written Comments 6/24/24, 6/25/24, 7/31/24* - Debra Northrup, Bill Review Manager, CorVel Corporation, Denver CO).

- The American Property Casualty Insurance Association objects to the rule requiring maintenance of an office within the state of Idaho. APCIA states that requiring a brick-and-mortar office is not required by Idaho statue and therefore this section goes beyond the rules' scope to clarify statute and the intent of Idaho legislators. APCIA would recommend striking 305.01.(a) in its entirety. (*Written Comment 8/1/24* - Lyn D. Elliott, Vice President, State Government Relations, American Property Casualty Insurance Association).

- Intermountain Claims proposes language that would add the word "adjusting office" rather than office. In the definitions section, adjusting office would be defined to include locations where claims are serviced, or something that would clarify an office does not need to be brick and mortar. (*Written Comment 8/1/24* - Chris Wagener, Worker's Compensation Supervisor, Intermountain Claims, Inc. Boise ID).

- Elizabeth Criner, Veritas, states the code does not specifically require a physical office, and would like to know why this section requires that there be an adequately staffed front officer within the state as well as resident claims adjusters. (7/29/24 Meeting). Criner comments that if adequate staffing refers to having sufficient adjusters, as opposed to a full front office, then clarification may be in order. Adjusting these days is not based on someone walking into a front office, it's being done much like a Webex meeting. (7/29/24 Meeting). Criner interprets the adequately staffed office as referencing a brick-and-mortar front office with secretaries where someone can walk in, as opposed to someone available over Zoom or Webex. (7/29/24 Meeting). Criner does not view the guidance memo from the Commission clarifying that a brick-and-mortar office is not required as sufficient. (7/29/24 Meeting).

Attorney Comments

- Emma Wilson, defense attorney, proposes alternate language that removes the requirement for an office within the state of Idaho, removes language reference "staffed by adequate personnel," and instead states that all claims administrators servicing claims and responsible for claims services must reside within Idaho. (*Written Comment 8/1/24* - Emma Wilson, Breen Veltman Wilson PLLC).

- Josh Scholer, Idaho State Division of Financial Management, agrees with Criner that the statute does not require an in state front office. He comments that a brick and mortar office is not required under current interpretation of the IDAPA rule. He is in support of removing the language "adequately staffed" due to its potential open-endedness in application or would support a objective checklist defining it. (7/29/24 Meeting).

§ 305.03 CORRESPONDENCE

PROPOSED RULED

03. Correspondence. All original correspondence involving adjusting decisions regarding Idaho worker's compensation claims shall be authorized and accessible through electronic reproduction from ~~and maintained at~~ an in-state offices. (3-23-22)

Surety/Third Party Services Comments

- Shelly Martin, Traveler's Insurance, suggests amending section 305.03 regarding correspondence to add that it may be maintained electronically. Martin suggested the language state the correspondence can be accessed and electronically reproduced within the in-state office. (11/8/23 Meeting).

§ 305.06 COMPENSATION PAYMENTS - GENERALLY

PROPOSED RULE

06. Compensation Payments - Generally. (3-23-22)

a. All compensation, as defined by Section 72-102, Idaho Code, must be issued from the in-state office. (3-23-22)

b. Except as ordered otherwise by the Commission, the insurance carrier or self-insured employer may make compensation payments by either: (3-23-22)

i. Check or other readily negotiable instrument; (3-23-22)

ii. Upon the Claimant's written request, through an electronic payment transfer to an account designated by the Claimant. The Claimant or Claimant's attorney may discontinue receiving the electronic transfer payment and revert to receiving compensation payments via check by written notification; or ~~When requested by the Claimant, electronic transfer payment to an account designated by the Claimant in accordance with the requirements of Subsection 305.07; or~~ (3-23-22)

iii. An insurance carrier or a self-insured employer may pay compensation through either: (1) an automated teller machine (ATM) card, (2) debit card, or (3) access card (hereinafter, collectively referred to as an "access card") to a Claimant if there is a signed agreement between the insurance carrier or self-insured employer and the Claimant. An insurance carrier or self-insured employer shall not reduce compensation payments paid to a Claimant through an access card for any fees, surcharges, and adjustments unless they are for direct costs in replacing an access card through an expedited mail service, international transaction fees, or out-of-network ATM fees. The Claimant or Claimant's attorney may discontinue receiving payment via access card by written notification. ~~When requested by the Claimant, electronic transfer payments made through an access card; if that option is made available by the carrier or self-insured employer, in accordance with the requirements of Subsection 305.08.~~
(3-23-22)

c. Notwithstanding subsection (ii) and (iii) above, ~~I~~if the Claimant is represented by an attorney who may have an attorney's lien for fees due on such compensation payments, the attorney must agree to payment by electronic transfer to Claimant's account or payment through an access card before such compensation may be paid other than by a check made payable to the Claimant and the attorney.
(3-23-22)

COMMENTS

Attorney Comments

- Darin Monroe, claimant attorney, expresses concern about notification to the attorney where the claimant is represented. The attorney should get some type of electronic notification of the payment and dates to assist with tracking. (7/29/24 Meeting).

Hospital Comments

- Hospitals can provide updated payment history to claimant's attorneys upon request. "what's wrong with copies of the NOCS being sent to the claimant's attorney." Payment history would include all payments, the amount, and the dates. (*Written Comment 7/29/24* - Kelli Segroves, Sr. Manager Workers Compensation, St. Luke's Health System).

Surety/Third Party Services Comments

- Requiring attorney notification when electronic claims are made creates an unnecessary burden. (*Written Comment 8/1/24* - Chris Wagener, Worker's Compensation Supervisor, Intermountain Claims, Inc. Boise ID).

§ 305.07 ELECTRONIC TRANSFER PAYMENTS

PROPOSED RULE

~~**07. Electronic Transfer Payments.** (3-23-22)~~

~~**a.** A Claimant may request that the insurance carrier or self-insured employer make compensation payments by electronic transfer to a personal bank account by providing the insurance carrier or self-insured employer in writing: the name and routing transit number of the financial institution and the account number and type of account to which the Claimant wants to have the compensation electronically transferred. The insurance carrier or self-insured employer shall provide the Claimant with a written form to fill out the required information by this subsection within seven (7) days of receiving a request for electronic transfer of payments from the Claimant unless the Claimant has already completed an on-line electronic form provided by the carrier or employer. (3-23-22)~~

~~**b.** The insurance carrier or self-insured employer may make compensation payments to the Claimant by electronic transfer to an account designated by the Claimant if the Claimant: (3-23-22)~~

~~i. Requests in writing that payment be made by electronic transfer; (3-23-22)~~

~~ii. Provides the information required by Paragraph 305.07.a. above; and (3-23-22)~~

~~iii. Is reasonably expected to be entitled to receive compensation payments for a period of eight (8) weeks or more from the point that Subparagraphs 305.07.b.i. and 07.b.ii. are satisfied. (3-23-22)~~

~~**c.** The insurance carrier or self-insured employer shall initiate payment by electronic transfer starting with the first benefit payment due on or after the twenty first day after the requirements of Paragraph 305.07.b., above are met, but shall continue to make timely payments by check until the insurance carrier or self-insured employer initiates benefit payment delivery by electronic transfer. (3-23-22)~~

~~**d.** If the Claimant has previously been receiving benefit payments by electronic transfer and wants to receive benefits by check, the insurance carrier or self-insured employer shall initiate benefit payment delivery by check starting with the first benefit payment due to the Claimant on or after the seventh day after receiving a written request for such payments. (3-23-22)~~

COMMENTS

Surety/Third Party Services Comments

- Shelly Martin, Traveler's Insurance, indicated support for removing this section. Martin commented that some of the sections are repetitive and could be consolidated. The parties should be able to use electronic payments if they agree, rather than only having the option if benefits exceed eight weeks. (11/8/23 Meeting).

§ 305.09 CHECKS AND DRAFTS - WAIVER OF IN STATE CHECK WRITING

PROPOSED RULE

09. Checks and Drafts. Checks must be signed and issued within the state of Idaho; drafts are 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)

COMMENTS

Surety/Third Party Services Comments

- Lene O'Dell (Risk Administration Services) suggested condensing section 305.09 regarding application for waiver to eliminate redundancy. O'Dell indicated pulling the check writing waiver was meant to penalize the administrator but inadvertently impacted the people receiving the checks more. (Meeting 11/8/24).

Attorney Comments

- Josh Scholer, Idaho State Division of Financial Management, discussed concerns with waiving requirements under section 305.09. Scholer indicated further discussion on the purpose of this rule would be beneficial. (Meeting 11/8/24).

§ 305.11.(a) PROMPT CLAIM SERVICING

PROPOSED RULE

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)

COMMENTS

Claimant Attorney Comments

- Claimant attorneys opposed removing language requiring income benefits be paid no later than four weeks or twenty-eight days from the date of disability. The IDAPA rule is duplicative of statute, but the requirement is often violated. Failure to comply with that requirement can result in financial ruin for injured workers. Removing the rule will increase disregard of prompt claim servicing. (*Written Comment 5/22/24* - Michael Kessinger, Goicoechea Law, LLC – Claimant Attorney)(*Written Comment 5/24/24* - Steve Carpenter, Browning Law – Claimant Attorney).

§ 305.12 AUDITS

PROPOSED RULE

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)

COMMENTS

Attorney Comment

- Josh Scholer, Idaho State Division of Financial Management, suggested adding a hyperlink to the Audit Guidelines in the rule. (11/8/23 Meeting).

Surety/Third Party Services Comments

- Shelly Martin, Traveler's Insurance, suggested changing the language to cover audits when the Commission can. (11/8/23 Meeting).

- Tina Crawford, CorVel, indicated that section 305.12 regarding audits should be clarified to define "periodic." Crawford suggested defining how frequent periodic audits would be or referencing the current process that triggers audits in the Audit Guidelines. (11/8/23 Meeting).

§ 401.04 RULE GOVERNING COMPUTATION OF AVERAGE WEEKLY WAGE

PROPOSED RULE

~~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)

COMMENTS

Other Comments

- Michael DeGraw, Industrial Commission, inquired why this section was being struck. Commissioner Sharp indicated the rule didn't specify every single example and commentary was unnecessary. (5/8/24 Meeting)

Attorney Comments

- Anthony Shively, claimant attorney, commented that if it doesn't cover all situations, it may be a good reason to keep it. (5/8/24 Meeting).

§ 402 CONVERSION OF IMPAIRMENT TO THE WHOLE MAN

PROPOSED RULE

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)

COMMENTS

Surety/Insurance

- Chris Wagener, Intermountain Claims, objects to section 402 in its entirety as creating unnecessary complications. There is no real remedy for when this rule results in an overpayment due to incorrect computation or differences in methodology. (*Written Comment 8/1/24* - Chris Wagener, Worker's Compensation Supervisor, Intermountain Claims, Inc. Boise ID).

- Cindy Weigel, Intermountain Claims, stated the section as it reads right now causes confusion. (5/8/24 Meeting)

- Stephanie Butler, State Insurance Fund, indicated she'd like to add for consideration under 402.01 a potential clause at the end that says, "unless the claim is in litigation." Butler also expressed concern about averaging impairment ratings in general, as it puts sureties in the position of paying out something that may not be recoverable. (5/8/24 Meeting)

- Josh Ewing, JME Claims, expresses it is easier to bear the burden if the money is not due at the end of the day. Sureties should be able to collect back. He expresses support for Emma Wilson's comments. (5/8/24 Meeting)

Defense Attorneys

- Emma Wilson, defense attorney, objects to subsection 402 in its entirety. The partial removals do not materially change the current language or procedure, and the rule still requires Commission involvement which requires time and creates expenses. Physicians are not required to use AMA guidelines, and the surety must average regardless of flawed or erroneous methodology. Historically, ratings converted to the whole person and paid at the

closest body part. It is inconsistent with what they are instructed to do based on the closest body part. (Comments at 5/8/24 Meeting; *Written Comment 8/1/24* - Emma Wilson, Breen Veltman Wilson PLLC).

- Mark Peterson, defense attorney, agreed with Stephanie Butler's (SIF) proposed language and how it would define litigation. Peterson stated through the litigation process, the burden is on the claimant to demonstrate that they're entitled to impairment and that issue is going before the Commission to decide. Peterson commented that it puts a lot of burden on a surety or employer to continue paying benefits while the Commission adjudicates the case. Peterson indicated that averaging impairments before it's adjudicated seems not to consider the fact that the burden is upon the claimant to demonstrate an entitlement to any kind of benefit. (5/8/24 Meeting).

Claimant Attorneys

- Brad Eidam, claimant attorney, expressed concern over removing this section. He asked why either side should be potentially prejudiced by not averaging just because the case is in litigation. It may not even be an issue in the litigation. Eidam indicated it could potentially result in penalizing an injured worker who might get a lower impairment compensation instead of averaging. (5/8/24 Meeting)

- Matthew Vook, claimant attorney, commented that he disagrees with the standard proposed by Stephanie Butler (SIF) which would require averaging unless the claim was in litigation. It would delay filing of complaints until after the impairment ratings are obtained. (5/8/24 Meeting).

- Jacob Stewart, claimant attorney paralegal, expressed that averaging impairments was a fair compromise. (5/8/24 Meeting).

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

PROPOSED RULE

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)

COMMENTS

Comment

- Dexton Lake (unknown affiliation, possibly Government Affairs Representative, Idaho Farm Bureau) inquired why permanent disability would be required if there has been dental repair. He objects to impairment, citing how a new tooth could be better than the original. (5/8/24 Meeting).

Surety/Third Party Services Comment

- Chris Wagener, Intermountain Claims, commented that that the loss of a tooth was comparable to the loss of a limb and had no concern with dental impairment. (5/8/24 Meeting).

§ 404 SUBMISSION OF MEDICAL REPORTS FROM PROVIDERS

PROPOSED RULE

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)

COMMENTS

Surety/Third Party Services Comments

- Debra Northrup, Corvel, and Tresa Brown, SIF, commented in favor of retaining the sentence "Whenever possible, billing information shall be coded using CPT. In the case of Hospitals, reports shall include a Uniform Billing Form 04." (7/11/24 Meeting).

- Chris Wagener, Intermountain Claims, expressed concern about the 12-month limitation indicating you can receive indemnity benefits for many years and the surety may want to be able to obtain records to make an appropriate decision of whether treatment would be related to the claim, especially in light of decisions where it could have significant financial ramifications. (5/8/24 Meeting).

- Stephanie Butler, SIF, indicated her support for Wagener's comment, but acknowledged it isn't clear what a correct time frame would be. (5/8/24 Meeting).

Attorney Comments

- Anthony Shively, claimant attorney, commented on his agreement with Wagener as an arbitrary 12-month expiration would just create more work. (5/8/24 Meeting)

- Jacob Stewart, claimant attorney paralegal, commented that the Commission's approved release form of the complaint pleading indicates "unless otherwise revoked, this authorization will expire upon resolution of worker's compensation claim." Stewart suggested that if any deadline is added, that it be consistent with the Commission's release

form; then the medical providers will have to except it unless it's revoked in writing or the claim is completed. (5/8/24 Meeting).

- Support was expressed for changes as put forth in the 4/29/24 working copy. (*Written Comments 5/7/24* - Jacob Stewart, Paralegal, James, Vernon & Weeks, P.A. – Claimant Firm).
    - *NOTE:* The 4/29/24 working copy included changes which were not kept. The current proposal no longer adds the language "for a period of 12 months." It also does not strike the sentence "Whenever possible, billing information shall be coded using CPT. In the case of Hospitals, reports shall include a Uniform Billing Form 04."

§ 405 – REIMBURSEMENT FOR TRAVEL EXPENSES SUSPENSION OF DRIVING PRIVILEGES

PROPOSED RULE

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)

COMMENTS

Claimant Attorney Comments

- Matthew Vook, claimant attorney, commented that the suspension portion of this section is contrary to I.C. § 72-405 and the purpose of workers' compensation, and he would support its elimination. (5/8/24 Meeting).

- Darin Monroe, claimant attorney, agreed with striking ineligibility due to revocation of driving privileges and stated there didn't appear to be anything in the statute that gave that authority. Anthony Shively, claimant attorney, also indicated support for striking that section. Jacob Stewart, claimant attorney paralegal, supports removal. This is not about punishing sureties, but providing benefits to insured workers. (5/8/24 Meeting).

- Jacob Stewart, claimant attorney paralegal, comments that the statute does not address rounding up or down for half-miles. (5/8/24 Meeting).

- Bradford Eidam, claimant attorney, expressed his support against keeping the penalty of not reimbursing a claimant because suspended driving privileges due to alcohol or drugs. Eidam indicated there was a disconnect between the worker's compensation case and the driver suspension. Eidam indicated that it seems counterproductive to the goal of the workers' compensation system to get injured workers seen by a health care provider so they can get well. (5/8/24 Meeting).

Surety/Third Party Services Comments

- Chris Wagener, Intermountain Claims, expresses opposition to striking the second part of the rule. He commented that it would be a punishment to a surety to incur extra costs of

providing transportation when someone broke a law outside of worker's comp. If someone had their license suspended prior to the work injury, they were getting to work somehow. The rule should stay as otherwise this is punishing sureties for actions beyond their control. (5/8/24 Meeting).

§ 601 SUBMISSION OF FROI AND SROI

PROPOSED RULE

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)

COMMENTS

Surety/Third Party Services Comments

- Stephanie Butler, SIF, expressed concern with the three-day deadline edition imposed and suggested a 7-day deadline as more reasonable. (5/8/24 Meeting).
- Chris Wagener (Intermountain Claims) agreed with Ms. Butler's statement; three days is short. (5/8/24 Meeting). He agreed that fifteen days is reasonable. (*Written Comment 8/1/24* - Chris Wagener, Worker's Compensation Supervisor, Intermountain Claims, Inc. Boise ID).
- Lene O'Dell, Risk Administration Services, commented that the deadline seems to conflict with Audit Guideline rule #4 which gives 15 working days for a response. (5/8/24 Meeting).
- Cindy Weigel, Intermountain Claims, expressed concern about the time frame for response, particularly where the surety may not have the information, and agreed with Ms. Butler's comment about 3-days being snug. (5/8/24 Meeting).

Hospital Comments

- Kelli Segroves, St. Luke's, expresses agreement with Weigel. (5/8/24 Meeting).

§ 801 RULE GOVERNING CHANGE OF STATUS NOTICE TO CLAIMANTS

PROPOSED RULE

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)

COMMMENTS

Claimant Attorney Comments

- Michael Kessinger commented that this requirement is routinely ignored by sureties and indicated it would be in the best interest of the injured workers to keep it in IDAPA. (6/24/24 Meeting).

- Darin Monroe commented that he agrees with Kessinger and prefers it remain in. He understands why it would seem redundant since it is in statute as well, but the rest of the rule does not make sense without it. (6/24/24 Meeting).

Surety/Third Party Services Comments

- Chris Wagener, Intermountain Claims, stated this was already covered in statute, and it would be duplicative. Wagener therefore supported striking the duplicative language. (6/24/24 Meeting). He also supports continuity between the change of status notices and

EDI transaction filings. (*Written Comment 8/1/24* - Chris Wagener, Worker's Compensation Supervisor, Intermountain Claims, Inc. Boise ID).

- Shelly Martin, Traveler's Insurance, inquired if there was a conflict with the audit guidelines. Martin commented on sending a change of status for medical only claims for closures. Martin indicated the statute and the IDAPA that is currently written do not specifically identify that a change of status needs to be sent when there is a closure, especially with med-only. Notice on a med-only seems unnecessary since any medical is really open for life. Martin indicated that clarification on whether a notice is required for closing of a med only claim would be beneficial. (6/24/24 Meeting).

- Chris Wagener, Intermountain Claims, indicated concern when sending out a change of notice statute for administrative closures as it confuses some injured workers into believing their case is closed. (6/24/24 Meeting).

- Chris Wagener, Intermountain Claims, suggested clarifying whether EDI electronic Commission rules are going to be different than notice to the injured worker. Those timelines should comport with each other. (6/24/24 Meeting).

Attorney Comments

- Michael Kessinger, claimant attorney, agreed with Chris Wagner's, Intermountain Claims, sentiment that change of status notices on administrative closures can confuse workers into believing their claim is closed. (6/24/24 Meeting).

§ 802 RULE GOVERNING APPROVAL OF ATTORNEYS FEES

PROPOSED RULE

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)

COMMENTS

NOTE: The original draft of this rule proposed a 14-day deadline, rather than 30 days.

Comment by Defense Attorney

- Emma Wilson, defense attorney, proposed language requiring that the request for attorney's fees be filed within 14 days of the settlement being filed or show good cause for the delay. As an alternative, the deadline could be 20 days based on the timeline for a motion to reconsider. (*Written Comment 6/25/24* - Emma Wilson, Breen Veltman Wilson PLLC). Wilson was in support of allowing exceptions when needed. (6/24/24 Meeting).

Comments by Claimant Attorneys

- Darin Monroe, claimant attorney, had concerns about the 14-day timeline. Monroe indicated the ISB keeps track of trust accounts. Monroe indicated he wasn't opposed to the deadline but suggested 21 or 30 days. Michael Kessinger, claimant attorney, echoed Monroe's concerns and did not see what problem the timeline would resolve. Kessinger

indicated more than 14 days would be desirable along with an option for waiver for good cause. Monroe inquired what the consequence would be if an attorney missed the deadline. (6/24/24 Meeting)

Other Attorney

- The Idaho Trial Lawyers' Association objected to the language "may be extended by the Commission upon the filing of a motion under JRP 3 demonstrating good cause for delay." ITLA proposed adding "may be waived for good cause shown" instead. (*Written Comment 8/1/24* - Barbara Jorden, Executive Director, Idaho Trial Lawyer's Association).

Surety/Third Party Services Comment

- Shelly Martin (Traveler's Insurance) indicated that an attorney fee dispute is likely holding up injured worker funds. Martin would support a fourteen-day deadline as reasonable. (6/24/24 Meeting).

§ 803.01 MEDICAL FEES – GENERAL PROVISIONS FOR MEDICAL FEES

PROPOSED RULE

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)

COMMENTS

Surety/Third Party Services

- SIF proposes adopting the CMS annual Clinical Laboratory Fee Schedule (CLFS) and billing guidelines. (*Written Comment 7/31/24* - Tresa Brown, Cost Containment Manager, SIF – Idaho Worker's compensation).

- Debra Northrup, CorVel, suggested more extensive changes to the fee schedules and rules than are currently proposed. Many of these changes request greater specific inclusion of Medicare guidelines or variation from those guidelines based on commercial standards. Northrup proposed a number of specific wording changes or standards to be adopted. Northrup proposed adopting the Clinical Laboratory Fee Schedule, Anesthesia Base Relative Value Units, a number of other specific fee schedules and tables, taking the Milliman report under consideration, and assessing policy differences. (*Written Comments 6/24/24, 6/25/24, 7/31/24* - Debra Northrup, Bill Review Manager, CorVel Corporation, Denver CO).

- Debra Northrup, CorVel, makes a number of comments relating to disputes between providers and sureties, and inquires if the clinical lab fee schedule or the Medicare DMEPOS fee schedule are incorporated through this. (7/11/24 Meeting). Patti Vaughn (Industrial Commission) responds that the statute specifically prohibits going to the clinical laboratory fee schedule when it comes to the physician fee schedule. (7/11/24 Meeting).

§ 803.02 MEDICAL FEES - ACCEPTABLE CHARGES FOR MEDICAL SERVICES PROVIDED BY PHYSICIANS UNDER THE IDAHO WORKER'S COMPENSATION LAW

PROPOSED RULE

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)

COMMENTS

Hospital/Medical Provider Comments

- A doctor from primary health commented that inflation has increased and it is difficult to maintain a viable clinic. Reimbursement rates from payers 99212-99214 must increase. (*Written Comment 5/20/24* - Stephen Martinez, M.D., Occupational Medicine, Primary Health Medical Group).

- A hospital representative requested modifies 80 and 81 be unchanged, as removing these modifiers would result in 16% reduction of payment to the physician fee schedule (*Written Comment 7/17/24* - Deanna Coy, Revenue Cycle Analyst, St. Luke's Health System).

- A hospital representative requested RBRVS be reviewed for increases. (*Written Comment 7/17/24* - Deanna Coy, Revenue Cycle Analyst, St. Luke's Health System)

Surety/Third Party Services Comments:

- Stephanie Butler, SIF, indicated that SIF supports the addition of subsection three for clarity and consistency. Ms. Butler indicated that SIF supported the removal of the two stricken sections. (6/24/24 Meeting).

  *This comment was made regarding a draft which struck the entirety of 803.02.b. None of these strikes were kept in the 7/29/24 draft.

- SIF proposes adopting the CMS-Medicare Physician Fee Schedule instead of the Resource-Based Relative Value Scale published by CMS. SIF supports striking the modifiers in subsection (b) and supports keeping the conversion factors in subsection (c). (*Written Comment 7/31/24* - Tresa Brown, Cost Containment Manager, SIF – Idaho Worker's compensation).

- Tresa Brown, SIF, inquires about the possibility of adopting a fee schedule from CMS for pathology and laboratory. (7/11/24 Meeting). Debra Northrup, CorVel, comments on differences between other areas of practice and worker's compensation in how those schedules work. (7/11/24 Meeting).

- Debra Northrup (CorVel) suggested more extensive changes to the fee schedules and rules than are currently proposed. Many of these changes request greater specific inclusion of Medicare guidelines or variation from those guidelines based on commercial standards. Northrup proposed a number of specific wording changes or standards to be adopted. Northrup proposed adopting the Clinical Laboratory Fee Schedule, Anesthesia Base Relative Value Units, a number of other specific fee schedules and tables, taking the Milliman report under consideration, and assessing policy differences. Northrup proposed a set of different conversion factors, dollar values in impairment ratings, and specific fees or unit values for certain codes. Northrup made proposals regarding outpatient hospital facility fees and charges. Northrup also proposed reorganizing headings for prescription drugs and establishing fees consistently. (*Written Comments 6/24/24, 6/25/24, 7/31/24* - Debra Northrup, Bill Review Manager, CorVel Corporation, Denver CO).

- Debra Northrup, CorVel, commented that coding guidelines and payment policies are different things. If you are going to follow Medicare's modifier 50 definition and policy, then say that. Otherwise, there is no guidance on whether to pay these differently. Northrup discussed modifier 81 from AMA CPT as an example. Northrup agrees with adoption of codes, but states this does not clarify the use of modifiers. Northrup states there is an education process to know exactly what should be paid for a given code and modifier scenario, which may or may not be allowed by Medicare under CMS guidelines. (6/24/24 Meeting).

- Debra Northrup, CorVel, inquired about acceptable charge issue and reasonableness. proposed changes to billing prescription drugs. Northrup commented on modifiers for

CRNA and anesthesiology billing. Shelly Martin, Traveler's Insurance, agreed with Northrup and indicated they receive the most pushback on anesthesia bills, so clarification would help providers. (6/24/24 Meeting).

- Debra Northrup, CorVel, referred to her written proposals and comments for specific codes and conversion factors related to work hardening conditions, impairment ratings, the E&M conversion factor, platelet rich plasm, and surgery conversion. (6/24/24 Meeting). Northrup commented that for critical access hospitals inpatient she would leave critical access hospitals inpatients as a percentage of bill charges, drop the percentage on implantable hardware, and have a separate category for the outpatient side of critical access hospitals. (6/24/24 Meeting). Northrup agreed with paying outpatient physical, occupational, and speech therapy services under the RVRBS physical medicine fee schedule. (6/24/24 Meeting). Northrup commented on the difficulty of determining certain status indicators and referenced her written proposals. (6/24/24 Meeting).

- Debra Northrup, Corvel, commented on subsection 803.02.b.iii as it related to Medicare regulations. (6/24/24 Meeting).

- Debra Northrup, CorVel, comments that modifies taken from other sources should also take the policy from those sources. Northrup objects to removal of the modifiers as they provide clarity to the CMS billing process, and removal will potentially result in problems when two different medical personnel work together to perform the same task. Northrup references details regarding the CMS and AMA guidelines, the Medicare payment standards, and how those codes and modifiers interact in situations such as arthroscopy or anesthesia. Northrup states that including the modifiers gives clarity in those situations. (7/11/24 Meeting). Northrup inquires about umbrella modifiers. (7/29/24 Meeting).

- SIF also objects to the removal of modifiers. (7/11/24 Meeting).

§ 803.02.(e) MEDICAL FEES – SERVICES WITHOUT A CPT CODE RVU OR CONVERSION FACTOR

PROPOSED RULE

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)

COMMENTS

NOTE: comments on this section overlap with those relating to the definition of usual and customary in § 010.

Surety/Third Party Services Comments

- Debra Northrup, CorVel, comments on difficulties related to provider billing when the schedules do not govern and the standard is through the 90th percentile rule or the usual and customary rule. Northrup comments that the 90th percentile is unreasonable, and the 80th percentile is reasonable. (7/11/24 Meeting).

- Tresa Brown, SIF, agrees that the 90th percentile should be lowered, and prefers the 75th percentile. (7/11/24 Meeting). Markup can be 700% for a DME, she prefers having a usual and customary standard have a percentage. (7/11/24 Meeting).

Medical Provider Comments

- There is currently some confusion over whether the charge on a physician bill is generally allowed based on the status indicator and is not included in the code ranges that have been assigned a conversion factor, are they allowed per the billed charge. Sureties and providers run into issues with application of other codes and status indicators. (*Written Comment 5/17/24* - Allison Sargent, Contract Management Clerk, Mountain View Hospital/Idaho Falls Community Hospital).

§ 803.02.(f) MEDICAL FEES - MEDICINE DISPENSED BY PHYSICIANS

PROPOSED RULE

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% 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. (3-23-22)

COMMENTS

Surety/Third Party Services Comments

Several sureties objected to the higher costs for medicines dispensed directly by physicians that can be obtained more economically from pharmacies or over the counter. Comments suggested requiring that surety approval be obtained before a physician dispenses medication, bar physician dispensing, or apply some other cap to limit costs. (7/11/24, 7/29/24 Meetings). These changes were opposed by medical providers.

- Chris Wagener, Intermountain Claims, comments on the greater expense of physician dispensed items that can be obtained less expensively, or ever over the counter. (7/11/24 Meeting). Medical products such as lidocaine patches should be $25 but can be dispensed from doctor's offices at charges of $2500. Durable medical equipment is sometimes rented from the doctor's office and that rental will be renewed indefinitely even after it surpasses the cost of buying the item. (7/11/24 Meeting). Wagener approves of the changes proposed in the July 29, 2024, draft. (*Written Comments 8/1/24* - Chris Wagener, Worker's Compensation Supervisor, Intermountain Claims, Inc. Boise ID).

- Shelly Martin, Traveler's Insurance, comments that medical products dispensed from doctor's offices may be prescribed at prescription levels, but will still not reflect the lesser cost available at the pharmacy through the AWP. The LidoPro pads can cost $1,500 to $2,000 for a month's supply. (7/11/24 Meeting). Where physicians get a benefit from the prescription company for dispensing out of their office, this affects what and how much the physician is prescribing. (7/11/24 Meeting). Martin comments that requiring authorization will not address the issue; the physicians that use these tactics have ready workarounds such as a form letter stating they are avoiding narcotics. This is not happening in regular insurance cases, just worker's compensation. She would be in favor of barring physician dispensing and requiring medications come from the pharmacy. Physicians are only prescribing these expensive topical medications, and rarely prescribe other types of medication. (7/11/24 Meeting).

- Tresa Brown states that physicians will select the NDC with the highest RVU or the highest reimbursement when self-dispensing, resulting in the surety paying $2,700 versus $14 if they gone to a pharmacy. She would be in favor of requiring authorization for physician dispensing as the first approach. Alternatively, she would prohibit physician dispensing. (7/11/24 Meeting).

- SIF proposes adding the sentence "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." (*Written Comments 7/31/24* - Tresa Brown, SIF Cost Containment Manager, Idaho Worker's Compensation).

- Healthe Systems supports restricting physician dispensing, which presents risks to safety, quality of care, and cost containment. Eight states provide limits on physician dispensing. Concurrent use of benzodiazepines with opioids has been highlighted for both higher payment distribution and relation to overdose deaths. Healthe provides a draft of potential language, and disagrees with the language as put forth in the Commission's July 29, 2024 draft as ambiguous. In particular, Healthe objects to the language "significantly lower-cost therapeutic equivalent," and instead advocates using "lesser of" language as it is used in many worker's compensation fee schedules. Healthe advocates using the same approach to repackaged drugs. (*Written Comment 7/31/24* - Isabel Hernandez, Advocacy & Compliance Analyst, Healthe Systems).

- Unknown/unintelligible audio: commenter states that Colorado dropped the payment for these to the values set for over the counter and would propose that the payment value be set as the lowest value of AWP of similar things/bioequivalents. (7/11/24 Meeting).

Attorney Comments

- Adam Fowler, defense attorney Optum Workers' Comp. and Auto, comments that physicians are specifically choosing individual NDC's or topical meds that have higher actual sale price values (AWP values) than what would typically be dispensed by a pharmacy. This permits working around rule language that limits costs for the pharmacy, which would provide a lower cost NDC. Fowler agrees that this is a loophole in worker's compensation that is not present in regular insurance, and Medicare in certain states will not pay for any physician dispensing. States have attempted to tackle this issue through approaches such as prior authorization requirements or capping topical medications at a dollar amount. Colorado put dollar caps on topical meds or certain types of topical meds. Regulations addressing packaged/prepackaged topical medications do not work as the NDC's are nonrepackaged from a manufacturer. Selection of NDCs is intentional to increase reimbursement. (7/11/24 Meeting).

Medical Providers

- The Idaho Medical Association opposed suggestions that prior authorization from a physician be required to deliver medication, as the rule delays care or even challenges or controls what medication is dispensed by a physician. (*Written Comment 7/26/24* - Mary Barinaga, MD, Idaho Medical Association President).

- Hospital comments that the rule currently provides that an acceptable charge is based on the AWP, but the hospital cannot always determine what calculations sureties are using to provide a lesser amount than is billed. (*Written Comment 5/17/24* – Allison Sargent, Contract Management Clerk, Mountain View Hospital/Idaho Falls Community Hospital).

§ 803.03 MEDICAL FEES - ACCEPTABLE CHARGES FOR MEDICAL SERVICES PROVIDED BY HOSPITALS AND AMBULATOR SURGERY CENTERS UNDER THE IDAHO WORKER'S COMPENSATION LAW

PROPOSED RULE

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)~~

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.

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

COMMENTS

Hospital Comments

- § 803.03.(c) - Hospital requests that charges align with CMS guidelines showing that outpatient hospitals and ASC's will get a percentage of the Medicare APC rate while leaving the implantable hardware with separate and unchanged reimbursement. (*Written Comment 12/12/23* - Proposed by Laurie Soliday, Contract Management Lead Mountain View Hospital/Idaho Falls Community Hospital).

- Hospital stated that "the reimbursement we should be receiving based on the regulations currently outlined in IDAPA is definitely fair and appropriate." However, calculating that reimbursement can be unclear for physicians. Specific disagreements with sureties on how coding should be assigned results in lower payments than the hospital believes the regulations require. For instance, sureties assign surgery charges based on total charges rather than line by line, bundle J2 and S codes with other status indicators, and use a physician's bills conversion factor for therapies at facilities. (*Written Comment 5/17/24* - Allison Sargent, Mountain View Hospital).

- A representative from Primary Health Medical Group stated that payors will not pay all dates of services on an accepted claim, and some payors will not pay certain codes (*Written Comment 5/20/24* - Lisa Corsi, Provider Enrollment Specialist, Primary Health Medical Group).

- A hospital representative requested a distinction be made between professional, facility, and critical access rules as currently payors/pricing companies are applying professional reduction to critical access. Also, outpatient physical, occupational, and speech are being billed on the UB form and the hospital expects facility pricing, not professional pricing. (*Written Comment 7/17/24* - Deanna Coy, Revenue Cycle Analyst, St. Luke's Health System)

Surety/Third Party Services Comments

- Debra Northrup, CorVel, requests that CAH's be dropped from 90 to 80%, and implants be dropped from 50 to 20%. (7/11/2024 Meeting).

- Tresa Brown, SIF, supports the additional language added to subsection 803.03.(c)(i) providing that services without an APC weight will receive 75% reasonable charge as the cost except when bundled with another service. (7/11/24 Meeting). Debra Northrup, CorVel, also supports this language. (7/11/24 Meeting).

- Debra Northrup, Corvel, and Tresa Brown, SIF, comment on status codes J1 and T1 and agree that language in subsection 803.03.(c)(2) does not need to be there. (7/11/24).

- Debra Northrup, Corvel, proposes cost reductions related to implants. (7/11/24).

- SIF proposes adopting 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. For both inpatient and critical access hospitals, SIF also proposes lowering implantable hardware charges from actual cost plus 50% to actual cost plus 10%, handling and freight charges included in the invoice cost. SIF supports adding the language in 03.c.i. and iii. SIF supports striking subsection 04.(2)(iii) along with the language being cut in 04.c.iii.(2)and 04.c.iv. (Tresa Brown, Cost Containment Manager, SIF Idaho Worker's Compensation).

- SIF suggests adopting 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 would be actual cost plus 30% or party agreement. (Tresa Brown, Cost Containment Manager, SIF Idaho Worker's Compensation).

§ 803.04 MEDICAL FEES - ACCEPTABLE CHARGES FOR MEDICINE PROVIDED BY PHARMACIES

PROPOSED RULE

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)

COMMENTS

Surety/Third Party Services Comment

- Debra Northrup, Corvel, inquired about proposed fees for physician adjustment from a coding perspective and suggested paying injectables by Average Sale Price. (6/24/24 Meeting; 7/11/24 Meeting). Northrup proposed rule language addressing costs for certain types of medications if dispensed by a physician, defining significantly lower costs, and addressing over the counter medications. (*Written Comments 6/24/24, 6/25/24, 7/31/24* - Debra Northrup, Bill Review Manager, CorVel Corporation, Denver CO).

§ 803.05 MEDICAL FEES - ACCEPTABLE CHARGES FOR MEDICAL SERVICES PROVIDED BY OTHER PROVIDERS UNDER THE IDAHO WORKER'S COMPENSATION LAW

PROPOSED RULE

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.

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

COMMENTS

Surety/Third Party Services Comments

- Chris Wagener, Intermountain Claims, comments that equipment rentals will be mandated by the physician office, who refuse to sell the device. The rental can end up costing twice what purchasing the device would. His surety paid more for a shoulder continuous ice compression unit than for a total shoulder replacement. He suggests giving ownership after a certain threshold has been met. The surety does not pay an exorbitant price, and the patient has that device if they ever need it again. (7/11/2024 Meeting). Wagener approves of changes in the July 29, 2024, draft dealing with rentals. (*Written Comment 8/1/24* - Chris Wagener, Worker's Compensation Supervisor, Intermountain Claims, Inc. Boise ID).

- Debra Northrup, CorVel, agrees with restricting costs for equipment rentals. She states Medicaid allows rental fees only up to the costs of the device. She also notes that some devices would typically be bundled up within the cost of a surgery, but are being supplied by a separate company to be billed separately. Automatic monthly billing is a problem, and the surety may receive monthly billing for supplies where the patient has not used the last supply. She would like to see the Commission adopt a durable medical fee schedule; CMS has a fee schedule for all states per zip code that covers 90%. After that, you could use the usual and customary charge or permit negotiations. (7/11/24 Meeting).

- Debra Northrup, CorVel, expresses support with the draft as presented at the 7/29/24 meeting, adding language that the DME is cost plus ten percent. (7/29/24 Meeting).

- Tresa Brown, SIF, agrees that durable medical equipment should be rent-to-purchase. She is not opposed to renting up to the purchase price and taking the CMS standards for 10% above purchase or the automated TENS unit. She recommends adopting CMS fee schedules related to this and bundling. (7/11/24 Meeting).

- Debra Northrup, Corvel, commented on defining physician/non-physician provider if they would be paid at the professional fee schedule or at the acceptable reasonable charge. (6/24/24 Meeting).

- Debra Northrup, CorVel, proposed adding language giving payors the option to rent or purchase durable medical equipment, and limiting maximum costs for rented equipment at 10% of the invoice cost, at which point the item would be considered purchased and owned by the claimant (*Written Comment 7/31/24* - Debra Northrup, Bill Review Manager, CorVel Corporation, Denver CO).

- Shelly Martin, Traveler's Insurance, would propose adding a reasonable charge for an interpreter based on what is used for Medicaid. (6/24/24 Meeting). Debra Northrup, CorVel, commented there are T codes for interpreters on the billing standard spectrum. (6/24/24 Meeting).

§ 803.06 Medical Fees - Dispute Resolution

PROPOSED RULE

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.
(3-23-22)

Other portions of the rule consistently apply a 30-day deadline for responses and requests as part of the dispute resolution process, but are not included here due to length.

COMMENTS

Surety/Third Party Services Comments

- Tresa Brown, SIF, requested that providers be given a deadline from the date of service to submit a bill. They are currently receiving bills five years after service. In the commercial end and under CMS standards, providers have 90 days to one year to submit the bill. (7/11/24 Meeting). SIF supports adding the time periods as amended in the July 29, 2024, draft. SIF would also support adding a sentence that subsection 6 does not govern disputes regarding Preferred Provider Organization (PPO) reductions. PPO reductions are between Provider of Services and their PPO Networks contracts. (*Written Comments 7/31/24* - Tresa Brown, Cost Containment Manager, SIF Idaho Worker's Compensation)

- Debra Northrup, CorVel, supports SIF's request that providers have a deadline to submit a bill, such as a year. If a claim was initially denied, the clock could start when the claim was accepted. (7/11/24 Meeting).

- Shellie Martin, Traveler's Insurance, supports a deadline to submit a bill, even up to two years. (7/11/24 Meeting).

- Chris Wagner, Intermountain Claims, and Cindy Weigel, Intermountain Claims, express support for replacing the language "industrial cause" with "industrial nature." (7/29/24 Meeting). Chris Wagener, Intermountain Claims, would replace the phrase "industrial

cause of the injury" with "industrial nature of the injury." (*Written Comment 8/1/24* - Chris Wagener, Worker's Compensation Supervisor, Intermountain Claims, Inc. Boise ID).

- Chris Wagener, Intermountain Claims, requests that a provider's fee dispute filing be required to name the surety rather than the claims administrator. The claims administrator often has multiple clients. (7/11/24 Meeting).

- Tresa Brown, SIF, requests that regulations deal with PPO reductions, as providers come after the surety for the PPO reduction after the bill has already been paid according to the fee schedules. Debra Nothrup, CorVel, comments on contractual issues and agrees this is an issue. (7/11/24 Meeting).

- Healthe Systems strongly supports the 12-month timely filing deadline proposed in the July 29, 2024, draft of the rules. (*Written Comment 7/31/24* - Isabel Hernandez, Advocacy & Compliance Analyst, Healthe Systems).

- Debra Northrup, CorVel, proposes language that bills or billing disputes submitted after 120 days are not eligible for dispute resolution, and bills or billing disputes submitted after 1 year are not compensable. (*Written Comment 7/31/24* - Debra Northrup, Bill Review Manager, CorVel Corporation, Denver CO). At an earlier stage in the negotiated rulemaking process, Northrup advocated adoption of proposed language for a provider and payor appeal process that differs from the current procedure. Northrup also proposed adopting standardized billing formats and different payor timelines and requirements. (*Written Comments 6/25/24, 6/26/24* - Debra Northrup, Bill Review Manager, CorVel Corporation, Denver CO).

Hospital Comments

- Hospital requests changes to the JRP rules that "Carve out the rules better for providers when a claim is in litigation." (*Written Comment 12/12/23* - Laurie Soliday, Contract Management Lead Mountain View Hospital/Idaho Falls Community Hospital).

- Hospital requests changes in medical care provider vs. worker's compensation surety dispute resolution, to increase provider and insurance response times from 30 to 45 days. (*Written Comment 12/12/23* - Laurie Soliday, Contract Management Lead Mountain View Hospital/Idaho Falls Community Hospital; *Written Comment 5/17/24* - Allison Sargent, Mountain View Hospital).

- Hospital requests clarification on effect of deadline for submitting billing disputes to the Commission. After 120 days, the Commission will no longer receive disputes over worker's compensation bills between sureties and medical providers. Some sureties have interpreted this deadline to mean a surety may refuse to pay a bill submitted after 120 days. (*Written Comment 5/17/24* - Allison Sargent, Mountain View Hospital).

Attorney Comments

- Emma Wilson, defense attorney, requests that where the rule states the industrial “cause” of the injury is unknown, the rule instead state industrial “nature” of the injury. (7/29/24 Meeting). Chris Wagner, Intermountain Claims, expresses support for replacing the language “industrial cause” with “industrial nature” citing that these are different questions. Cindy Weigel, Intermountain Claims, concurs. (7/29/24 Meeting).

MISCELLANEOUS OR GENERAL COMMENTS

- The Commission inquired how the industry felt about hyperlinks in the rule. The consensus was it would be acceptable. (11/8/23 Meeting).

- The Idaho Trial Lawyer's Association expressed general support for the rules proposed in the July 29, 2024, draft, with one disagreement on subsection 802.03.(c) regarding extending the 30 day time period to submit a charging lien. (*Written Comment 8/1/24* - Barbara Jorden, Idaho Trial Lawyer's Association).