

State of South Carolina

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Workers' Compensation Commission

MEMORANDUM

TO: COMMISSIONERS

FROM: Gary Cannon
Executive Director

DATE: January 18, 2021

RE: Medical Services Provider Manual

The Commission is required to update the Medical Services Provider Manual annually, with the new rates and policy changes effective April 1. In order to provide you ample time to review the recommended changes and allow the stakeholders to provide public comment we present the recommended changes at the January Business Meeting. Wayne Ducote and Bridgette Amick of our staff have been working with representatives of Fair Health a national, independent, not-for-profit organization since September 2020. Fair Health representatives include Christine O'Donnell, Dr. Joel Brill, Linda Stelmach, Lydia Muna and Donna Smith.

Attached you will find the following documents

- Fee Schedule Analysis 2021
- Summary of Changes to the Medical Services Provider Manual for 2021
- An Analysis of the Anesthesia Conversion Factor 2021
- A copy of "Medical Services Provider Manual 2021", with changes to the policy text

Staff will post these documents on the Commission's website and send an Advisory Notice to all stakeholders giving notice of the public comment period and the documents availability on the Commission's website.

Staff recommends the Commission schedule a time at the February Business Meeting to receive public comment from stakeholders on the proposed changes. Further we recommend the Commission approve any changes Conversion Factor and changes to the policy text in the Medical Services Provider Manual at the March Business Meeting.



Fee Schedule Analysis

January 13, 2021

FAIR Health appreciates the opportunity to assist the South Carolina Workers' Compensation Commission in updating the Medical Services Provider Manual (MSPM). This analysis uses medical call data (2019 dates of service) provided by the National Council on Compensation Insurance, Inc. (NCCI) and South Carolina maximum allowable payment (MAP) amounts to develop conversion factors and propose MAP values for the 2021 fee schedule.

FAIR Health received paid amounts from NCCI for the 2019 calendar year, aggregated at the procedure code/modifier level. FAIR Health used the data from 2019 to:

1. Develop a "fee schedule-neutral" conversion factor designed to reflect a similar level of spending based on 2020 MAP amounts; and
2. Project paid amounts for 2021 based on multiple conversion factor alternatives.

For 2021, CMS increased RVUs for office visits for new and established patients, CPT codes 99202-99205 and 99212-99215. These codes reflect some of the most frequently performed services in the South Carolina workers' compensation program. To maintain budget neutrality and offset the increased reimbursement for evaluation and management services, CMS significantly reduced the 2021 conversion factors for both professional services and anesthesia. The South Carolina statutory cap of +/- 9.5% on changes from rates from the prior year's MSPM in part controls some of these changes. The updated RVUs and South Carolina caps on rate changes are embedded in the projections presented below.

On December 27, 2020 the Consolidated Appropriations Act, which includes pandemic relief and national budget provisions, was signed into law. The Act includes provisions that defer use of a complexity adjustment for evaluation and management procedures and mandates an increase to the Medicare conversion factors for 2021. To comply with these changes and maintain budget neutrality, CMS recalculated the conversion factors for 2021, which were updated on January 7.

The information in this report is based on conversion factors published by CMS on January 7, 2021.

2019 Paid Data and Frequencies

The following is a summary of the 2019 data received from NCCI:

NCCI Data Call - 2019 Calendar Year (Before Validation)

Service Type	Total Paid	Total Charged	Transactions	Units
CPT (Without Anesthesia)	\$56,724,510.07	\$121,604,885.32	693,636	962,897
Anesthesia*	\$1,595,861.29	\$9,166,281.92	6,072	666,175
HCPCS (Without Ambulance)	\$16,816,157.03	\$24,016,642.04	69,062	1,595,262
Ambulance**	\$2,613,438.44	\$4,792,517.52	13,917	346,230
Total	\$77,749,966.83	\$159,580,326.80	782,687	3,570,564

* Assumes most units are minutes

** Assumes most units are miles

Data Used in the Analysis

FAIR Health used the following methodology to analyze the NCCI data and project future payments based on fee schedule MAPs:

- The NCCI paid data from 2019 were used to determine the number of occurrences (frequency) for each service.
- Services were reviewed at the procedure code/modifier level to account for differences in paid amounts based on fee schedule MAP amounts and policies. For example:
 - The occurrences for codes reported with modifier 26 and TC were projected separately, based on the MAP amounts in the fee schedule.
 - HCPCS Codes reported with modifiers NU (new), UE (used) and RR (rental) were projected separately based on the occurrences in the NCCI data and fee schedule MAP values.
 - Records with other modifiers or with modifiers NU, UE and RR appended to codes where these modifiers are not applicable and/or expected were considered as though the records did not contain modifiers.
 - Services containing modifiers that are paid at adjusted amounts according to South Carolina policies (assistant surgeon modifiers 80-82 and AS) were projected based on 2019 occurrences and adjusted MAP amounts.

Fee Schedule-Neutral Conversion Factor- 2020 Projections

- Total dollar amounts were projected based on 2019 occurrences and 2020 RVUs.
- Using these frequencies and RVUs and incorporating the +/- 9.5% cap on MAP increases and decreases compared to the prior year where applicable, FAIR Health calculated a conversion factor designed to maintain spending at the 2019 level for each service area.
- The total fee schedule budget neutral conversion factor is 41.09.
- Ambulance data is paid at 100% of Medicare and is not included in this analysis.
- Please see the separate analysis for anesthesia data.

2020 Projections

Category	Frequency	Total 2020 RVUs	NCCI Payment	Budget Neutral Conversion factor
Evaluation and Management	127,182	307,602	\$13,815,061.31	44.91
HCPCS Level II	179,967	147,573	\$5,044,921.00	34.19
Medicine & Injection	14,830	28,971	\$1,336,460.26	46.13
Pathology & Laboratory	12,064	9,758	\$499,016.75	51.14
Physical Medicine	705,857	622,537	\$22,684,937.91	36.44
Radiology	51,896	89,301	\$4,571,755.77	51.19
Special Reports	1,114	1,281	\$58,787.28	45.89
Surgery	34,520	253,559	\$11,997,981.53	47.32
Total	1,127,430	1,460,582	\$60,008,921.81	41.09

The relatively low conversion factor in this analysis is influenced by payments that are lower than fee schedule MAPs for certain high frequency codes in the physical medicine and HCPCS service areas. The lower payments in the physical medicine section may be related to network contracts. Payment for boxes of alcohol wipes and pairs of electrodes at rates lower than fee schedule MAPs may be influencing the conversion factor for the HCPCS section. In addition, NCCI paid data reflect significant payments for codes that are paid based on “individual consideration”.

Because the HCPCS and Physical Medicine sections have high frequencies relative to other service areas, these anomalies have a large influence on the budget neutral conversion factor.

Comparison of Alternate Conversion Factors – 2021 Projections

- The projections of paid amounts for the 2021 fee schedule are based on 2019 frequencies and 2021 RVUs, to which conversion factors of 48.85* (equal to 140% of the CMS conversion factor), 49, 50, 50.3 (the current South Carolina conversion factor), 51 and 52 were applied. The cap of +/- 9.5% of the prior year’s MAP value for each service was applied, when appropriate, in providing these projections.
 - * While not mandated, the South Carolina conversion factor has generally been targeted to 140% of the CMS conversion factor (or 48.85)
- The 2021 MAP values used for these projections include certain changes in how services not covered under the Medicare Professional Fee Schedule were valued:
 - If a service is not valued in the Medicare Physician Fee Schedule, FAIR Health determined whether the service was valued by another Medicare fee schedule (e.g., the Clinical Laboratory, DMEPOS or Average Sales Price fee schedule). FAIR Health used Medicare values in the analysis whenever a Medicare value was available.
 - If Medicare did not provide a professional value in *any* fee schedule for a service, FAIR Health gap filled the value using FAIR Health benchmark values or FAIR Health’s FH® Medicare GapFill PLUS product.
 - FAIR Health does not recommend that the State establish gap fill values for new codes effective January 1, 2021 that were not valued by Medicare. Setting a gap fill value before actual claims information has been received could set an inappropriate baseline against which the +/-9.5% cap would be applied in future years. FAIR Health will evaluate those codes and, based on the claims received during calendar year 2021, propose gap fill values for the 2022 MSPM.

2021 Projections

Category	Total \$ 2021 with CF = 48.85	CF48.85	Total \$ 2021 with CF = 49	CF49	Total \$ 2021 with CF = 50	CF50	Total \$ 2021 with CF = 50.3	CF50.3	Total \$ 2021 with CF = 51	CF51	Total \$ 2021 with CF = 52	CF52
Evaluation and Management	\$16,580,930	45.50	\$16,597,120	45.5	\$16,704,653	45.8	\$16,736,705	45.9	\$16,792,843	46.1	\$16,841,034	46.2
HCPCS Level II	\$7,586,940	51.10	\$7,592,333	51.1	\$7,628,523	51.3	\$7,639,381	51.4	\$7,664,718	51.6	\$7,699,361	51.8
Medicine & Injection	\$1,521,768	48.50	\$1,524,799	48.6	\$1,544,866	49.3	\$1,550,826	49.5	\$1,562,423	49.8	\$1,576,597	50.3
Pathology & Laboratory	\$503,374	49.30	\$504,869	49.4	\$513,738	50.3	\$516,728	50.6	\$523,477	51.2	\$529,189	51.8
Physical Medicine	\$31,026,622	48.80	\$31,109,533	48.9	\$31,671,765	49.8	\$31,840,650	50.0	\$32,231,889	50.7	\$32,791,291	51.5
Radiology	\$4,532,432	49.10	\$4,545,890	49.2	\$4,634,765	50.2	\$4,661,234	50.5	\$4,717,725	51.1	\$4,782,935	51.8
Special Reports	\$65,075	48.90	\$65,270	49.0	\$66,565	50.0	\$66,952	50.3	\$67,860	51.0	\$69,150	52.0
Surgery	\$12,921,333	49.00	\$12,959,079	49.1	\$13,209,367	50.1	\$13,284,334	50.4	\$13,454,249	51.0	\$13,677,471	51.8
Grand Total	\$74,738,474	48.26	\$74,898,893	48.36	\$75,974,242	49.06	\$76,296,810	49.27	\$77,015,184	49.73	\$77,967,028	50.34

Upon approval of a conversion factor for 2021, FAIR Health will provide an updated Medical Services Provider Manual, which will include any approved changes in policies and a final set of rate tables.

Please let us know if you have any questions.

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Summary of Changes

2021 Medical Services Provider Manual

January 13, 2021

FAIR Health has completed the revisions to the fee schedule under the direction of the South Carolina Workers' Compensation Commission (WCC). The codes in the existing fee schedule have been brought current by including codes established for 2021 and deleting obsolete codes. Maximum allowable payment (MAP) amounts will be updated based on the conversion factors adopted by the Workers' Compensation Commission. In addition to administrative changes such as updating copyright dates and URL links, substantive changes to the text, which are outlined below, are included in the proposed version of the 2021 Medical Services Provider Manual (MSPM). Page numbers refer to the pages in the South Carolina MSPM effective April 1, 2020.

Where applicable, new text is underlined and deleted text is marked with a ~~strikethrough~~.

1. Chapter II. General Policy

Copies of Reports and Records (Page 9) - Language is updated to provide clarity and match the Copies of Reports and Records text on page 483 of in Section 8, Special Reports and Services.

COPIES OF REPORTS AND RECORDS

Providers are entitled to charge for the cost of copying records and reports except when such documents are requested by the Commission or for the purpose of substantiating a charge and/or medical necessity. (See Appendix A for S.C. Code Section 42-15-95 and Regulation 67-1301.)

~~The maximum charge for providing records and reports other than for substantiating medical necessity is \$25.00 for a clerical fee plus \$0.65 per page for the first 30 pages **in Print or Electronic format**, and \$0.50 per page thereafter provided *in an electronic format*, which may not exceed \$150.00 per request, plus sales tax, and actual cost for postage to mail the documents. Providers must respond to a request for copies within 14 days of receipt or face a penalty of up to \$200.00. Section 42-15-95 of the S.C. Code, which governs charges for copies, can be found in Appendix A.~~

Providers are required to include supporting documentation when submitting claims, or when required by an insurance carrier, self-insured employer, or the Commission to submit substantiating documentation, and may not charge for these required reports. (See Regulation 67-1302 B(2).) However, when the records or reports are not for the purposes listed above, providers may charge for copying costs. Copying charges are \$0.65 per page for the first 30 pages provided in *electronic format*, and \$0.50 per page thereafter provided *in an electronic format, which may not exceed \$150.00 per request, plus a clerical and handling fee of \$25.00 plus tax and actual postage costs. Providers must respond to a request for copies within 14 days of receipt or face a penalty of up to \$200.00. Section 42-15-95 of the S.C. Code, which governs charges for copies, can be found in Appendix A. Providers are entitled to charge for the cost of copying records and reports except when such documents are requested by the Commission or for the purpose of substantiating a charge and/or medical necessity.*

Providers are required to include supporting documentation when submitting claims, or when required by an insurance carrier, self-insured employer, or the Commission to submit substantiating documentation, and may not charge for these required reports. (See Regulation 67-1302 B(2).)

However, when the records or reports are not for the purposes listed above, providers may charge for copying costs. Copying charges are \$0.65 per page for the first 30 *printed* pages, and \$0.50 per *printed* page thereafter, *which may not exceed \$200.00 per request*, plus a clerical and handling fee of \$25.00 plus tax and actual postage costs. Providers must respond to a request for copies within 14 days of receipt or face a penalty of up to \$200.00. Section 42-15-95 of the S.C. Code, which governs charges for copies, can be found in Appendix A. Providers are entitled to charge for the cost of copying records and reports except when such documents are requested by the Commission or for the purpose of substantiating a charge and/or medical necessity.

A facility or provider may charge a patient or the patient's representative no more than the actual cost for duplicating an x-ray film or digital image. Actual cost means the cost of materials and supplies used to duplicate the x-ray film or digital image and the labor and overhead costs associated with the duplication.

Providers who use a medical records company to make and provide copies of medical records or x-ray images must ensure that neither the Commission nor the reviewer is billed for the cost of copies when the purpose of the copies is to substantiate a charge and/or medical necessity.

Note: Providers do not need to obtain authorization from the injured worker to release medical records relating to a workers' compensation claim. An employee who seeks treatment under the provisions of the Workers' Compensation Act is considered to have given consent for the release of medical records relating to the examination or treatment.

2. Part II: Fee Schedule

Icons (page 31) – Language is added to the icon for state-specific code to bring attention to a change in code numbers for state specific codes. An additional icon, an asterisk (*), has been added to identify codes that are eligible to be performed via telemedicine.

∞ State-specific code. This code is unique to South Carolina Workers' Compensation Commission. Note that state-specific codes have been assigned new code numbers in the 2021 *Medical Services Provider Manual*.

* Telemedicine-eligible code. This code may be reimbursed when provided via telemedicine.

Telemedicine Policy (page 32) – A temporary telemedicine policy is inserted after the Surgical Assistant section.

Telemedicine

Telemedicine is the use of electronic information and telecommunication technologies to provide care when the provider and patient are in different locations. Technologies used to provide telemedicine include telephone, video, the internet, mobile app and remote patient monitoring. Services provided by telemedicine are identified by the use of location code 02 (telemedicine) and Modifier 95, Synchronous Telemedicine Service, on the bill.

Certain services that are eligible for reimbursement under the *South Carolina Medical Services Provider Manual* when provided by telehealth during the COVID-19 pandemic emergency are identified with an asterisk (*) in the rate tables. Telemedicine may not be used for emergent conditions. The maximum payment for telemedicine services is 100% of the billed charge, not to exceed the non-facility maximum allowable payment (MAP) listed in the rate tables. Service level adjustment factors are applicable based on the licensure of the healthcare professional providing the telemedicine service.

Additional services may be provided via telemedicine with pre-authorization by the payer.

The location for the telemedicine service is defined as the location of the patient/injured worker. Providers must be licensed to practice in South Carolina and telemedicine services may be provided by physicians, physician assistants, psychologists, nurse practitioners, physical therapists, occupational therapists, speech therapists and social workers. Telemedicine activities provided by physical therapy assistants and occupational therapy assistants must be supervised and directed by a physical therapist or occupational therapist, as appropriate, whose license is in good standing in South Carolina.

The South Carolina Workers' Compensation Commission will determine the expiration date of this policy, which will be aligned with the suspension of the COVID-19 Pandemic Emergency.

If the pandemic emergency is lifted prior to March 31, 2022, telemedicine services may be provided with pre-authorization through March 31, 2022.

3. **Section 1: Evaluation and Management (E/M) Services (Page 33)**

Language is included to reflect a change to E/M office visits for new and established patients (CPT 99202-99205 and 99211-99215), effective January 1, 2021, which are defined based on the level of medical decision making defined for each service or the total time spent on the date of service.

Documentation must support the level of E/M service reported.

For complete instructions on identifying and billing E/M services, please refer to the Evaluation and Management Services Guidelines of the ~~2020~~ 2021 CPT book.

~~E/M service descriptors have seven components. These components are: history, examination, medical decision-making, counseling, coordination of care, nature of presenting problem, and time.~~
The appropriate level of E/M service is based on the level of medical decision making defined for each service or the total time spent on E/M services on the date of service.

Evaluation and Management Time

~~The times listed in the code descriptors are averages. Actual time spent by the provider may be slightly higher or lower depending upon the actual clinical circumstances; however, providers should select the CPT code that best describes the amount of time actually spent. Beginning in 2021, time alone may be used to select the appropriate code level of office or other outpatient evaluation and management services, codes 99202-99205 and 99212-99215. For office visits and other outpatient visits, time is based on the amount of time spent face to face with the patient and not the time the patient is in an examining room.~~

For inpatient hospital care, time is based on unit floor time. This includes the time the physician is present on the patient's hospital unit and at the bedside rendering services. This also includes time spent reviewing the patient's chart, writing additional notes, and communicating with other professionals and/or the patient's family.

Additional codes may be reported with the office or other outpatient visit codes to indicate a prolonged visit.

Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the **other** E/M services when counseling and/or coordination of care dominates the service. The appropriate time should be documented in the medical record when it is used as the basis for code selection.

~~Time is used as the controlling factor to select a level of service when more than 50 percent of the patient encounter is spent in counseling and coordination of care. Time spent counseling and the extent of the counseling and/or coordination of care must be documented.~~

4. **Section 3: Surgery (Page 69)**

Correcting a typographical error in the numbering of modifiers for bilateral and multiple procedures.

~~54~~ 50 Bilateral Procedure

~~52~~ 51 Multiple Procedures

5. **Section 8: Special Reports and Services**

Special Reports (Page 483) – Update the language in the first two paragraphs as follows:

A special report may be billed and paid when the provider furnishes information above and beyond that which is required by Commission policy or by the laws and regulations of the South Carolina Workers' Compensation Act. ~~Special Reports~~, CPT® code 99080, special reports, should not be used to bill for completing a report which is included in the CPT descriptor of the service provided ~~or for reporting the results of an impairment rating made during an E/M service.~~ However, CPT code 99080 may be billed in conjunction with, and in addition to, CPT code 99455, work related or medical disability examination, to report the results of an impairment rating made developed during the examination.

Payment for a special report is \$55.00 for a checklist-type report which requires a review of the medical record, and \$70.00 for a written report or for completing the Commission's Form 14B. Prepayment for form or report completion is prohibited.

The purpose of WCC Form 14B Physician's Statement is to consolidate medical information, already existing in the patient's medical file, onto a single, easily referenced document. The Form 14B is a summary of information generated from the patient's previous medical exams, including the diagnosis, date of maximum medical improvement, permanent impairment, work restrictions, retained hardware, and need for future medical care and treatment. The Form 14B must be signed by the treating physician, who is a qualified physician or surgeon.

The Form 14B is required to be submitted when an employer's representative requests an informal conference to approve settlement on a Form 16A pursuant to R.67-802(A)(1)(a); when an employer's representative requests a Form 16A be approved in accordance with R.67-802(A)(2)(a); and when an employer's representative requests an informal conference to approve settlement on a full and final, clincher basis in accordance with R.67-803(B)(1)(a).

The Workers' Compensation Act provides that "...a physician or hospital may not collect a fee from an employer or insurance carrier until the physician or hospital has made the reports required by the Commission in connection with the case." S.C. Code Ann. § 42-15-90(A) (1976, as amended).

Copies of Reports and Records (Page 483) – Update language to provide clarity and match the Copies of Reports and Records language in the General Policies section on page 9.

COPIES OF REPORTS AND RECORDS

Providers are required to include supporting documentation when submitting claims, or when required by an insurance carrier, self-insured employer, or the Commission to submit substantiating documentation, and may not charge for these required reports. (See Regulation 67-1302 B(2).) However, when the records or reports are not for the purposes listed above, providers may charge for

copying costs. Copying charges are \$0.65 per page for the first 30 pages provided in ~~Print or~~ electronic format, and \$0.50 per page thereafter provided *in an electronic format, which may not exceed \$150.00 per request*, plus a clerical and handling fee of \$25.00 plus tax and actual postage costs. Providers must respond to a request for copies within 14 days of receipt or face a penalty of up to \$200.00. Section 42-15-95 of the S.C. Code, which governs charges for copies, can be found in Appendix A. Providers are entitled to charge for the cost of copying records and reports except when such documents are requested by the Commission or for the purpose of substantiating a charge and/or medical necessity.

Providers are required to include supporting documentation when submitting claims, or when required by an insurance carrier, self-insured employer, or the Commission to submit substantiating documentation, and may not charge for these required reports. (See Regulation 67-1302 B(2).) However, when the records or reports are not for the purposes listed above, providers may charge for copying costs. Copying charges are \$0.65 per page for the first 30 *printed* pages, and \$0.50 per *printed* page thereafter, *which may not exceed \$200.00 per request*, plus a clerical and handling fee of \$25.00 plus tax and actual postage costs. Providers must respond to a request for copies within 14 days of receipt or face a penalty of up to \$200.00. Section 42-15-95 of the S.C. Code, which governs charges for copies, can be found in Appendix A. Providers are entitled to charge for the cost of copying records and reports except when such documents are requested by the Commission or for the purpose of substantiating a charge and/or medical necessity. Providers who use a medical records company to make and provide copies of medical records must ensure that neither the Commission nor the reviewer is billed for the cost of copies when the purpose of the copies is to substantiate a charge and/or medical necessity.

Note: Providers do not need to obtain authorization from the injured worker to release medical records relating to a workers' compensation claim. An employee who seeks treatment under the provisions of the Workers' Compensation Act is considered to have given consent for the release of medical records relating to the examination or treatment.

Medical Testimony (Page 484) – Update to reflect new codes, which are not part of the American Medical Association's (AMA) schema.

MEDICAL TESTIMONY

Medical testimony by personal appearance of a physician, whether before a Commissioner or in a court of law, is reported using ~~CPT code 99075~~ South Carolina specific code ~~99076~~ codes SC001 and SC002. Payment is based on the time spent "in court" only. Time for preparation or travel is not considered when determining payment. Use ~~CPT~~ South Carolina specific code 99075SC001 to report the initial hour, and South Carolina specific code 99076SC002 to report each additional quarter hour of medical testimony by personal appearance by a physician. For all other providers, use South Carolina specific code ~~99077~~ SC003.

Medical testimony by deposition of a physician is reported using South Carolina specific service codes ~~99072~~ SC004 and ~~99073~~ SC005. Use South Carolina specific code 99072SC004 to report the initial hour and code ~~99073~~ SC005 to report each additional quarter hour of medical testimony by deposition of a physician. Time is measured based on the actual time spent in deposition. Time spent reviewing records is not considered when determining payment. For all other providers, use South Carolina specific code ~~99074~~ SC006.

6. Section 10: Pharmacy (Page 691)

This section stipulates only those policies and procedures that are unique to Pharmacy. Additional policies and procedures that apply to all providers are listed in Part I of this *Medical Services Provider Manual*.

PRESCRIPTION DRUG MONITORING PROGRAM

Treating physicians prescribing medication or drugs must comply with the requirements of Act 91 enacted by the SC General Assembly May 31, 2017.

REIMBURSEMENT

Payment for prescription drugs is limited to the lesser of the amount established by the following formula, or by the pharmacist's or health care provider's usual and customary charge. The formula applies to both brand name and generic drugs. However, all prescriptions must be filled using generic drugs, if available, unless the authorized treating physician directs that it be dispensed as written. Opioids/scheduled controlled substances that are prescribed for treatment shall be provided through a pharmacy. The dispensing provider shall keep a signature on file indicating the injured worker or his/her authorized representative has received the prescription.

Average Wholesale Price + \$5.00

All bills under this section shall be itemized for proper reimbursement. Bills submitted for reimbursement shall be based on the original manufacturer's Average Wholesale Price (AWP) of the drug product on the date the drug was dispensed, and must include the National Drug Code (NDC) of the product dispensed. Medi-Span, published by Wolters-Kluwer Health, or IBM Micromedex RED BOOK, shall be used as the source for determining the average wholesale price (AWP). Where the AWP of a medication is not published by Medi-Span or REDBOOK, any nationally published pharmacy price index may be used as a secondary source. In case of a dispute on AWP values for a specific NDC, the parties should take the lower of their referenced published values. If published AWP data becomes unavailable, substitute Wholesale Acquisition Cost (WAC) + 20%. Any issue arising as to the source of average wholesale price may be administratively reviewed by the Commission's Medical Services Division.

Any medication or drugs not specifically prescribed by the treating physician shall not be reimbursed. In the event the treating physician recommends and/or prescribes a particular drug or medication that can be purchased over-the-counter (without a prescription), and the injured employee pays for the drug or medication, the injured employee is entitled to reimbursement for the purchase upon submission of the appropriate receipts to the employer/insurance carrier.

The price determined by the formula will be the maximum allowable payment a provider can be paid under the Workers' Compensation Act. In instances where the pharmacy's charge is lower than the maximum allowable payment, or where the pharmacy has agreed by contract with an employer, insurance carrier, or their agent to a contractual amount that is lower than the maximum allowable amount, reimbursement shall be made at the lower amount in accordance with the terms of the contract.

REPACKAGED DRUGS

The entity packaging two or more products together makes an implied claim that the products are safe and effective when used together and shall be billed as individual line items identified by their original AWP and NDC. Bills for repackaged drug products must include the original manufacturer or distributor's stock package NDC used in the repackaging process. Reimbursement for a drug that has been repackaged or relabeled shall be calculated by multiplying the number of units dispensed times the per-unit AWP set by the original manufacturer for the underlying drug, plus a ~~single \$5.00~~ dispensing fee of \$5.00, **except** where the carrier/payer has contracted for a different amount. A repackaged NDC Number shall not be used and shall not be considered the original manufacturer's NDC Number.

If the original manufacturer's or distributor's stock package NDC information is not provided or is unknown, the payer shall select the most reasonable and closely associated AWP to use for reimbursement of the repackaged drug. In no case shall the repackaged or relabeled drug price

exceed the amount otherwise payable had the drug not been repackaged or relabeled. Supplies are considered integral to the package and are not separately reimbursable. Manufacturers of a repackaged or relabeled drug shall not be considered an "original manufacturer."

COMPOUND DRUGS

All medications must be reasonably needed to cure and relieve the injured worker from the effects of the injury. Compound drugs must be preauthorized for each dispensing, and shall be billed by listing each drug included in the compound by NDC, and calculating the charge for each drug separately. Any compounded drug product billed by the compounding pharmacy or dispensing physician shall be identified at the ingredient level and the corresponding quantity by their original manufacturer's National Drug Code (NDC) when submitted for reimbursement. Payment for compounded prescription drugs shall be based on the sum of the average wholesale price by gram weight fee for each ingredient, plus a single dispensing fee of \$5.00. If the NDC for any compounded ingredient is a repackaged medication NDC, reimbursement for the repackaged ingredient(s) shall be calculated as provided above. A compounded NDC Number shall not be used and shall not be considered the original manufacturer's NDC Number. No payment shall be required for an ingredient not identified by an NDC. Any component ingredient in a compound medication for which there is no NDC shall not be reimbursed. Any component ingredient in a topical compound medication that is not FDA approved for topical use shall not be reimbursed.

PRESCRIPTION STRENGTH TOPICAL COMPOUNDS

In order to qualify as a compound under this section, the medication must require a prescription; the ingredients must be combined, mixed, or altered by a licensed pharmacist or a pharmacy technician being overseen by a licensed pharmacist, a licensed physician, or, in the case of an outsourcing facility, a person under the supervision of a licensed pharmacist; and it must create a medication tailored to the needs of an individual patient. All ingredient materials must be listed by quantity used per prescription. Continued use (refills) may require documentation of effectiveness including functional improvement. Category fees include materials, shipping and handling, and time. Regardless of how many ingredients or what type, compounded drugs cannot be reimbursed higher than the Category III fee. The 30-day Maximum Fee Schedule value shall be fractioned down to the prescribed and dispensed amount given to the injured worker. Automatic refilling is not allowed. All topical compounds shall be billed using the South Carolina Worker's Compensation Commission code corresponding with the applicable category as follows:

Category I SC0801, \$80.00 per 30-day supply

Any anti-inflammatory medication or any local anesthetic single agent.

Category II SC0802, \$160.00 per 30-day supply

Any anti-inflammatory agent or agents in combination with any local anesthetic agent or agents.

Category III SC0803, \$240.00 per 30-day supply

Any agent(s) other than anti-inflammatory or local anesthetic agents, either alone, or in combination with other anti-inflammatory or local anesthetic agents.

ADMINISTRATION KITS

Administration kits packaged by the manufacturer and assigned a single National Drug Code (NDC) may be reimbursed the Average Wholesale Price (AWP) of the kit without additional markup. Kits packaged by the provider or other source are considered to be part of the administration of the pharmaceutical and are not separately reimbursed even if reported with an NDC or HCPCS Level II code. Only those supplies and materials over and above those usually provided in the office of the physician or other qualified health care professional may be reported in addition to the pharmaceutical drug and administration as discussed above and in Part I Chapter III of the ~~2020~~ 2021 *Medical Services Provider Manual*.



Analysis of Anesthesia Conversion Factor

January 13, 2021

The South Carolina Workers' Compensation Commission requested FAIR Health to review the conversion factor that determines reimbursement for anesthesia services under the South Carolina Medical Services Provider Manual.

FAIR Health reviewed the anesthesia conversion factor from several aspects:

- Comparison to Medicare
- Comparison to private health insurance
 - Billed charges
 - Contracted amounts
- ASA survey results from 2020
- Comparison to other states' workers' compensation fee schedules

The current anesthesia conversion factor in the South Carolina Medical Services Provider Manual (MSPM) is \$30.00. The anesthesiology maximum allowable payment (AMAP) is the sum of the Basic MAP amount plus the Time Value Amount payment. The Basic MAP amount is set in the fee schedule based on the conversion factor x base units. The Time Value amount is calculated based on the \$30 conversion factor x each 15-minute time unit.

For example:

CPT 01380 – anesthesia for all closed procedures on knee joint

	60-Minute Surgery (4 Time Units)	120-Minute Surgery (8 Time Units)
Basic MAP (3 base units)	\$ 90.00	\$ 90.00
Time Value Amount	\$ 120.00	\$ 240.00
Total AMAP	\$ 210.00	\$ 330.00

Medicare

For 2021, CMS increased RVUs for office visits for new and established patients, CPT codes 99202-99205 and 99212-99215. To maintain budget neutrality and offset the increased reimbursement for evaluation and management services, CMS reduced the 2021 conversion factors for both professional services and anesthesia. The current South Carolina anesthesia conversion factor of \$30 is equal to 139.15% of the 2021 national Medicare anesthesia conversion factor of \$21.56 and 144.02% of Medicare's 2021 South Carolina anesthesia conversion factor of \$20.83. This relationship is similar to the South Carolina professional conversion factor, which is 144.16% of the Medicare 2021 conversion factor.

On December 27, 2020 the Consolidated Appropriations Act, which includes pandemic relief and national budget provisions, was signed into law. The Act includes provisions that defer use of a complexity adjustment for evaluation and management procedures and mandates an increase to the Medicare conversion factors for 2021. To comply with these changes and maintain budget neutrality, CMS recalculated the anesthesia and professional services conversion factors for 2021.

The information in this report is based on conversion factors that were updated by CMS on January 7, 2021.

	Anesthesia – National Comparison	Anesthesia – South Carolina Comparison	Other Professional Services
South Carolina Conversion Factor	\$30.00	\$30.00	\$50.30
2021 Medicare Conversion Factor	\$21.56 (National)	\$20.83 (Adjusted by CMS for South Carolina)	\$34.8931
Ratio	139.15%	144.02%	144.16%

Private Health Insurance

FAIR Health collects data for anesthesia services from private payors (more than 40 payors contribute data for services performed in South Carolina) and uses this data to develop benchmarks, including benchmarks for anesthesia conversion factors. Insurers and administrators that participate in the FAIR Health Data Contribution Program are required to submit all of their data; they cannot select or “cherry pick” data to contribute to FAIR Health. We are providing benchmarks for anesthesia conversion factors in two different ways:

- Charge benchmarks based on the non-discounted charges billed by providers before any network discounts are applied; and
- Allowed benchmarks based on imputed allowed amounts, which reflect network rates that have been negotiated between the payor and the provider.

The benchmarks below are based on anesthesia services in the FAIR Health database provided in the state of South Carolina. Charge benchmarks are based on claims from July 2019 through June 2020 and allowed benchmarks are based on imputed allowed amounts from claims incurred during calendar year 2019.

Type	Average	Percentiles													
		5th	10th	15th	20th	25th	30th	35th	40th	45th	50th	60th	70th	80th	90th
Billed Anesthesia	128.33	50.77	60.64	70.28	79.70	88.65	97.09	104.44	109.89	114.70	119.72	131.95	154.66	172.99	190.32
Allowed Anesthesia	60.14	24.79	29.44	34.13	39.32	43.17	46.66	49.60	52.19	54.39	56.93	62.20	70.24	81.59	88.56

The benchmarks for allowed anesthesia may be compared to the South Carolina conversion factor, as the allowed line represents the amounts allowed by payors under their network contracts. This aligns to what is paid to anesthesiologists and certified registered nurse anesthetists (CRNAs) for patients covered by workers' compensation.

In this analysis, a \$30 conversion factor approximately aligns to the 10th percentile for private insurance. That means that 90% of the imputed allowed values in the FAIR Health database are equal to or greater than \$30. The 50th percentile (conversion factor of \$56.93) is the median conversion factor value in the private insurance data and the average allowed conversion factor benchmark is \$60.14.

ASA Survey Results for Commercial Fees Paid for Anesthesia Services

The American Society of Anesthesiologists (ASA) publishes an annual study on conversion factors. FAIR Health downloaded the 2020 study from the ASA website at <https://monitor.pubs.asahq.org/journal.aspx>. A copy of the ASA Monitor newsletter containing the 2020 survey is appended to this report.

According to the publication, the ASA anonymously surveys anesthesiology practices across the country, asking them to report the conversion factors for up to five of their largest commercial managed care contracts. This study publishes the results of that survey, which are normalized based on 15-minute time units. That is the same time unit used by South Carolina in the MSPM.

South Carolina practices are included in the Southeast Region in the ASA survey. In the 2019 survey, an insufficient number of responses were received to include state-level results for South Carolina.

Conversion Factor	National		Southeast Region		South Carolina		
	2019	2020	2019	2020	2018	2019*	2020
Low	23.73	31.50	33.34	32.00	26.60	N/A	33.00
Median	72.00	73.00	77.00	78.68	80.00	N/A	72.00
Average	77.01	82.14	81.16	87.33	86.77	N/A	82.02
High	256.50	323.22	256.50	184.50	185.00	N/A	162.00

* In 2019, there were too few respondents to report results at the South Carolina state level, so comparisons to 2018 are included.

State Workers' Compensation Fee Schedules

FAIR Health reviewed anesthesia conversion factors documented in state workers' compensation fee schedules.

State	Conversion Factor (per 15-minute time unit)
South Carolina	\$30.00
Alabama	\$56.82
Colorado	\$46.50
Florida	\$29.49
Georgia	\$60.08
Kentucky	\$78.53
Louisiana	\$50.00
Maryland	\$21.69
Mississippi	\$50.00
North Carolina	\$58.20 – first 60 min \$30.75 – after 60 min
Oklahoma	\$48.50
North Dakota	\$64.92
Tennessee	\$75.00
Virginia (6 regions)	\$49.00 - \$77.00

FAIR Health assists Colorado, Georgia, Kentucky, Mississippi, North Dakota and Oklahoma in updating their fee schedules. As we are doing for the South Carolina Workers' Compensation Commission, we provide research and analysis to support decision making. FAIR Health does not make or recommend fee schedule changes.

Summary

FAIR Health presents this analysis to the Commission to assist with decision making. In summary:

- The current South Carolina anesthesia conversion factor is \$30 or 144.02% of the 2021 Medicare conversion factor for South Carolina and 139.15% of the national Medicare conversion factor.
- The ratio of the South Carolina workers' compensation anesthesia to Medicare is generally aligned with the 144.16% ratio of the conversion factor for other professional services (\$50.30) in comparison to Medicare (\$34.8931). However, the MAP amounts in the MSPM may also be limited by the +/- 9.5 percent cap on increases or decreases each year, and the formula-based conversion factors would not be applicable to those services.
- The \$30 conversion factor is low in comparison to contracted amounts paid through private health insurance as reflected in FAIR Health benchmarks and ASA survey results.
 - The mean and median conversion factor benchmarks developed by FAIR Health, which are based on data contributions for services performed in South Carolina, are lower than the ASA survey results, which are based on up to five of the largest commercial contracts reported by anesthesiology practices responding to the ASA survey.
- South Carolina's \$30 conversion factor falls within the range of conversion factors used by other states' workers' compensation programs; however, it is on the lower end of the range.

A copy of the ASA publication *ASA Survey Results for Commercial Fees Paid for Anesthesia Services – 2020* appears on the following pages.



ASA Monitor®

THE LEADING SOURCE FOR PERIOPERATIVE HEALTH CARE NEWS

Remimazolam: Is the Sedative of the Future Here?

Dibash K. Das, PhD

Sedative and anesthetic safety is continuously reviewed as part of quality assessments. Yet, the market for sedation and anesthesia has been short on pharmaceutical development, and standard options for moderate sedation medications have not changed in three decades.

Typically, either propofol or a benzodiazepine (e.g., midazolam) with or without a narcotic (e.g., fentanyl) is used to obtain sedation for procedures. Both strategies have pros and cons. A disadvantage of propofol is the requirement of constant monitoring by an anesthesia provider due to its potential for respiratory- and cardio-depressive effects,

which results in additional costs and higher risks, since there is no reversal agent available for propofol to be able to quickly stop sedation if required. For midazolam, although these side effects are less pronounced, there is a slower onset and a longer duration of action that can impact patient throughput and overall efficiency. Consequently, the search for an elusive ideal anesthetic remains.

Remimazolam (BYFAVO™), developed by PAION AG, is a novel molecular, water-soluble, ultra-short-acting intravenous benzodiazepine that was developed to address the shortcomings of current sedation strategies. A key feature of remimazolam

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Severe Sequelae, Chronic Headache Linked to PDPH

Jessica Ansari, MD Pamela Flood, MD, MA

Post-dural puncture headache (PDPH) is a well-known complication of neuraxial anesthetic procedures resulting in an acute postural headache within five days of a dural puncture (*Minerva Anesthesiol* 2019;85:543-53). Patients generally experience a severe, dull, frontal or occipital headache, often associated with neck pain, tinnitus or

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ASA Survey Results: Commercial Fees Paid for Anesthesia Services, 2020

Stanley W. Stead, MD, MBA, FASA Sharon K. Merrick, MS, CCS-P

ASA is pleased to present the annual commercial conversion factor survey for 2020. Each summer we survey anesthesiology practices across the country. We ask them to report up to five of their largest managed care (commercial) contract conversion factors (CF) and the percentage each contract represents of their commercial population, along with some demographic information. Our objectives for the survey are to report to our members the average contractual amounts for the top five contracts and to present a view of regional trends in commercial contracting.

Summary

Based on the 2020 survey results, the national average commercial conversion factor was \$82.14, ranging between \$76.09 and \$85.75 for the five contracts. The national median increased to \$73.00, ranging between \$69.00 and \$77.25 for the five contracts (Figure 1, Table 1). In the 2019 survey, the mean conversion factor ranged between \$73.79 and \$80.76, and the median ranged between \$69.00 and \$78.00. In contrast, the current national Medicare conversion factor for anesthesia services is \$22.2016, or about 27.03% of the

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SPECIAL SECTION

Critical Care Medicine: Lessons From an Unprecedented Pandemic 30-35

Guest Editor: George Williams, MD, FASA, FCCM, FCCP

Payment and Practice Management

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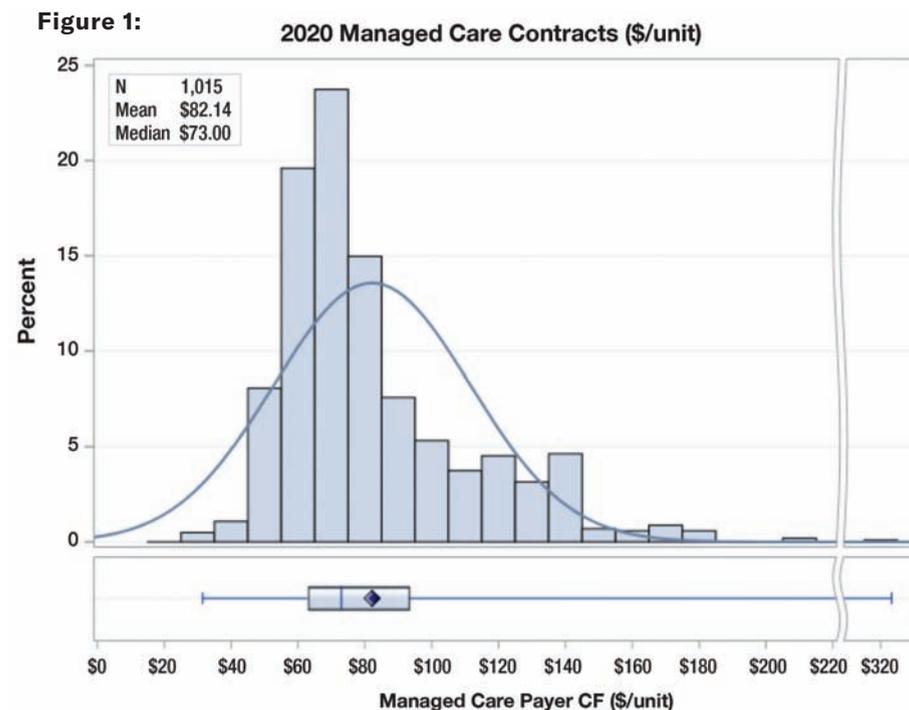
2020 overall mean commercial conversion factor.

Figure 1 shows the frequency in percent and distribution of contract values. In order to show all the values in limited space, we are using a broken axis for all plots. The ranges plotted are \$0-\$200, with a break indicated by wavy lines and then \$310-\$330. The estimated normal distribution is the solid blue line. We have added a box-and-whiskers plot of the same data immediately below the histogram. The left and right whiskers delineate the minimum and maximum values. The box represents the interquartile range, the left edge of the box is the 25th percentile, the vertical line in the box is the median, and the right edge of the box is the 75th percentile. The solid diamond in the box is the mean.

Table 1 provides the overall survey results by reported managed care contract. As with previous surveys, we requested that participants submit data on five commercial contracts. Most practices submitted three or more contracts. The survey reflects valid responses from 238 practices in 43 states. The 2019 survey results included data from 270 practices in 43 states.

Methodology

The survey was disseminated in June and July 2020. To comply with the principles established by the Department of Justice (DOJ) and the Federal Trade Commission



(FTC) in their 1996 Statements of Antitrust Enforcement Policy in Health Care, the survey requested participants provide data that were at least three months old. In addition, the following three conditions must be met:

1. There are at least five providers reporting data upon which each disseminated statistic is based, and
2. No individual provider's data represent more than 25% on a weighted basis of that statistic, and

3. Any information disseminated is sufficiently aggregated such that it would not allow recipients to identify the prices charged or compensation paid by any particular provider.

To comply with the statements, we are only able to provide aggregated data. Since some states did not respond, and other states had insufficient response rates, we are unable to provide specific data for all states. We term "Eligible States" those states that



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 CEO, Stead Health Group, Inc.



Sharon K. Merrick, MS, CCS-P
 ASA Director of Payment and Practice Management.

submitted sufficient data to be compliant with DOJ and FTC principles, and we provide state-specific data for only those states. We have 17 Eligible States this year.

“Based on the 2020 survey results, the national average commercial conversion factor was \$82.14, ranging between \$76.09 and \$85.75 for the five contracts.”

Table 1: National Managed Care Anesthesia Conversion Factors (\$/unit), 2020

Conversion Factors	Contract 1	Contract 2	Contract 3	Contract 4	Contract 5	ALL
Mean	\$76.09	\$80.73	\$85.30	\$85.06	\$85.75	\$82.14
Low	\$33.00	\$31.50	\$41.00	\$39.00	\$32.00	\$31.50
25th Percentile	\$60.72	\$63.00	\$63.55	\$64.00	\$65.00	\$62.95
Median	\$69.00	\$72.00	\$75.00	\$74.75	\$77.25	\$73.00
75th Percentile	\$85.00	\$90.00	\$98.47	\$97.50	\$104.00	\$93.61
High	\$209.75	\$166.00	\$323.22	\$184.50	\$211.71	\$323.22
Number of Responses	238	227	209	188	153	1,015
Percentage of Managed Care Business	21.1%	9.14%	5.41%	3.65%	2.74%	9.34%

Table 2: Respondent Information by Major Geographic Region, 2020

Region	Practices	Cases	Mean Units/ FTE MD	Mean Units/ Case	FTE MD	FTE Nurse Anesthetist	FTE AA
Eastern	35	1,540,302	11,865	10.98	1,555.5	1,056.2 (253.0)	11 (65)
Midwest	42	1,907,427	16,652	10.46	1,171.7	1,200.7 (136.2)	40 (0)
Southern	70	2,990,754	21,244	10.16	1,767.0	2,334.4 (415.0)	491.5 (0)
Western	50	1,930,614	8,742	11.01	2,678.5	503.7 (73)	15 (15)
ALL	197	8,369,097	15,310	10.58	7,172.7	5,094.8 (877.2)	557.5 (80)

(Number in brackets indicate the number of non-employed FTEs)
Note: 197 of the 238 practices reported case, unit or FTE data.

This is the tenth year we offered the survey electronically through the website www.surveymonkey.com. ASA urged participation through various electronic mail offerings, including ASA committee list serves, ASAP Weekly (all-member e-mail digest), Vital Signs, the Monday Morning Outreach, communications to state component societies and our Anesthesia Administrator and Executive (AAE) members, and via the ASA website.

The responses to the survey represented 246 unique practices. However, due to respondents providing incomplete data, we excluded eight responses from the overall analysis. Our results are based on the data from 238 practices.

Results

Table 2 presents respondent information for 197 practices (41 practices did not provide us with practice demographics) in the analytic sample per Major Geographic Region as identified by the Medical Group Management Association (MGMA) (asamonitor.pub/30PLj9B). These regions are as follows:

- Eastern: CT, DE, DC, ME, MD, MA, NH, NJ, NY, NC, PA, RI, VT, VA, WV
 - Southern: AL, AR, FL, GA, KS, KY, LA, MS, MO, OK, SC, TN, TX
 - Midwestern: IL, IN, IA, MI, MN, NE, ND, OH, SD, WI
 - Western: AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY
- These 197 practices employ or contract with 7,172.7 full-time equivalent (FTE) physician anesthesiologists, 5,094.8 FTE nurse anesthetists, and

557.5 FTE anesthesiologist assistants (AAs). The practices also work with an additional 877.2 FTE nurse anesthetists and 80 FTE AAs for whom the practice does not directly pay compensation (i.e., facility hires or contracts the nurse anesthetist or AA).

The 238 practices reported a total of 1,015 managed care contracts. This is fewer than the 1,125 contracts reported last year.

Table 3 provides the same respondent information by Minor Geographic Region as identified by the MGMA.

- CAAKHI: CA, AK, HI
- Eastern Midwest: IL, IN, KY, MI, OH
- Lower Midwest: AR, KS, LA, MO, OK, TX
- Mid Atlantic: DC, DE, MD, VA, WV
- North Atlantic: NJ, NY, PA
- Northeast: CT, MA, ME, NH, RI, VT
- Northwest: ID, OR, WA
- Rocky Mountain: AZ, CO, MT, NM, NV, UT, WY
- Southeast: AL, FL, GA, MS, NC, SC, TN
- Upper Midwest: IA, MN, ND, NE, SD, WI

Nine hundred eighty-two (982) of the contracts are based upon a 15-minute unit, 11 upon a 12-minute unit, 16 are based upon a 10-minute unit and six are based upon an 8-minute unit. We normalized all contract conversion factors with 8- 10- and 12-minute time units to the typical 15-minute time unit using an adjustment factor of 1.4208 for 8-minute units, 1.2404 for 10-minute units and 1.1202 for 12-minute units (Table 4).

Table 3: Respondent Information by Minor Geographic Region, 2020

Region	Practices	Cases	Mean Units/ FTE MD	Mean Units/ Case	FTE MD	FTE Nurse Anesthetist	FTE AA
CAAKHI	16	904,090	8,528	13.06	1,332.3	106 (58.0)	0 (0)
Eastern Midwest	37	1,420,934	19,245	11.04	866.0	910.9 (135.0)	40 (0)
Lower Midwest	29	1,332,869	19,921	9.87	928.8	1287 (0)	88 (0)
Mid Atlantic	9	273,780	13,747	13.29	253.1	236.0 (45.5)	0 (0)
North Atlantic	18	1,068,794	11,422	10.51	1,160.7	707.4 (90.5)	11 (65)
Northeast	6	101,307	8,161	9.75	90.5	34.8 (42)	0 (0)
Northwest	18	729,777	9,343	10.09	963.2	314.7 (0)	0 (0)
Rocky Mountain	16	296,747	8,271	10.12	383.0	83.0 (15)	15 (15)
Southeast	40	1,650,512	21,190	10.31	837.4	1034.5 (490)	403.5 (0)
Upper Midwest	8	590,287	6,506	6.66	357.7	380.8 (1.2)	0 (0)
ALL	197	8,369,097	15,310	10.58	7,172.7	5,094.8 (877.2)	557.5 (80)

(Number in brackets indicate the number of non-employed FTEs)
Note: 197 of the 238 practices reported case, unit or FTE data.

Table 4: Conversion Factor Adjustment Based on Time Units, 2020

Time Units	Time Units	Sum of Base and Time Units	CF Value Ratio based for 15-minute units
CMS PSPS 2018¹			
Mean Base Units	5.211		
Minutes/Case	72.405		
8-minute time units	9.051	14.262	1.4208
10-minute time units	7.241	12.452	1.2404
12-minute time units	6.034	11.245	1.1202
15-minute time units	4.827	10.038	1.0000

1. Mean Minutes per Case and Base Unit is determined from the 2018 CMS Physician/Supplier Procedure Summary (PSPS) Master File (“Master File”).

https://www.cms.gov/NonIdentifiableDataFiles/06_PhysicianSupplierProcedureSummaryMasterFile.asp

Table 5: Respondents Having Flat Fee Components, 2020

	Flat Fee (Any)	Labor & Delivery	Cataracts	Endoscopy	Pain	Other
Eastern	21	17	0	3	1	7
Midwest	25	19	0	13	0	1
Southern	32	25	0	6	2	4
Western	10	9	1	4	1	3
Total	88	70	1	26	4	15

Others include cosmetic and plastic surgery, bundled surgical procedures, Total Joint Replacement, spine surgery, general surgery, invasive monitoring and open heart surgery.

“The highest conversion factor reported was \$323.22. In 2019 the highest conversion factor reported was \$256.50.”

The adjustment factors are calculated as ratios based on the mean time and mean base units per case. To make these calculations, we have used the CMS Physician/Supplier Procedure Summary (PSPS) data set (asamonitor.pub/3gRrtQD), which represents over 21 million anesthesia claims.

The mean time was 72.405 minutes and mean base units per case were 5.211 base units. Making the same calculations described above, the adjustment factors are very similar to last year: 1.411 for 8-minutes units, 1.235 for 10-minute units, and 1.117 for 12-minute units.

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Payment and Practice Management

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Groups continue to report flat fee contracts for certain procedures. Table 5 shows respondents who identified that they had flat fee contracts. 88 of the 158 groups (55.7%) responding to this question negotiated at least one flat fee contract. 44.3% of the respondents have flat fee contracts for Labor and Delivery.

Table 6 reports the conversion factor by MGMA Major Region. Contract 1 reflected the highest percentage of the reported commercial business, Contract

“In the 2019 survey, the Medicare conversion factor was 28.9% of the overall commercial mean. In this year’s survey, it has fallen to 27.03%.”

2 reflected the second highest percentage, and so on. Thus, when looking at the data, you can see that Contract 1 not only reflects the greatest number of responses (238), but also the highest average percentage of managed care business (21.1%, Table 1). We also reported the total number of responses for each contract in Table 1. Figure 2 shows the contract data for each major region as a box-and-whiskers plot.

We had a sufficient data sample to provide detailed information for all ten MGMA Minor Regions (Figure 3). Table 7 shows contract data for the minor regions.

This is the sixth year we are presenting state-specific data. Although

Table 6: Major Region Managed Care Anesthesia Conversion Factors (\$/unit), 2020

	Contract 1	Contract 2	Contract 3	Contract 4	Contract 5	ALL
Eastern	n=47	n=44	n=40	n=38	n=33	n=202
Mean	\$91.61	\$91.98	\$106.37	\$101.10	\$100.50	\$97.85
Low	\$53.00	\$54.83	\$51.00	\$45.00	\$52.43	\$45.00
25th Percentile	\$69.00	\$68.67	\$81.45	\$75.00	\$72.00	\$72.00
Median	\$91.24	\$90.03	\$100.50	\$97.00	\$89.68	\$93.00
75th Percentile	\$105.00	\$112.42	\$123.57	\$130.00	\$131.00	\$120.00
High	\$209.75	\$144.00	\$323.22	\$173.60	\$211.71	\$323.22
Midwest	n=50	n=48	n=45	n=41	n=34	n=218
Mean	\$68.34	\$72.54	\$71.41	\$71.47	\$68.01	\$70.44
Low	\$49.37	\$46.00	\$48.00	\$46.62	\$47.05	\$46.00
25th Percentile	\$60.72	\$64.00	\$60.00	\$61.00	\$57.00	\$60.72
Median	\$65.00	\$70.13	\$69.00	\$66.80	\$65.00	\$67.82
75th Percentile	\$72.00	\$76.25	\$75.00	\$74.25	\$76.00	\$74.25
High	\$136.00	\$144.00	\$136.00	\$117.60	\$124.00	\$144.00
Southern	n=86	n=83	n=75	n=63	n=46	n=353
Mean	\$70.87	\$80.06	\$82.11	\$84.14	\$87.82	\$80.00
Low	\$33.00	\$42.00	\$43.00	\$45.00	\$32.00	\$32.00
25th Percentile	\$54.00	\$58.00	\$60.00	\$60.00	\$65.00	\$59.04
Median	\$65.00	\$72.00	\$72.00	\$71.00	\$83.41	\$72.00
75th Percentile	\$83.00	\$88.54	\$95.00	\$102.83	\$104.00	\$90.50
High	\$169.00	\$162.00	\$184.50	\$184.50	\$155.00	\$184.50
Western	n=55	n=52	n=49	n=46	n=40	n=242
Mean	\$78.03	\$79.85	\$85.73	\$85.17	\$86.27	\$82.70
Low	\$40.75	\$31.50	\$41.00	\$39.00	\$57.85	\$31.50
25th Percentile	\$63.20	\$62.00	\$67.00	\$69.00	\$68.50	\$66.00
Median	\$69.75	\$71.27	\$79.54	\$76.96	\$76.63	\$74.48
75th Percentile	\$80.00	\$83.62	\$95.00	\$90.45	\$94.63	\$90.45
High	\$166.00	\$166.00	\$166.00	\$166.00	\$166.00	\$166.00

we had respondents from 43 states, only 17 states were identified as eligible states (Figure 4, Table 8). Eligible states were those that complied with the DOJ and FTC requirements, listed above. We believe by providing this data, we can encourage more participation in the 2021 CF study and

increase the state-level detail of our reporting.

Observations

Based on our review of the analysis, the most interesting findings include:

- The national average conversion factor increased to \$82.14, while the median,

\$73.00 and the range of mean values increased from a range of \$73.79 - \$80.76 in 2019 to a range of \$76.09 - \$85.75 in 2020.

- As was the case in our 2018 and 2019 surveys, the Eastern Region has the highest mean this year. The Eastern Region mean in 2019 was \$86.73 and this year it is \$97.85.

Table 7: Minor Region Managed Care Anesthesia Conversion Factors (\$/unit), 2020

MGMA Minor Region	Contracts	Low	25 th Percentile	Median	Mean	75 th Percentile	High
CAAKHI	79	\$39.00	\$67.91	\$78.73	\$94.20	\$126.00	\$166.00
Eastern Midwest	190	\$46.00	\$60.00	\$64.03	\$67.73	\$72.50	\$144.00
Lower Midwest	140	\$40.00	\$54.50	\$64.19	\$70.64	\$76.50	\$169.00
Mid Atlantic	43	\$53.10	\$66.17	\$75.00	\$82.09	\$87.00	\$169.00
North Atlantic	105	\$45.00	\$80.00	\$100.00	\$105.37	\$127.00	\$323.22
Northeast	40	\$51.00	\$85.50	\$94.96	\$97.45	\$110.00	\$144.00
Northwest	90	\$53.00	\$64.15	\$69.53	\$72.45	\$77.91	\$132.00
Rocky Mountain	73	\$31.50	\$68.00	\$76.00	\$82.89	\$97.00	\$144.00
Southeast	216	\$32.00	\$65.00	\$78.68	\$87.33	\$104.00	\$184.50
Upper Midwest	39	\$65.00	\$70.00	\$74.25	\$83.25	\$91.00	\$136.00

“We will continue to monitor the trends in the commercial conversion factor survey results and will launch the survey again in June.”

- The highest conversion factor reported was \$323.22. In 2019 the highest conversion factor reported was \$256.50.
- In the 2019 survey, the Medicare conversion factor was 28.9% of the overall commercial mean. In this year’s survey, it has fallen to 27.03%.

Table 8: Eligible States Managed Care Anesthesia Conversion Factors (\$/unit), 2020

State	Contracts	Low	25 th Percentile	Median	Mean	75 th Percentile	High
AL	12	\$55.00	\$63.00	\$63.00	\$71.13	\$75.75	\$104.00
CA	71	\$39.00	\$71.00	\$82.20	\$97.54	\$129.29	\$166.00
FL	65	\$32.00	\$74.00	\$104.00	\$103.98	\$127.35	\$184.50
GA	52	\$49.86	\$72.50	\$81.88	\$87.68	\$100.90	\$153.00
IN	30	\$49.37	\$64.00	\$74.00	\$74.10	\$78.00	\$114.75
KS	28	\$55.00	\$65.00	\$73.00	\$78.83	\$80.00	\$139.50
LA	38	\$42.00	\$52.00	\$53.50	\$53.91	\$55.50	\$72.00
MI	65	\$47.05	\$59.45	\$60.72	\$61.93	\$64.00	\$131.75
MS	21	\$34.00	\$50.00	\$57.00	\$52.60	\$58.00	\$61.00
NY	55	\$45.00	\$95.00	\$120.00	\$122.01	\$137.00	\$323.22
OH	64	\$46.00	\$62.75	\$69.00	\$68.90	\$72.67	\$144.00
OK	24	\$52.00	\$60.00	\$63.71	\$63.88	\$67.00	\$81.47
PA	33	\$50.00	\$59.00	\$69.36	\$74.90	\$89.00	\$139.50
SC	33	\$33.00	\$65.00	\$72.00	\$82.02	\$88.54	\$162.00
TX	34	\$40.00	\$60.93	\$82.50	\$85.21	\$117.00	\$169.00
UT	20	\$31.50	\$70.66	\$74.50	\$74.25	\$79.33	\$96.75
WA	70	\$53.50	\$64.00	\$69.00	\$71.28	\$79.00	\$104.00

Conclusions

This year’s survey was challenged as many practices were coping with the COVID-19 pandemic. Our sample size was slightly less this year, but still represents a significant portion of US practicing anesthesiologists, nurse anesthetists and anesthesiologist assistants. We were pleased to have

respondents report across a broad geographic basis, allowing us to provide detailed regional responses. The number of practices reporting allowed us to report state-specific data from 17 states. Most practices included complete demographic information and

Figure 2: 2020 Managed Care Contracts (\$/unit) by MGMA Major Region

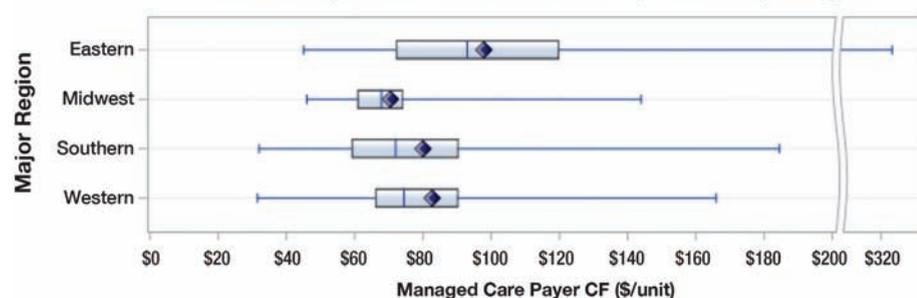


Figure 3: 2020 Managed Care Contracts (\$/unit) by MGMA Minor Region

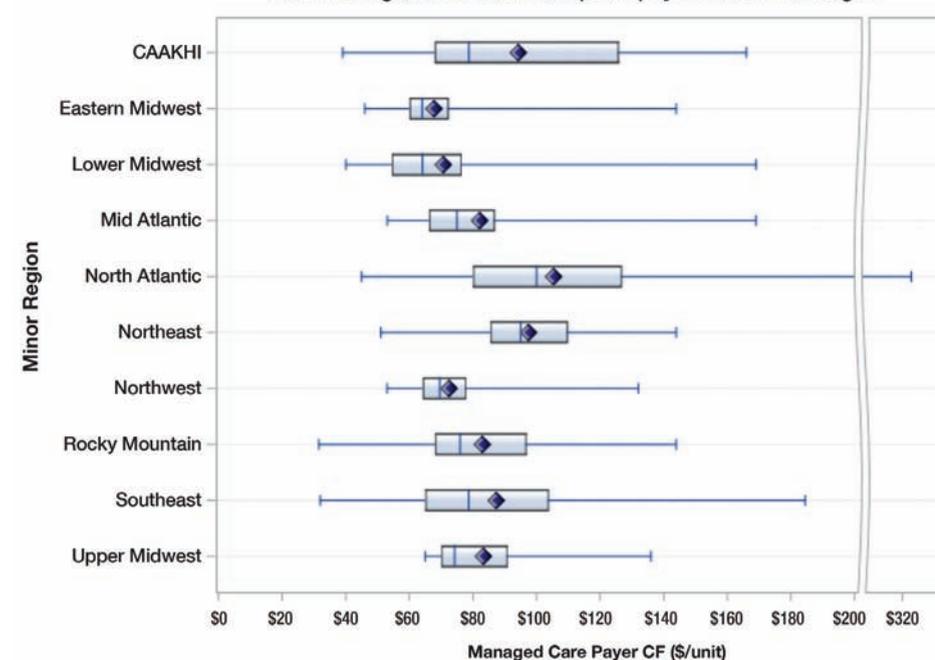
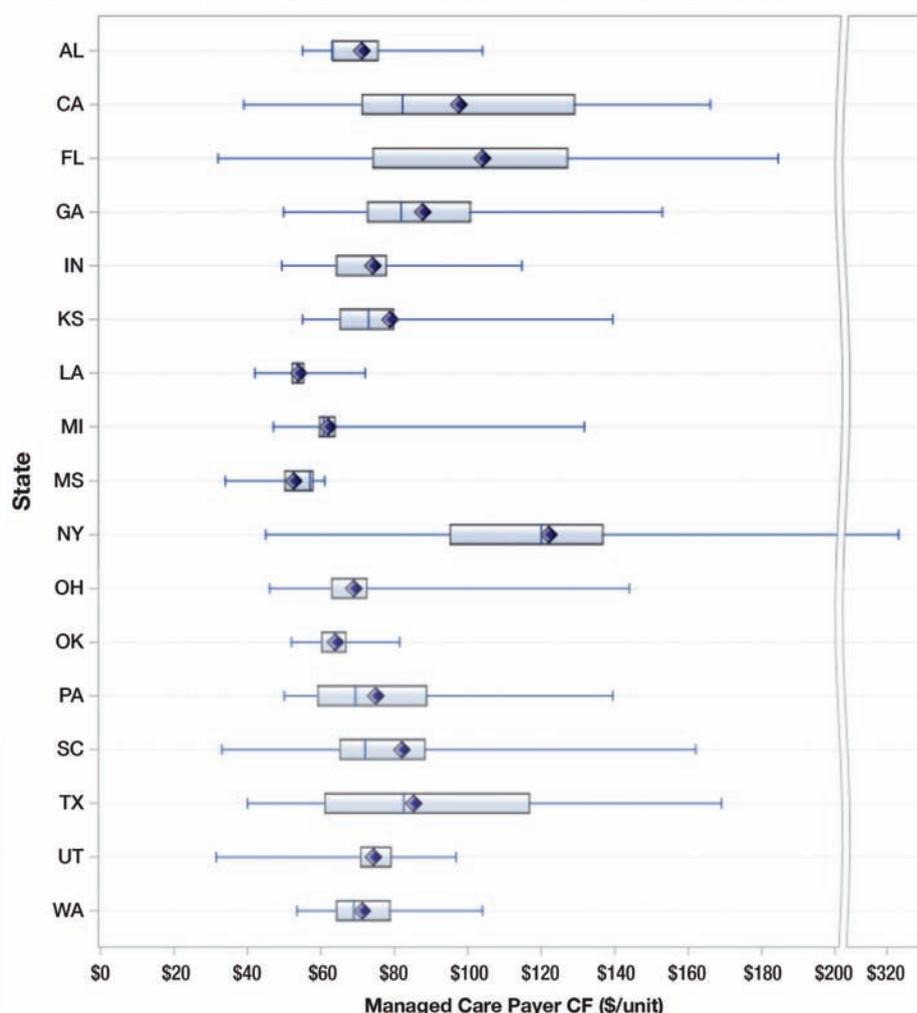


Figure 4: 2020 Managed Care Contracts (\$/unit) by Eligible States



we are hopeful that this trend will continue, and all respondents will supply complete information in future surveys.

We will continue to monitor the trends in the commercial conversion factor survey results and will launch the survey again in June 2021. It is important that as many practices as possible

participate in the 2021 survey to help us obtain an accurate representation of the anesthesia commercial conversion factor. We hope that a significant growth in participants will allow us to publish data for every state. We look forward to your future participation and thank all of the practices that contributed to the 2020 results. ■

2020-2021 South Carolina Workers' Compensation Medical Services Provider Manual

Effective April 1, 20202021



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The ~~2020~~2021 *South Carolina Workers' Compensation Medical Services Provider Manual* is designed to be an accurate and authoritative source of information about medical coding and reimbursement. Every reasonable effort has been made to verify its accuracy, and all information is believed reliable at the time of publication. Absolute accuracy, however, cannot be guaranteed.

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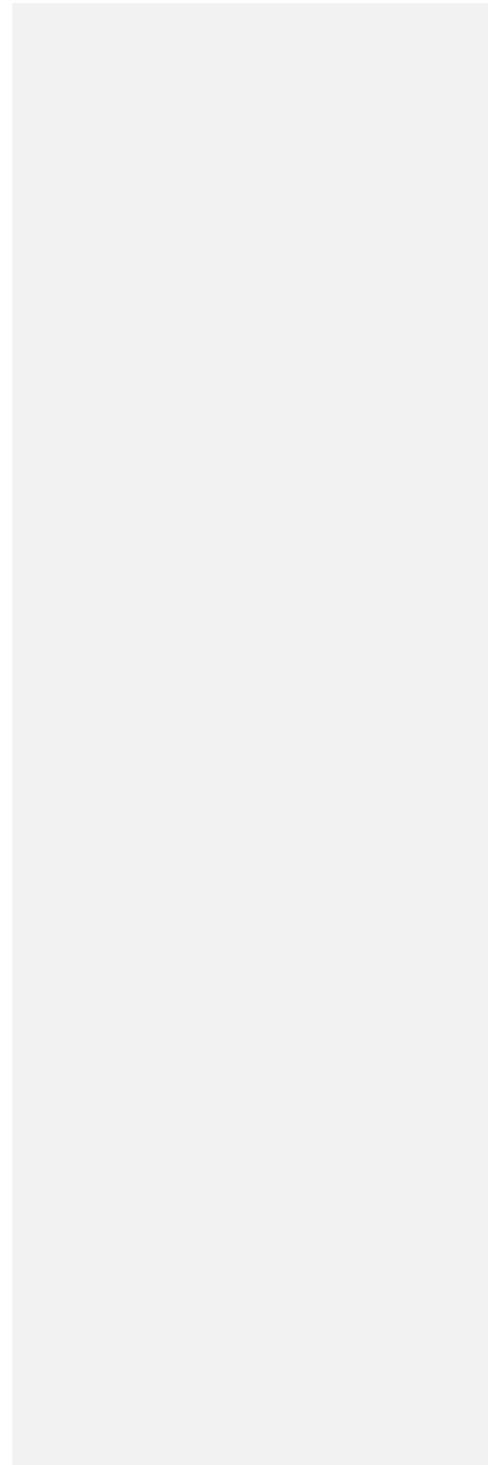
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Part I



Chapter I. Overview and Guidelines

INTRODUCTION

The ~~2020-2021~~ *South Carolina Workers' Compensation Medical Services Provider Manual* contains the policy governing the Commission's Medical Services Program and a schedule of maximum allowable payment (MAP) amounts for services covered by the program. All policies and MAP amounts are effective for dates of service on or after April 1, ~~2020~~2021. The MAP amounts listed herein are deemed by the Commission to be fair and reasonable and were developed under the statutory authority provided by Section 42-15-90 and Section 42-15-70 of the South Carolina Code of Laws, 1976, as amended. The information contained in this manual is organized as follows:

Part I (Chapters I–V) outlines the general policies and procedures applicable to all providers and payers.

Part II is comprised of 10 sections with a section for each category of services covered by the Commission's Medical Services Program. Each section features the policies and procedures, service codes, and MAP amounts that are unique to that category of services.

Part III is an appendix designed to assist users of this manual. The appendix features a reference of workers' compensation laws and regulations and other pertinent information.

The *Medical Services Provider Manual* was designed to be as user friendly as possible. If you have any suggestions for further improvements, or to report any possible errors, please contact:

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<https://wcc.sc.gov/insurance-and-medical-services/medical-services-division> or the FAIR Health website <https://orders.fairhealth.org>. Subscribers should regularly check these sites for changes.

Healthcare Common Procedure Coding System

The Healthcare Common Procedure Coding System (HCPCS) is used in this fee schedule. Level I of the HCPCS is comprised of *Current Procedural Terminology* (CPT[®]), a coding system maintained by the American Medical Association (AMA) consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other medical care providers. CPT codes, comprised of five digits, are published and updated annually by the AMA. Level I of the HCPCS, CPT codes, does not include codes needed to separately report medical items or services that are regularly billed by suppliers other than physicians.

Level II of the HCPCS is a standardized coding system that is used primarily to identify services, products, and supplies not included in the CPT codes, such as some procedures and tests, durable medical equipment, prosthetics, orthotics, and supplies. Level II HCPCS codes were established for submitting claims for these items. The Centers for Medicare and Medicaid Services (CMS) maintains and distributes HCPCS Level II codes. Level II HCPCS, also referred to as alpha-numeric codes, consist of a single alphabetical letter followed by four numeric digits.

Providers Covered by the Manual

All providers of health care services must be appropriately licensed, certified, and/or accredited so as to be legal and legitimate providers in the State of South Carolina. The providers covered by this manual include, but are not limited to:

1. **Physicians and Surgeons;**
2. **Limited Licensed Practitioners** to include oral and maxillofacial surgeons, chiropractors, podiatrists, dental surgeons, optometrists, and clinical psychologists;

3. **Non-Physician Practitioners** to include, but not limited to, physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, physicians' assistants, nurse practitioners, certified registered nurse anesthetists, and medical or clinical social workers.

Service Level Adjustment Factor

Payments to nurse practitioners, physician assistants, and clinical social workers must be adjusted according to a service level adjustment factor (SLAF). To determine the maximum allowable payments to these providers, multiply the MAP amounts listed in the Schedule by the following SLAFs:

Nurse Practitioners: .85

Physician Assistants: .85

Clinical Social Workers: .75 for therapeutic and diagnostic services other than diagnostic tests; no adjustment is necessary for diagnostic tests

Physical Therapy Assistants: .85

Occupational Therapy Assistants: .85

Example: To determine payment for 30 minutes of individual psychotherapy (CPT code 90832 value \$94.50 for non-facility) provided by a clinical social worker, multiply the MAP amount in the Schedule by the service level adjustment factor, $\$94.50 \times .75 = \70.88 .

Incident-to guidelines are not applicable to services rendered under the 2020-2021 South Carolina Workers' Compensation Medical Services Provider Manual.

Services Listed in Part II

The South Carolina workers' compensation schedule of maximum allowable payment (MAP) is found in the 10 sections of Part II of this *Medical Services Provider Manual*. Each section contains the policies and procedures and Schedule of MAP amounts that are unique to that category of services. Services are listed in numeric order according to the codes assigned to them by the American Medical Association in *CPT 2020-2021* (CPT book).

For certain procedures in this Schedule, a distinction is made in the maximum allowable price based on the setting of the service. In these cases, prices are set for both office and facility settings. This distinction is based on the higher cost to the physician in providing the service in the office (non-facility) setting. Facility settings include hospitals, ambulatory surgical centers, and skilled nursing facilities.

The Schedule lists the CPT or HCPCS icons, codes, modifiers, code descriptions, MAP amounts (for facility and

non-facility based services), the number of follow-up days, and whether an assistant surgeon is allowed.

Part II is organized as follows:

SECTION 1. Evaluation and Management Services includes services such as office visits, hospital visits and consultations, CPT codes 99202-99499;

SECTION 2. Anesthesia includes anesthesiology and anesthetic injection services, CPT codes 00100-01999 and 99100-99140.

SECTION 3. Surgery includes CPT codes 10004-69999;

SECTION 4. Radiology including diagnostic ultrasound, and nuclear medicine, CPT codes 70010-79999;

SECTION 5. Pathology and Laboratory includes CPT codes 80047-89398 and HCPCS codes G0480-G0483 and G0659. HCPCS codes applicable to Pathology and Laboratory are also included in Section 9, HCPCS Level II;

SECTION 6. Medicine and Injections includes CPT codes 90281-95830, 95836, 95857-96999, 97151-97158, 97597-97610, 97802-97814, 97802-98972 and 99500-99607. HCPCS codes applicable to Medicine and Injections are included in Section 9. HCPCS Level II;

SECTION 7. Physical Medicine includes CPT codes 95851-95852, 97010-97150, 97161-97546, 97750-97799, and osteopathic/chiropractic manipulation treatment codes 98925-98943;

SECTION 8. Special Reports and Services including medical testimony, CPT codes 99070-99091, and 99151-99199 and SC001-SC006;

SECTION 9. HCPCS Level II includes codes A0021-V5364. Codes applicable to air and ground ambulance transportation are A0021-A0999 and S9960-S9961; and

SECTION 10. Pharmacy.

Services Not Listed in this Schedule

The Schedule does not include fees for general dental services, routine preventive vision care, inpatient or outpatient hospital charges, vocational or occupational rehabilitation (except for physical or occupational therapy codes). This Schedule is not used to determine payment for those services. Payment for facility services should be made in accordance with policies in the current *Hospital and Ambulatory Surgical Center Payment Manual*. Payment for other services not included in this Schedule should be based on usual and customary charges or negotiated between the provider and payer.

Commented [CO2]: Update example with new rates

The *Medical Services Provider Manual* is based on ~~2019-2021~~ CPT coding as well as selected codes from the ~~2019-2021~~ Healthcare Common Procedure Coding System (HCPCS) Level II. This Schedule is not intended as a substitute for either the CPT book or HCPCS book. Those sources include a comprehensive listing of all codes, descriptions, modifiers, and guidelines regarding the use of these codes. Providers must use *CPT 2020-2021* coding to bill for services even if a more current edition of CPT is available. If and when more recent codes are adopted by the Commission, an update will be released announcing the new codes and MAP amounts. Should such an update be issued, providers may then bill those CPT codes.

If you have questions, please call the Medical Services Division at 803.737.5700.

Maximum Allowable Payment (MAP) Amounts

This fee schedule is based on the Centers for Medicare and Medicaid Services' (CMS) resource based relative value scale (RBRVS) and FAIR Health's Medicare gap fill methodology. Relative values are derived based on the work involved in providing each service including the physician's education and specialty training required, the practice expense involved including office expenses, and malpractice insurance expense. Gap-fill values are developed for procedure codes not valued or included in Medicare fee schedules

Most MAP amounts in Part II are pre-calculated and listed as dollar amounts (Anesthesia services require the user to add a time value amount (TVA) to the basic MAP amount to determine the total MAP amount). The MAP amounts were determined by multiplying a conversion factor by the ~~2020-2021~~ geographically-adjusted relative value unit (RVU) for each service. Pursuant to South Carolina Law § 42-15-90(C)(1), procedure code MAP amounts were capped at a plus or minus 9.5 percent increase or decrease from the ~~2019-2020~~ fee schedule.

Conversion Factors (Effective April 1,

2020-2021 Anesthesia	\$30.00
All Other Services	\$50.30

Determining Payment

The maximum allowable payment (MAP) values listed in the *Medical Services Provider Manual* represent the maximum amounts that a provider can legally be paid for rendering services under the Workers' Compensation Act. In instances where the provider's usual charge is lower than the MAP amount, or where the provider has agreed by contract with an employer or insurance carrier to accept discounts or fees lower than the Commission's MAP, payment is made at the

lower amount.

Any provider who accepts an amount greater than that specified in this Schedule is in violation of the South Carolina Code of Laws Section 42-15-90 and is subject to any penalties specified by that law. Submitting a claim that lists a charge for a service at an amount greater than the MAP amount listed in the Schedule usually will result in that claim being reviewed and reduced, thereby delaying payment.

Each category of services listed in Part II has its own set of policies and procedures that determine how those services must be reported and paid. Those policies and procedures are detailed in the narrative portion of each section in Part II. Therefore, it is essential that providers read and understand the policies and procedures applicable to the service(s) rendered before submitting claims.

Services Without Maximum Allowable Payment (MAP) Amounts

Some services listed in the Schedule have not been assigned a MAP amount, but are listed as "IC" (individual consideration) in the MAP columns. Payment for those services will be determined by the payer based upon the documentation submitted by the provider to substantiate the charges billed including an adequate definition or description of the nature and extent of the service and the time, effort, and equipment necessary to provide the service. (See Chapter III for specific information about the types of documentation and reports that may be required.)

Payment will be based upon the documentation submitted by the provider to substantiate the charges billed. Policies and instructions for pricing and paying IC services are found in Chapter IV. Payment Policy. If the payer cannot make a determination based on the information submitted by the provider, the payer should contact the provider and request additional information as necessary. Providers may not charge for copies of reports, records, or other materials when they are required to substantiate a charge.

Other services may be listed with the value of "NC" (not covered). These services are not covered and should not be billed or reimbursed.

Codes Not Listed in the Schedule

Every effort has been made to include all codes that are relevant to the treatment of workers' compensation injuries and illnesses. However, it is possible that an appropriate code will not be listed in the Schedule. If you have questions whether a code may be used for this program please call the Medical Services Division at 803.737.5700 or email medical@wcc.sc.gov.

Commented [C03]: Update if anesthesia conversion factor changes

Providers Filing Claims

Claims should be completed and filed with the appropriate payer as soon as possible after the initial visit or treatment and at reasonable and regular intervals throughout the course of treatment. When filing a claim, send the original claim form to the employer and/or insurance carrier. **Do not** submit claims to the Commission for payment. Appropriate physician notes and documentation estimating lost time from work and permanent impairment should be included. This estimate of time lost from work may be changed as the patient's condition warrants.

Claims Review and Reduction

All claims for payment of medical services rendered under the Workers' Compensation Act must be reviewed prior to payment to ensure that payment is made according to the policies and MAPs outlined in this *Medical Services Provider Manual*. The Commission requires insurance carriers,

self-insured employers, and third-party administrators to be approved by the Commission to conduct claims review. (See Appendix C for reviewer approval criteria.)

No insurance carrier, self-insured employer, or third-party administrator may rely on the Commission for bill review. Parties interested in becoming approved reviewers may submit a letter of interest to the Medical Services Division.

Any provider who has a question regarding a reduction should write or call the party that reviewed the claim prior to contacting the Commission. If the matter cannot be resolved by contacting the reviewer, submit the claim and any documentation to the South Carolina Workers' Compensation Commission Medical Services Division for review with a clear statement describing the issue. (See Chapter IV for further requirements and policies regarding claims review.)

Chapter II. General Policy

This chapter contains the policies and procedures governing the South Carolina Workers' Compensation Commission's Medical Services Program that apply to all authorized medical providers and payers.

EMPLOYER RESPONSIBILITIES

Upon becoming aware of an injury, an employer must offer medically necessary remedial treatment, care, and attendance to an injured employee. Employers may direct employees to a specific medical provider. However, the provider selected and the care authorized must be appropriate to the injury.

AUTHORIZATION TO TREAT

Medical providers must receive authorization from the employer or insurance carrier prior to providing treatment, except for emergency care when the carrier cannot be reached. If an employer/carrier has reason to believe that the proposed treatment is not medically necessary to the employee's work-related injury, the employer/carrier is not obligated to approve the treatment. An employer who authorizes treatment, whether verbally or in writing, enters into a contract with the provider and is responsible for paying for that service, even if it is determined later that the injury was not work-related. When authorizing treatment, every effort should be made to verify, as specifically as possible, what service or services the provider is proposing. Whenever possible, approve services by CPT code. This will help eliminate any possibility of a dispute between the provider and the employer/carrier regarding the review and payment of the bill.

Providers should, whenever possible, obtain written authorization from the employer. Providers may request that the employer fax or email a written authorization at the time authorization is given. If it is not possible to obtain written authorization, the provider must document the authorization by noting the date and time of the authorization and the name of the individual who authorized treatment. Verifying employment or that the employer has workers' compensation coverage is not authorization to treat. Procedures that are not routinely performed (experimental) should not be authorized. (See Medical Necessity in this chapter.)

Referrals

When an authorized provider makes a referral to a second provider for continued care of an injured employee, the second physician must receive authorization from the employer/carrier before providing treatment.

Employers/carriers who have reason to believe that the treatment proposed is not medically necessary to the employee's work-related injury may refuse authorization to the second physician.

Non-Physician Providers

Non-physician medical providers may be authorized by the insurance carrier to treat an injured employee if their services are medically necessary and have been prescribed by an authorized physician. If authorized by the insurance carrier, these medical providers must submit their claims in accordance with South Carolina regulations and the policies contained in this manual.

PROVIDER SELF-REFERRAL LAW

South Carolina law (Chapter 113, Title 44, SC Code) restricts physicians and other providers from making patient referrals to diagnostic and treatment facilities in which they have an economic interest. The exceptions are facilities owned by physicians prior to enactment of the Provider Self-Referral Act (May 1993) and facilities in rural or underserved areas. Physicians referring patients under these exceptions must notify patients in writing of their economic relationships and provide information about charges. They must also provide information about alternative sites for services. Additional information about the self-referral law is available through either the South Carolina Department of Health and Environmental Control or the South Carolina Medical Association.

MEDICAL NECESSITY

Any medical intervention used to identify or treat a workers' compensation on-the-job injury or work-related illness must be medically necessary. For the purpose of workers' compensation, an intervention is medically necessary when:

1. It is used for a medical condition;
2. There is sufficient evidence to draw conclusions about the intervention's effect on health outcomes;

3. The evidence demonstrates that the intervention can be expected to produce its intended effects on health outcomes;
4. The intervention's expected beneficial effects on health outcomes outweigh its expected harmful effects; and
5. The intervention is the most cost-effective method available to address the medical condition.

The intervention must also be widely accepted by the practicing peer group, based on scientific criteria, and determined to be reasonably safe. It must not be of an experimental, investigative, or research nature. Services that do not meet these qualifications must not be approved or paid for under the Workers' Compensation Act.

DOCUMENTING SERVICES RENDERED

Providers are required to submit documentation to substantiate charges for services rendered under the Workers' Compensation Act. Such documentation may include:

1. An operative report for a surgical procedure;
2. A report for an Independent Medical Evaluation (IME) or consultation;
3. Clinical notes for a visit to determine Maximum Medical Improvement (MMI) and permanent impairment rating;
4. A plan of care for physical medicine therapy;
5. Report of psychiatric evaluation and tests;
6. Results of neuromuscular testing procedures;
7. Any report required by procedure code descriptors; and
8. Any report required by the policies of this manual.

Failure to provide such documentation when requested may result in a service being disallowed and payment denied and may result in the provider being fined up to \$200.00 pursuant to S.C. Code Section 42-15-95. For this reason, it is in the provider's own interest to maintain appropriate documentation and reports. Examples of medical documentation that may be requested include medical records, patient plan of care, or narrative documentation.

Medical Records

The provider's medical record is the basis for determining medical necessity and for substantiating the service(s) rendered; therefore, the record may be requested by the insurance carrier. Medical records may be stored as paper or electronic records, must be legible, and include information pertaining to:

1. The patient's history and physical examination appropriate to the level of service indicated by the presenting injury or illness;
2. Operative reports, test results, and consultation reports; and
3. Progress, clinical or office notes that reflect subjective complaints of the patient, objective findings of the practitioner, assessment of the problem(s), and plan(s), or recommendation(s).

Narrative Documentation

When specifically requested, the provider must substantiate the medical necessity of a proposed treatment. This documentation may include copies of office notes or other specific information that demonstrates the need for the proposed treatment. When it is necessary to substantiate the medical necessity of any service beyond the information contained in the medical record, the treating physician must provide in writing the supporting documentation. Such additional documentation may include objective findings that support the need for medical treatment, the estimated period of time and the estimated number of services required for treatment, the anticipated benefits to the patient, and/or the reasons for continuing treatment. Providers may not be paid for submitting documentation to substantiate charges or medical necessity.

RELEASE OF INFORMATION

Providers do not need to obtain authorization from the injured worker to release medical records relating to a workers' compensation claim. An employee who seeks treatment under the provisions of the Workers' Compensation Act is considered to have given consent for the release of medical records relating to the examination or treatment. (See Appendix A for S.C. Code Section 42-15-95 and Regulation 67-1308.)

All information compiled by a health care provider pertaining directly to a workers' compensation claim must be provided to the insurance carrier, the employer, the employee, their respective attorneys or certified rehabilitation professionals, or to the Commission within fourteen days after receipt of written request.

A health care provider who examines or treats an injured worker may discuss or communicate an employee's medical history, diagnosis, causation, course of treatment, prognosis, work restrictions, and impairments with the insurance carrier, employer, their respective attorneys or certified rehabilitation professionals, or the Commission without the employee's consent. The employee must be:

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1. Notified by the employer, carrier, or its representative requesting the discussion or communication with the health care provider in a timely fashion, but no less than ten days' notice unless the parties agree otherwise. Notification may be oral or in writing;
2. Advised by the employer, carrier or its representative requesting the discussion or communication prior the discussion or communication;
3. Allowed to attend and participate, along with the claimant's attorney, if any; and
4. Provided a copy of the written questions at the same time the questions are submitted to the health care provider and provided a copy of the response from the health care provider.

COPIES OF RECORDS AND REPORTS

Providers are entitled to charge for the cost of copying records and reports except when such documents are requested by the Commission or for the purpose of substantiating a charge and/or medical necessity. (See Appendix A for S.C. Code Section 42-15-95 and Regulation 67-1301.)

~~The maximum charge for providing records and reports other than for substantiating medical necessity is \$25.00 for a clerical fee plus \$0.65 per page for the first 30 pages in *Print or Electronic format*, and \$0.50 per page thereafter provided in an *electronic format*, which may not exceed \$150.00 per request, plus sales tax, and actual cost for postage to mail the documents. Providers must respond to a request for copies within 14 days of receipt or face a penalty of up to \$200.00. Section 42-15-95 of the S.C. Code, which governs charges for copies, can be found in Appendix A.~~

Providers are required to include supporting documentation when submitting claims, or when required by an insurance carrier, self-insured employer, or the Commission to submit substantiating documentation, and may not charge for these required reports. (See Regulation 67-1302 B(2).) However, when the records or reports are not for the purposes listed above, providers may charge for copying costs. Copying charges are \$0.65 per page for the first 30 pages provided in *electronic format*, and \$0.50 per page thereafter provided in an *electronic format*, which may not exceed \$150.00 per request, plus a clerical and handling fee of \$25.00 plus tax and actual postage costs. Providers must respond to a request for copies within 14 days of receipt or face a penalty of up to \$200.00. Section 42-15-95 of the S.C. Code, which governs charges for copies, can be found in Appendix A. Providers are entitled to charge for the cost of copying records and reports except when such documents are requested by the Commission or for the purpose of substantiating a charge and/or medical necessity.

Providers are required to include supporting documentation when submitting claims, or when required by an insurance carrier, self-insured employer, or the Commission to submit substantiating documentation, and may not charge for these required reports. (See Regulation 67-1302 B(2).) However, when the records or reports are not for the purposes listed above, providers may charge for copying costs. Copying charges are \$0.65 per page for the first 30 *printed* pages, and \$0.50 per *printed* page thereafter, *which may not exceed \$200.00 per request*, plus a clerical and handling fee of \$25.00 plus tax and actual postage costs. Providers must respond to a request for copies within 14 days of receipt or face a penalty of up to \$200.00. Section 42-15-95 of the S.C. Code, which governs charges for copies, can be found in Appendix A. Providers are entitled to charge for the cost of copying records and reports except when such documents are requested by the Commission or for the purpose of substantiating a charge and/or medical necessity.

A facility or provider may charge a patient or the patient's representative no more than the actual cost for duplicating an x-ray film or digital image. Actual cost means the cost of materials and supplies used to duplicate the x-ray film or digital image and the labor and overhead costs associated with the duplication.

Providers who use a medical records company to make and provide copies of medical records or x-ray images must ensure that neither the Commission nor the reviewer is billed for the cost of copies when the purpose of the copies is to substantiate a charge and/or medical necessity.

Note: Providers do not need to obtain authorization from the injured worker to release medical records relating to a workers' compensation claim. An employee who seeks treatment under the provisions of the Workers' Compensation Act is considered to have given consent for the release of medical records relating to the examination or treatment.

Chapter III. Billing Policy

This chapter contains policies and procedures governing providers submitting claims to payers for payment and payers or medical providers submitting claims to the Commission for review. Specific instructions for completing claim forms are found in Chapter V. Additional billing policies are listed in Part II of this document. Each section in Part II contains billing information and policies specific to the category of services listed in that section.

BILLING INFORMATION

Providers must submit legible and complete health insurance claim forms. A complete claim form is one in which all information necessary to process the claim is present, accurate, and listed in the proper location on the claim form. Any attachment to a claim form must be labeled in the upper right corner with the patient's name, Social Security number, and date of accident. (See Chapter V for complete details on completing claim forms.)

Any provider who files a claim or causes a claim to be filed on his/her behalf is indicating that the service(s) reported was both medically necessary and rendered as billed.

BALANCE BILLING AND PURSUING COLLECTION FROM THE CLAIMANT

If a provider's charge is greater than the maximum allowable payment (MAP) amount, the provider must not bill the patient or the employer for the difference pursuant to Section 42-15-90 of the S.C. Code of Laws. When a provider renders a service that is not covered under workers' compensation, the provider may not charge the patient for the service unless the patient understands that the service is not covered and has agreed in writing to assume responsibility for payment prior to rendering the service.

It is unlawful for a medical provider to actively pursue collection procedures against a workers' compensation claimant prior to the final adjudication of the claimant's claim. A medical provider who violates this statute after receiving written notice from the claimant or the claimant's attorney is guilty of a misdemeanor and may be fined \$500.00, payable to the claimant.

MISSED APPOINTMENTS

Providers must not bill for missed appointments. Payment is only made for actual services rendered. Notify the insurance carrier/employer if the injured worker is not following the prescribed course of treatment.

MEDICAL CLAIM FORMS

The Commission has adopted the CMS Form 1500 (version 02/12) as its Form 14-A. The CMS-1500 is the standard health insurance claim form used in physician offices.

Claim forms may be obtained from the United States Government Printing Office at <http://bookstore.gpo.gov> and are available from printing companies and office supply stores. A sample of the form is found at the end of Chapter V of this fee schedule and can be downloaded from CMS at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1188854.html>

SERVICE CODES

The AMA's *Current Procedural Terminology* (CPT) and selected groups of CMS's Healthcare Common Procedure Coding System (HCPCS) codes are used to report services. CPT coding is used primarily for services and HCPCS coding is used primarily for select procedures, supplies, and durable equipment. All codes, descriptors, and MAP amounts are listed in Part II. Services not listed in the Schedule will be considered by individual consideration or are not covered. (For details regarding payment by individual consideration or not covered services, see Chapter IV. Payment Policy.)

INJECTABLE PHARMACEUTICALS, SUPPLIES, AND DURABLE EQUIPMENT

HCPCS codes are used to report injectable pharmaceuticals, supplies, and durable medical equipment. These codes, descriptors, and MAP amounts are found in Part II.

Supplies provided to an injured worker, or supplies used over and above those normally required to perform a service, may be billed using the appropriate code as listed in Section 9, HCPCS Level II. If no code is available in Section 9 to

accurately describe the supply, use CPT code 99070 and price the supply at actual cost plus 20 percent.

ADMINISTRATION KITS

Administration kits packaged by the manufacturer and assigned a single National Drug Code (NDC) may be reimbursed the Average Wholesale Price (AWP) of the kit without additional markup. Kits packaged by the provider or other source are considered to be part of the administration of the pharmaceutical and are not separately reimbursed even if reported with an NDC or HCPCS Level II code. Only those supplies and materials over and above those usually provided in the office of the physician or other qualified health care professional may be reported in addition to the pharmaceutical drug and administration as discussed above and in Part I of the [2020-2021 Medical Services Provider Manual](#).

MEDICALLY UNLIKELY EDITS (MUEs)

Medically unlikely edits (MUEs) are applied according to the provider type. If the supply is provided in the physician office, use the physician MUE; if the medical service is provided in the inpatient or outpatient facility, use the facility MUE. For a DME supply only, a Medicare-approved provider is not required to dispense the DME. The place of service (physician or facility) MUE schedule would be referenced for coverage. Significant supplies dispensed in the physician office may be reimbursed according to the guidelines in this Fee Schedule even if the MUE is 0. (See Part I Chapter IV, Paying for Supplies for more details regarding reimbursing supplies.)

MODIFIERS

A modifier is a two-digit code that is added to a CPT or HCPCS code to indicate that a service or procedure has been performed under or altered by a specific set of circumstances that do not change the definition or code. The Commission encourages providers to use modifiers to enhance the accuracy of medical services reporting, though use of a modifier may not affect actual payment. For certain services and/or circumstances the use of a modifier is required. However, the use of a modifier does not guarantee additional payment to the provider.

The modifiers applicable to South Carolina workers' compensation are listed in the various sections of Part II as they apply (e.g., the modifiers that apply to radiology services are listed in Section 4. Radiology). For a complete listing of all CPT modifiers, please refer to *CPT 2019-2020*, Appendix A.

SUBMITTING CLAIMS FOR PAYMENT

Providers are responsible for submitting claim forms to the employer or insurance carrier for payment. If you are unsure who the insurance carrier is, contact either the employer or the Commission's Coverage Division at coverage@wcc.sc.gov. Please do not send claim forms to the Commission for payment.

Providers should report medical services and supplies by submitting to the employer or insurance carrier a properly completed and legible CMS-1500 claim form or by the electronic submission of 837p format as soon as possible after the initial visit or treatment. Claims for follow-up treatment should be submitted at regular and reasonable intervals throughout the course of treatment. From time-to-time there may be delays in billing. Generally, those delays are not grounds for denying payment.

Any medical provider who discovers an incorrect payment within two years of the original billing may resubmit the claim to the payer for the correct payment. Likewise, any payer who discovers an overpayment made to a provider within two years of the original billing may request a refund from that provider. (See Appendix A for Regulation 67-1305.)

COLLECTING MEDICAL FEES

The Commission does not pay medical providers. Insurance companies, self-insurance funds, or self-insured employers providing workers' compensation coverage are directly responsible for payment of services.

To determine the status of an unpaid claim contact the employer or insurance carrier. If you are unsure who is responsible for paying the claim contact the employer to determine who the insurance carrier is. If the employer does not provide this information, you may contact the Commission in one of the following methods. The Commission maintains a current and historical record of insurance coverage for employers covered under the Workers' Compensation Act. This web-based system can be accessed at <https://wcc.sc.gov/insurance-and-medical-services/verify-coverage>

Click on the *Verify Coverage* link and enter the information requested to access the verification site. Enter the information including the date of the accident and the employer information. The name of the insurance carrier for that employer for that date will be displayed. You may also contact the Commission's Coverage Division at coverage@wcc.sc.gov for assistance.

If the employer/carrier does not make payment after being contacted, the provider may pursue payment through their normal means such as a collection agency or by legal action

against the employer/carrier. The employee may not be billed for a medical claim that is the responsibility of the employer/carrier under the Workers' Compensation Act. (See Balance Billing and Pursuing Collection from the Claimant earlier in this chapter.)

EXPLANATION OF BENEFITS (EOB)

The Commission and entities approved by the Commission may review and reduce provider charges to coincide with the guidelines of the Medical Services Program as outlined in this manual. Whenever the amount paid differs from the lesser of the amount billed or MAR, the reviewer/insurance carrier must include with the payment an Explanation of Benefits (EOB). The EOB must explain why the charge(s) has been reduced or disallowed. If the reviewer/insurance carrier uses codes to explain the adjustment, it must furnish the

provider with a written explanation of each code used. The EOB must also include appropriate identifying information so the provider can relate a specific payment to the applicable claimant, the procedure billed, and the date of service.

All EOBs must include a notice informing providers of their right to request an administrative review by the Commission's Medical Services Division in case of a disputed payment that cannot be resolved by contacting the reviewer/carrier. (For more information, see Chapter IV. Payment Policy, Disputed Payments.)

The EOB may be provided as a paper document or electronically for those providers accepting electronic funds transfer (EFT).

Chapter IV. Payment Policy

This chapter contains policies and procedures governing the payment of workers' compensation claims for medical services. The information herein will serve as a guide to payers when determining appropriate payment for medical claims.

GENERAL PAYMENT POLICY

Payment will be made only for authorized, medically necessary services (see Chapter II. Medical Necessity) that are performed by a physician, performed under a physician's supervision or direction, or performed pursuant to a physician's prescription. The amount paid will be the lesser of the provider's usual and customary charge or the maximum allowable payment (MAP). Payment will be made only for actual services rendered; no payment will be made for missed appointments.

TIMELINESS

Payment to authorized medical providers shall be made in a timely manner but no later than 30 days of the request for payment, pursuant to Section 42-9-360 of the South Carolina Code of Laws. Exceptions to the 30-day requirement may be made when the bill requires review by the Commission, or when documentation necessary for the review of the bill was not submitted with the claim and must be requested from the provider.

Information Submitted to the Commission

Payers must submit to the Commission a copy of the claim form reporting the initial visit for each physician, a change of condition, and final medical rating. All documents and claim forms must be maintained on file and furnished to the Commission within 10 days of a request.

MEDICAL SERVICES RENDERED IN ANOTHER STATE

The MAP amounts listed in this manual are not applicable to medical services rendered outside of the State of South Carolina even when the services are provided under the South Carolina Workers' Compensation Act. Therefore, insurers and self-insureds should inquire about and negotiate rates with out-of-state providers prior to authorizing care, except in emergency situations.

OUT-OF-STATE INJURIES OR WORK-RELATED ILLNESSES TREATED IN SOUTH CAROLINA

Occasionally an individual who was injured in another state will seek treatment from a medical provider in South Carolina. In such a case, the injury may not be under the jurisdiction of the South Carolina Act. If the injury is under the jurisdiction of another state's workers' compensation act, the policies and procedures listed in this manual would not apply. However, when a worker receives medical services in South Carolina pursuant to the South Carolina Act, payment is subject to the requirements and MAP amounts of this manual regardless of the site of injury. Providers may contact the payer to determine whether benefits are being provided pursuant to South Carolina law or the laws of another state.

PAYER RESPONSIBILITIES

Date stamps or other information the payer or reviewer may wish to place on the claim form must not interfere with or obscure the information entered by the provider.

Additionally, the payer must not alter the information entered on the claim form or in the electronically submitted claim. If a claim form is illegible or incomplete the payer/reviewer may either call the provider and ask for clarification or return the claim to the provider for correction or completion.

NATIONAL CORRECT CODING INITIATIVE

The Commission has adopted and follows the National Correct Coding Initiative (NCCI). This coding initiative was developed and is updated under the direction of the Centers for Medicare and Medicaid Services (CMS) to promote correct coding of health services and prevent payment for improperly coded services. The NCCI is comprised of edits to evaluate claims when a provider bills more than one service for the same patient for the same date of service. It is based on coding conventions in the American Medical Association's Current Procedural Terminology (CPT) book, coding guidelines from national societies, and analysis of medical and surgical practices. The purpose of the NCCI is to ensure that the most comprehensive group of codes are billed rather than the component parts, and to edit codes that cannot reasonably be performed together based on either the definition or anatomical considerations. The NCCI is a nationally recognized system used by Medicare

since 1996, and followed by state Medicaid programs and health insurance carriers. More information about the National Correct Coding Initiative can be found at: https://www.cms.gov/Medicare/Coding/NationalCorrectCodingInitEd/index.html?redirect=/NationalCorrectCodingInitEd/01_overview.asp

Medically Unlikely Edits

CMS has adopted medically unlikely edits (MUE) that are part of the NCCI. The MUE edits identify how many times a specific procedure can be reported per day or per claim. Not all CPT or HCPCS codes will have an MUE assigned. These are nationally recognized edits used by Medicare since 2007 and followed by state Medicaid programs and health insurance carriers. More information about the medically unlikely edits can be found at:

<https://www.cms.gov/Medicare/Coding/NationalCorrectCodingInitEd/MUE.html>

Medically unlikely edits (MUEs) are applied according to the provider type. If the supply is provided in the physician office use the physician MUE; if the medical service is provided in the inpatient or outpatient facility, use the facility MUE. For DME supply only, a Medicare-approved provider is not required to dispense the DME. The place of service (physician or facility) MUE schedule would be referenced for coverage. Significant supplies over and above those usually included with the procedures rendered that are dispensed in the physician office may be reimbursed according to the guidelines in this Fee Schedule even if the MUE is 0. (See Part I Chapter IV, Paying for Supplies for more details regarding reimbursing supplies.)

Add-on Code Edits

CMS has adopted add-on code edits. These edits identify the primary procedure that should be reported with the add-on code, or those codes that do not specify a primary procedure. Add-on codes are identified as a type I, II, or III.

- Type I has a limited number of identifiable primary procedure codes;
- Type II does not have a specific list of primary procedure codes; and
- Type III has a list of some, but not all, primary procedure codes identified.

For example, add-on code guidelines indicate that code 99292 may be reported by a provider who does not report 99291 if another provider of the same specialty from the same group reports 99291 on the same date. The add-on code edits have been recognized by Medicare since 2013, and followed by state Medicaid programs and health insurance carriers. More information about the add-on code

edits can be found at:

<http://www.cms.gov/Medicare/Coding/NationalCorrectCodingInitEd/Add-On-Code-Edits.html>

REVIEWING FOR CORRECT CODING

Approved reviewers must review claims to ensure that proper billing procedures were followed but must not routinely down-code services as a method of reducing costs. However, there may be instances where a reviewer, based on a conscientious review of the documentation, has legitimate reason to question whether the code billed accurately describes the service(s) rendered.

Services Not Substantiated by Documentation

In a case where the reviewer cannot find evidence in the office notes or operative report that the service was performed, the charge for that service may be denied. The EOB must indicate the reason for the denial.

Services Not Accurately Coded

When a service billed is supported by documentation but the code selected by the provider is not the most accurate code available to describe that service, the reviewer must not deny payment for the service but must recommend payment at the MAP amount of the more accurate code. The disputed amount shall be limited to the amount of the difference between the MAP of the code billed and the MAP of the code recommended by the reviewer.

The payer may not take the position that the provider's acceptance of payment constitutes agreement with the decision. A provider maintains the right to payment for the service rendered and the right to dispute the difference between the MAP of the code billed and the MAP of the code paid.

The EOB must indicate that the service was paid according to the code that appeared to best describe the service rendered as documented. A provider who disagrees with the coding reassignment may dispute the decision according to the guidelines stated in the Payment Dispute Resolution Process section later in this chapter.

Examples of common coding errors include:

- An office visit is coded at a higher level than substantiated by the medical record;
- Two x-ray codes are billed when a single x-ray code describes the number of views taken; and
- A debridement code is billed with another code whose descriptor includes debridement.

Providers can reduce the frequency of services being re-coded by following the guidelines established by this *Medical Services Provider Manual*.

DETERMINING PAYMENT FOR SERVICES LISTED AS INDIVIDUAL CONSIDERATION (IC)

Some services listed in the Schedule have not been assigned a MAP amount but are listed as “IC” (individual consideration) in the MAP column. Payment for those services will be determined by the payer based upon the documentation submitted by the provider to substantiate the charges billed (see Chapter III for specific information about the types of documentation and reports that may be required). The payer will pay IC services based upon a review of the submitted documentation, the recommendation of the payer’s medical consultant and/or the payer’s review of prevailing charges for similar services.

If the payer cannot make a determination based on the information submitted by the provider, the payer should contact the provider and request additional information as necessary. Providers may not charge for copies of reports, records, or other materials when they are required to substantiate a charge.

MULTIPLE PATIENT VISITS PER DAY

Unless authorized by the employer/carrier and substantiated by medical necessity, only one patient visit per day per authorized provider may be paid. If a provider submits a claim for two office visits on the same day and does not substantiate the medical necessity, only the highest level of service provided will be paid. (See Medically Unlikely Edits in this chapter.)

SEPARATE PROCEDURES

The narrative for many CPT codes includes a parenthetical statement that the procedure represents a “separate procedure.” The inclusion of this statement indicates that the procedure, while possible to perform separately, is generally included in a more comprehensive procedure, and the service is not to be billed when a related, more comprehensive, service is performed. The “separate procedure” designation is used with codes in the surgery (CPT codes 10004–69990), radiology (CPT codes 70010–79999), and medicine/physical medicine/special reports (CPT codes 90281–99199, ~~and~~ 99500–99607 and SC001-SC006) sections. When a related procedure from the same section, subsection, category, or subcategory is performed, a code with the designation of “separate procedure” is not to be billed with the primary procedure. (See National Correct Coding Initiative in this chapter.)

TOTAL PROCEDURES BILLED SEPARATELY

Certain diagnostic procedures (neurologic testing, radiology and pathology procedures, etc.) may be performed by two separate providers who will each submit a separate claim for the professional and technical components. When this occurs, payment will be made according to the professional and technical MAP amounts listed in the Schedule.

The billing procedures in Part II stipulate that providers must indicate on the claim form that the technical and professional components were performed separately by adding a modifier to the CPT code. Modifier 26 indicates that only the professional component was performed and modifier TC indicates that only the technical component was performed.

The total reimbursement will not exceed the combined MAP of the professional component and the technical component.

For additional information, refer to the policies for the specific category of services in Part II.

PAYING FOR SUPPLIES

Providers may be paid for medically necessary supplies provided to an injured worker, or for supplies used over and above the supplies normally required for a service. Part II Section 9 of this Manual lists the coding and MAPs for supplies typically used. In the event that a supply cannot be identified using the codes listed in Part II Section 9, payment should be made at the actual cost of the item plus 20 percent. A carrier or claims reviewer who has legitimate reason to believe that a charge exceeds cost plus 20 percent may request from the provider a copy of the invoice(s) showing the actual cost of the item(s). Reviewers must not routinely request invoices as a matter of course, and should avoid requesting copies of invoices when charges are for minimal amounts. (See Medically Unlikely Edits (MUEs) above for more information regarding DME supplies.)

CLAIMS REVIEW AND REDUCTION

Only the Commission and Commission-approved medical claims review companies, third-party administrators, insurance carriers, and self-insured employers may review and reduce claims. Parties interested in becoming approved reviewers may submit a letter of interest to the Medical Services Division. No party may rely on the Commission for bill review services. (See Appendix C for more information about becoming an approved reviewer.)

EXPLANATION OF BENEFITS (EOB)

Whenever an approved claims reviewer reduces the amount of a charge or denies payment of a charge, that reviewer must

provide an Explanation of Benefits (EOB) to the medical provider. Whenever payment is made for an amount different than the amount billed for a service, an EOB must accompany the payment.

The EOB must be a separate document (payers may not write codes or explanations directly on the original claim form) and must contain appropriate identifying information so the provider can relate a specific payment to the applicable claimant, the service billed, and the date of service. Acceptable EOBs may include:

1. Copies of the claim on which payments and EOB codes are listed; and
2. Manually produced or computerized forms or electronic communication that contains EOB codes, narrative explanations, and the appropriate identifying information.

The EOB must clearly explain why the provider's charge has been reduced or disallowed. Payers may develop codes to explain the reason for adjustment or denial, and must furnish the provider with a narrative explanation of each EOB code used.

The EOB must also include a statement informing the provider of their right to a review by the Medical Services Division in the case of a dispute that cannot be resolved by contacting the reviewer.

Sections 67-1305 (B) and (C) of the South Carolina Code of Regulations state:

- B. A Medical provider who disagrees, based on Commission payment policy, with a reduction *[to a medical bill]* may appeal the decision *[to reduce the medical bill]* directly to the payer/reviewing entity.
- C. If the disagreement cannot be resolved between the provider and the payer/reviewer, the matter may then be referred to the Commission's Medical Services Division for review and resolution.

Include verbiage below on EOB:

Formal Disputes Only: Such requests are to be submitted through the South Carolina Workers' Compensation Commission website at:

<https://wcc.sc.gov/archived-documents/medical-services/payment-dispute-resolution-process>

or in writing to SCWCC Medical Services Division, Post Office Box 1715, Columbia, South Carolina 29202.

PAYMENT DISPUTE RESOLUTION PROCESS

Timely Payment

State of South Carolina law (42-9-360(d)) provides that "Payment to an authorized health care provider for services shall be made in a timely manner but no later than thirty days from the date the authorized health care provider tenders request for payment to the employer's representative, unless the commission has received a request to review the medical bill."

In cases in which a medical provider has not received full payment for Workers' Compensation services pursuant to the South Carolina Workers' Compensation Act (when such payment is not adjusted through contractual agreements in place between the parties), the medical provider may observe the following procedure.

1. If, following the earlier of the expiration of the initial 30-day billing period, or the receipt of a partial payment for services billed, the medical service provider believes they are entitled to additional payment under the Workers' Compensation Act (WCA), the medical service provider shall issue a written "2nd Notice for Payment." Sample letters are available at:
https://wcc.sc.gov/sites/default/files/Documents/Footer/Archived_Documents/Medical_Services/Payment%20Dispute%20and%20Notice%20-%20partial%20payment.pdf

The Commission encourages the provider to tender a "2nd Notice" via "receipt confirmed" means (e.g., certified mail; commercial delivery carrier; etc.) or confirmation of electronic submission.
2. If, 30 days following the issuance of a "2nd Notice for Payment," the medical services provider has:
 - a. received no response from the payer, the provider may submit a petition and supporting documentation to the Medical Services Division stating that:
 - i. the payer has not responded to the "2nd Notice";
 - ii. the provider is entitled to the lesser of the billed payment amount or the South Carolina Workers' Compensation Commission (SCWCC) maximum allowable payment; and
 - iii. the provider desires the SCWCC to issue a finding supporting payment from the payer.
 - b. not received full payment, the provider may petition the South Carolina Workers' Compensation Commission Medical Services Division to review the case and issue a determination. Supporting documentation as defined within the petition

Policy

document must be provided to the SCWCC at the time of submission.

3. Upon receipt and review of the provider's petition, the SCWCC may (if the provided information warrants) initiate an information discovery process. During this process, the SCWCC shall issue a "Notice of Dispute" to the payer, the employer, and the provider, and shall include copies of all documentation provided to the SCWCC concerning the case. The payer shall have 30 days from the issuance of the "Notice of Dispute" to respond to the SCWCC.
 - a. In cases in which the provider alleges that the payer has not responded to the "2nd Notice," the SCWCC shall issue a "Notice of Dispute" and request that the payer provide evidence that it did respond in writing (as evidenced by certified mail receipt) to the "2nd Notice" within the 30-day period described in section 2 above.
 - b. In cases in which the provider confirms that payer has provided written response to the "2nd Notice," payer shall provide to the SCWCC documentation justifying its non-payment or partial payment of provider's bill.
4. Within 21 days of the earlier of the expiration of the "Notice of Dispute" period or the payer's response to the "Notice of Dispute," the SCWCC shall issue its determination of the case. If such determination instructs specific action to be taken by the parties to the case, such action must be completed within 14 days of the issuance of the SCWCC's determination.
5. Please note: The Payment Dispute Resolution Process is not designed to permit the intentional delay of payment of provider service fees. Medical Bill Review entities which are found to have withheld payment on non-substantiated grounds may be subject to administrative fines and penalties up to the suspension and/or revocation of their approval to conduct South Carolina Workers' Compensation Medical Bill Review services.
6. Medical Bill Dispute documents must be submitted to the South Carolina Workers' Compensation Commission, Medical Services Division, via the State of South Carolina Secure Email account to ensure a secure and safe manner to submit personal identifiable information (PII) and Personal Health Information (PHI). (See Request a State of South Carolina Secure Email in this chapter.)

Payment Reconsideration

When a provider is dissatisfied with a payer's reduction or denial of a charge for any service, the provider may make a written request for reconsideration to the payer/reviewer within 60 days from receipt of the EOB. The request must

include a copy of the claim in question, the payer's EOB and any supporting documentation to substantiate the charge/service in question. A dispute must be based on extenuating circumstances involved in the case or when a provider believes that the review was not in accordance with Commission policy. Providers may not dispute a payment because of dissatisfaction with a MAP amount.

Upon receipt of a request for reconsideration, the payer must review and re-evaluate the original bill and accompanying documentation, using its own medical consultant if necessary, and respond to the provider within 30 days of the date of receipt. The payer's response to the provider must explain the reason(s) behind the decision and cite the specific policy upon which the final adjustment was made.

If the provider finds the result of the payer's reconsideration unsatisfactory, that provider may then request the Medical Services Division resolve the dispute. Send a written request for resolution of a disputed payment to the Division within 60 days of the payer's reconsideration, or 90 days from the date of the original request for reconsideration when the payer has not responded. A request for resolution of a disputed payment must include the following:

1. a cover letter detailing the nature of the dispute and what the provider believes is the correct resolution;
2. copies of the original and resubmitted bills;
3. copies of the EOB;
4. copies of supporting documentation; and
5. copies of correspondence and/or specific information regarding contact with the payer.

The Medical Services Division will review the information, make a determination and provide written notification of its decision to both the provider and the payer within 30 days of receipt.

As noted above, all documents containing Personal Identifiable Information (PII) and Personal Health Information (PHI) must be submitted using a secure email account. (See Request a State of South Carolina Secure Email in this chapter.)

The Commission's review and determination is final.

Request a State of South Carolina Secure Email

The following steps must be taken to obtain a secure email account with South Carolina Workers' Compensation Commission (SCWCC).

1. Send an email to mbdispute@wcc.sc.gov with the following in the subject line (please do not alter the wording):

Sign up for a SC State Secure Email Account Request

2. You will receive two emails:

3. Upon receipt of the WELCOME email, click the link to “Activate your personal account” and follow the instructions on the page. Once you have finished setting up your new secure email account you will see an inbox. Please read the initial email for additional instructions on initiating a new Medical Bill Dispute or adding additional documentation to an existing medical dispute.

Medical Bill Dispute Form

Copies of the medical bill dispute form may be obtained at:

<https://wcc.sc.gov/archived-documents/medical-services/payment-dispute-resolution-process>

A copy of this form is included at the end of this chapter.

APPROVED REVIEWERS SUBMITTING CLAIMS TO THE COMMISSION FOR REVIEW

THE SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION DOES NOT PROVIDE MEDICAL BILL REVIEW SERVICES.

Payers and bill review entities must become approved to review workers' compensation claims for medical services and, as approved reviewers, must attempt to process all claims submitted to them for payment.

In the very rare instances where a claim involves **unusual circumstances** or **unusually complex coding**, the reviewer may, after conducting the initial review, refer the claim to the Medical Services Division for review. Such requests for

review may be submitted to the Commission only via secure email and **MUST** include an explanation of why the reviewer believes the issue represents an unusual circumstance or unusually complex coding matter. Reviewers found to be submitting frequent and/or non-unusual or complex matters for review by the Commission may face fines/penalties and/or revocation of their bill review privileges. A claim submitted to the Medical Services Division for review must be accompanied by:

- a cover letter indicating what service(s) the provider had been approved to render;
- a printout showing the results of the initial review; and
- any documentation or correspondence relating to the claim.

All claims and accompanying documentation sent to the Commission must include the seven-digit Workers' Compensation Commission File Number, the payer code number, employer's FEIN and payer file number in the upper right corner. All documents submitted should be in duplicate, and the payer should maintain a copy of the claim and any attachments.

Claims submitted for review and related documents must be submitted to the South Carolina Workers' Compensation Commission, Medical Services Division, via the State of South Carolina Secure Email account to ensure a secure and safe manner to submit personal identifiable information (PII) and Personal Health Information (PHI). (See Request a State of South Carolina Secure Email in this chapter.)

Any claim submitted to the Medical Services Division without all required information as listed above may be returned for correction or completion.

State of South Carolina

1333 Main Street, 5th Floor
P.O. Box 1715
Columbia, S.C. 29202-1715



TEL: (803) 737-5700
www.wcc.sc.gov

Workers' Compensation Commission

INITIAL MEDICAL BILL DISPUTE FORM

Date:

PERSON REQUESTING MEDICAL BILL REVIEW/DISPUTE

Name:

Email Address: Telephone:

WCC # (if available): Carrier Claim #:

PATIENT INFORMATION

Patient Name

Prefix: First Name: Middle Initial: Last Name: Suffix:

Last 5 digits of Social Security Number:

MEDICAL PROVIDER INFORMATION

Name of Provider:

Provider Mailing Address:

City, State, Zip:

Provider Contact Name:

Provider Contact Email Address:

Provider Contact Telephone:

Provider Contact Supervisor Name:

Provider Contact Supervisor Email Address:

Provider Contact Supervisor Telephone:

EMPLOYER INFORMATION

Employer Name:

Employer Mailing Address:

City, State, Zip:

Employer Contact Name:

Employer Contact Email Address:

Employer Contact Telephone:

INSURANCE CARRIER INFORMATION

Carrier Name:
Carrier Mailing Address:
City, State, Zip:
Carrier Contact Name:
Carrier Contact Email Address:
Carrier Contact Telephone:

THIRD PARTY ADMINISTRATOR (TPA)

TPA Contact Name:
TPA Contact Email:
TPA Contact Telephone:

CASE INFORMATION

Dates of Service (mm/dd/yyyy – may enter multiple dates):
Date of Injury (DOI) (mm/dd/yyyy):
First Bill Date (mm/dd/yyyy):
2nd Notice Date (mm/dd/yyyy – must be at least 30 days after first bill date):
Employer/Carrier/TPA response date (mm/dd/yyyy) – must be after first bill date and up to 30 days after second notice:

REASON FOR THE DISPUTE

Instructions:

This form and the following attachments should be submitted via **secure** email to the Medical Services Division at MBDispute@wcc.sc.gov. The document file name of attachments should include the patient's last name and a description of the document is (i.e., first bill, second notice, or EOB), date of injury (i.e., yyyyymmdd).

- INITIAL MEDICAL BILL DISPUTE FORM** (document file name example: Iname_MBD_yyyymmdd.pdf)
- First Bill** – (document file name example: Iname_First_Bill_yyyymmdd.pdf)
- Second Notice** – (document file name example: Iname_Second_Notice_yyyymmdd.pdf)
- EOB** – (document file name example: Iname_EOB_yyyymmdd.pdf)
- Supplemental documentation** – (document file name example: Iname_Additional_Correspondence_yyyymmdd.pdf) (if applicable)
- Provider/Carrier Authorization:** verbal Written (document file name example: Iname_authorization_yyyymmdd.pdf)

Attachments: Attachments must be in .pdf format (when creating your .pdf, please create as black and white and condensed version of .pdf to reduce the size of the attachments. The size limitation for secure mail attachments is 5MB).

If, following a review of the submitted information, the Medical Services Division determines that the submitted petition is complete and the issue presented is within the regulatory purview of the Medical Services Division to review, the Medical Services Division shall notify the Employer's Representative of the petition/dispute through a "Notice of Dispute" (with copy to the Provider) and request that, within 30 days of such notification, the Employer's Representative provide documentation supporting its denial or modification of payment to the Provider. Within 21 days of the earlier of the close of the 30 day response period or receipt of the Employer's Representative's documentation, the SCWCC Medical Service Division shall make determination concerning the petition/dispute. Per SCWCC Regulations, the decision of the Medical Services Division shall be final.

Chapter V. Completing and Submitting Claims

This chapter contains specific instructions for completing medical claim forms. Failure to provide the information in the manner requested herein may result in claims being returned for correction or additional information, thereby delaying payment.

CLAIMS PREPARED BY A BILLING SERVICE

Claims prepared for a provider by a billing service must comply with all applicable sections of this Manual. The claim form must include the name, address, and telephone number of the billing service.

COPIES OF OFFICE NOTES, OPERATIVE REPORTS, AND RECORDS

Office notes, operative reports, and records pertaining to the services must be attached to the claim form when filing for the payment of medical services under the Workers' Compensation Act. These reports and records are required information and must be submitted at no charge.

Providers do not need to obtain authorization from the injured worker to release medical records relating to a workers' compensation claim. An employee who seeks treatment under the provisions of the Workers' Compensation Act is considered to have given consent for the release of medical records relating to the examination or treatment. (See Chapter II. Release of Information.)

INSTRUCTIONS FOR COMPLETING THE CMS-1500 CLAIM FORM

The instructions listed below indicate the information required to process claims for workers' compensation cases. The term "not applicable" means only for purposes of workers' compensation. Providers may include on the claim form any additional information required for their own purpose, or for the purpose of the carrier so long as it does not interfere with the information requested in the instructions below. If an element from the claim form is not listed below, it may be considered not applicable. The same

information must be provided for electronic submission of claims using 837p format.

Elements 1 Through 33 of CMS-1500 Form, 02/12 Version

1. **Mark the "OTHER" box.**
- 1a. **Insured's I.D. Number:** Enter the patient's Social Security Number or other identifier number.
2. **Patient's Name:** Enter the patient's last and first name and middle initial.
3. **Patient's Birth Date and Sex:** Enter the month, day, and year of the patient's birth (MM/DD/YY). Mark the appropriate box to indicate whether the patient is male or female.
4. **Insured's Name:** Enter the name of the employer.
5. **Patient's Address:** Enter the patient's complete address and telephone number for identification purposes.
6. **Patient's Relationship to Insured:** Not applicable.
7. **Insured's Address:** Enter the employer's complete address and telephone number.
8. **Reserved for NUCC Use:** Not applicable.
9. **Other Insured's Name:** Not applicable.
- 9a-9d. **Other Insured's Policy or Group Number:** Not applicable.
- 10a-c. **Is Patient's Condition Related To:** Mark the appropriate box.
Note: This information is necessary for third parties to determine patient's eligibility for workers' compensation insurance. Mark the appropriate box for items 10a through 10c.
- 10d. **Claim Codes (Designated by NUCC):** Not applicable.
11. **Insured's Policy Group or FECA Number:** Enter the name of the workers' compensation insurance carrier. If the employer listed in Element 4 is self-insured, enter the name of the employer or the name of the

- employer's claims administration division. If you are unsure of the carrier you may call the employer, or contact the SCWCC Coverage Division at coverage@wcc.sc.gov. To obtain this information from the SCWCC you will need to have the patient's name, social security number, date of injury, and employer name.
- 11a. **Insured's Date of Birth/Sex:** Not applicable.
 - 11b,c. **Other Claim ID/Insurance Plan Name:** Enter the worker's compensation file number (WCC#). List the insurance carrier name or employer's name if self-insured.
 12. **Patient's or Authorized Person's Signature:** Not applicable.
 13. **Insured's or Authorized Person's Signature:** Not applicable.
 14. **Date of Current Illness/Injury:** If the patient presents as a result of an accident, enter the date the accident occurred. If the patient presents as a result of an illness, enter the date of first symptoms. Date must be in MM/DD/YY format.
 15. **Other Date:** Provider should give dates (MM/DD/YY) only if the patient had symptoms the same as or similar to those for which the current claim is being submitted.
 16. **Dates Patient Unable to Work in Present Occupation:** If the claim is being filed by the primary physician responsible for the patient, enter the dates during which that physician expects the patient to be unable to return to work. Dates must be in MM/DD/YY format.
 17. **Name of Referring Physician or Other Source:** If applicable, enter the referring physician's name and professional title (e.g., M.D.).
 - 17b. **NPI:** If applicable, enter the referring physician's national provider identifier (NPI) number.
 18. **Hospitalization Dates Related to Current Services:** If the service billed is rendered as a result of, or subsequent to, a related hospitalization, enter the appropriate dates. Dates must be in MM/DD/YY format.
 19. **Additional Claim Information:** List any permanent injuries sustained by the worker.
 20. **Outside Lab/\$ Charges:** If laboratory work is being charged on this bill, this element must be completed. If the work was performed outside of the physician's office, mark "YES" and enter the amount charged for the service.
 21. **Diagnosis or Nature of Illness or Injury:** Enter the ICD-10-CM diagnosis code in order of primary importance. (Use the appropriate ICD-10-CM diagnosis code adopted by CMS as determined by date of service.) For each diagnosis indicated on the claim form, reference the alpha character A-L not the ICD-10-CM codes in Element 24E. This entry should substantiate the relationship between the diagnosis entered in Element 21 and the procedure code entered in Element 24D.
 22. **Resubmission Code:** Not applicable.
 23. **Prior Authorization Number:** If applicable, enter the prior authorization number from the carrier or employer.
 - 24A. **Date(s) of Service:** "FROM-TO" dates (MM/DD/YY to MM/DD/YY) may be utilized when the same service is provided on consecutive days. Otherwise, services must be itemized on a separate line for each date of service.
 - 24B. **Place of Service:** Enter the place of service code for each procedure performed.
 - 24C. **EMG:** Not applicable.
 - 24D. **Procedures, Services, or Supplies:** Enter the appropriate CPT or HCPCS procedure code from the *Medical Services Provider Manual* or the CPT book. When appropriate, the CPT or HCPCS two-digit modifier code must follow the procedure code.
 - 24E. **Diagnosis Pointer:** Enter the diagnosis reference alpha characters A-L from Element 21 that corresponds to the service entered in 24D.
 - 24F. **\$ Charges:** For each service rendered, enter either the provider's usual charge or the MAP amount listed in the Schedule, whichever is less.
 - 24G. **Days or Units:** Enter the number of units of service.
 - 24H. **EPSCT:** Not applicable.
 - 24I. **ID QUAL:** Not applicable.
 - 24J. **Rendering Provider ID:** Enter the NPI for the rendering provider.
 25. **Federal Tax I.D. Number:** Enter the provider's Federal Employer Identification Number (FEIN) and mark the "EIN" box. If the provider does not have a FEIN number, enter the provider's social security number and mark the "SSN" box.
 26. **Patient Account Number:** [Optional] Providers may wish to enter their own patient account number for identification purposes.
 27. **Accept Assignment:** Not applicable.

- | | |
|--|--|
| 28. Total Charge: Enter the total of all charges listed in Element 24E. Do not carry charges from one claim form forward to another claim form. | direct, personal supervision of the physician or provider, that the foregoing is true, accurate, and complete, and that the services were medically necessary and reasonable for the conditions indicated in Element 21. |
| 29. Amount Paid: Not applicable. | |
| 30. Reserved for NUCC Use: Not applicable. | |
| 31. Signature of Physician or Supplier Including Degrees or Credentials: Enter the provider signature and the date the claim was prepared.

Affixing the signature certifies that the services were rendered as reported either personally or under the | 32. Name and Address of Facility Where Services Rendered (if other than home or office):
Self-explanatory. |
| | 33. Physician's, Supplier's Billing Name, Address, Zip Code & Phone #: Self-explanatory. |

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 04/16

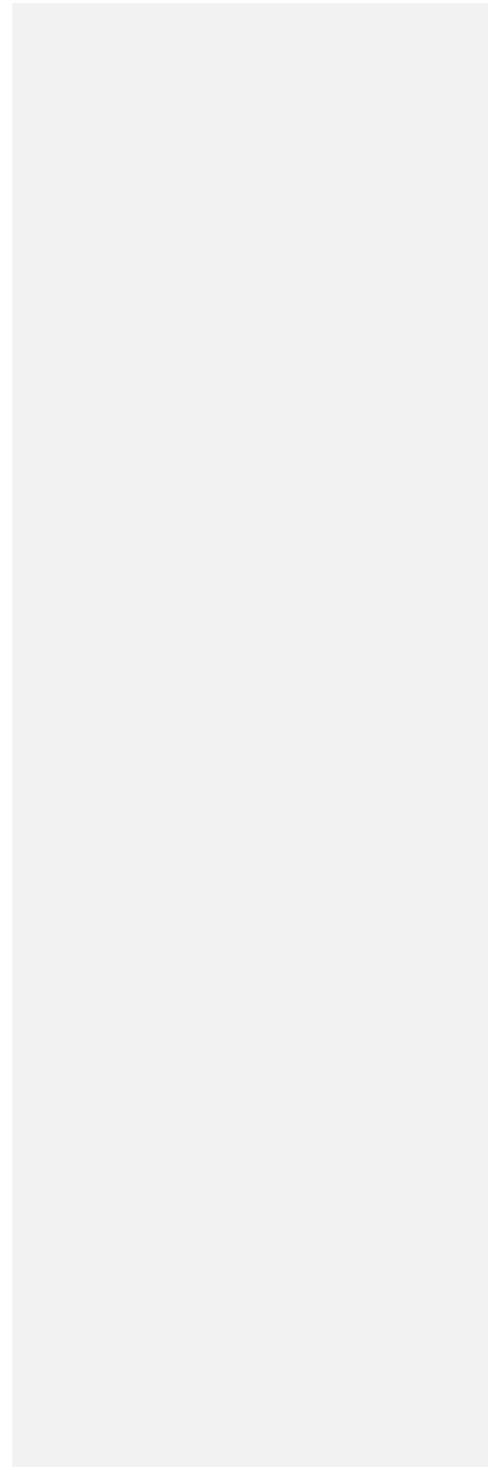
<input type="checkbox"/> PICA <input type="checkbox"/> PICA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GOV. EMP. HEALTH PLAN <input type="checkbox"/> COVA <input type="checkbox"/> OTHER <input type="checkbox"/>		1a. INSURED STATE NUMBER (For Programs 1-5 only)							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX <input type="checkbox"/> M <input type="checkbox"/> F		4. INSURER'S NAME (Last Name, First Name, Middle Initial)				
5. PATIENT'S ADDRESS (City, Street)			6. PATIENT RELATIONSHIP TO INSURED (Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURER'S ADDRESS (City, Street)				
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			9. IS PATIENT'S CONDITION RELATED TO:		10. EMPLOYER'S CURRENT STATUS (YES <input type="checkbox"/> NO <input type="checkbox"/>				
9. OTHER INSURED'S POLICY OR GROUP NUMBER			10. AUTO ACCIDENT PLACE (STATE) (YES <input type="checkbox"/> NO <input type="checkbox"/>		11. IS THERE ANOTHER POLICY WITH BENEFITS (YES <input type="checkbox"/> NO <input type="checkbox"/> Complete items 12, 13, and 14.				
10. INSURANCE PLAN NAME OR PROGRAM NAME			11. CLM (Classification)		12. INSURER'S POLICY OR PROGRAM NUMBER				
13. INSURER'S AUTHORITY TO PROVIDE SERVICES (Signature of medical biller to the undersigned physician or supplier for services described below.)									
14. DATE OF CURRENT INJURY OR ILLNESS (MM/DD/YY)									
15. HOSPITALIZATION DATES (FROM MM/DD/YY TO MM/DD/YY)									
16. OUTSIDE LABS (YES <input type="checkbox"/> NO <input type="checkbox"/>									
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z)									
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM/DD/YY TO MM/DD/YY)									
19. PROVIDER'S SERVICE OR SUPPLIER (A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z)									
20. PROVIDER'S OR SUPPLIER'S IDENTIFICATION NUMBER (NPI)									
21. FEDERAL TAX I.D. NUMBER (SSN, EIN)									
22. PATIENT'S ACCOUNT NO.									
23. SERVICE FACILITY LOCATION INFORMATION									
24. TOTAL CHARGE (S)									
25. AMOUNT PAID (S)									
26. REF. FOR NUCC USE									
27. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include degrees or credentials. Verify that the submission on the invoice Apply to this bill and into medical bill review.)									
28. SIGNATURE OF PHYSICIAN OR SUPPLIER (NPI)									

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Part II



Fee Schedule

FEE SCHEDULE LAYOUT

Each of the 10 sections in Part II contains the policies, procedures, and schedule of maximum allowable payment (MAP) amounts that apply only to a specific category of services. For example, the policies and MAP amounts that apply only to anesthesia services are found in Section 2, Anesthesia. General policies are listed in the five chapters of Part I. Services listed in Part II appear in the same order as found in the American Medical Association's [2020-2021 Current Procedural Terminology \(CPT\) book](#).

The Schedule lists the following elements:

- Applicable icons;
- CPT or HCPCS code;
- Modifier, if applicable;
- Code description;
- MAP amount;
- Follow-up days; and
- Assistant surgeon.

Icons

The following icons are used in the *Medical Services Provider Manual* fee schedule:

- **New code.** This code is a new CPT or HCPCS code for [2021](#).
- ▲ **Revised code.** The description of this CPT or HCPCS code was revised for [2021](#).
- + **Add-on code.** This code is identified as an add-on code and should never be reported without the appropriately identified primary procedure.
- ⊗ **Modifier 51 exempt.** This code is exempt from multiple procedure reduction and modifier 51 should not be appended.
- # **Resequenced code.** This code is identified in the CPT book as a resequenced code. It is printed in this fee schedule in its numeric order. Resequenced codes and descriptions are placed with related codes out of numeric sequence in the CPT book.

∞ **State-specific code.** This code is unique to South Carolina Workers' Compensation Commission. [Note that state-specific codes have been assigned new code numbers in the 2021 Medical Services Provider Manual.](#)

* **Telemedicine-eligible code.** [This code may be reimbursed when provided via telehealth/telemedicine.](#)

Administrators should continue to rely on the National Correct Coding Initiative (NCCI) coding edits for payment guidance.

Maximum Allowable Payment

The maximum allowable payment (MAP) is listed for each service. Some services have been assigned IC (individual consideration) in the MAP column. For certain procedures in this Schedule, a distinction is made in the maximum allowable price based on the setting of the service. In these cases, prices are set for both office and facility settings. This distinction is based on the higher cost to the physician in providing the service in the office (non-facility) setting. Facility settings include hospitals, ambulatory surgical centers, and skilled nursing facilities. Those fees listed under the MAP Non-Fac column represent services provided in an office and other non-facility settings. The MAP Fac column lists the MAP for services rendered in a facility setting.

Payment is determined by the payer based upon submitted documentation. Other services may be listed with the value of "NC" (not covered) and should not be billed or reimbursed. Additional information regarding IC and NC can be found in Chapter 1, Overview and Guidelines in the subsection titled "Services Without Maximum Allowable Payment (MAP) Amounts."

Follow-up Days

When a service listed in the Schedule is assigned a number of follow-up days, no payment will be made for office or hospital visits during the follow-up period. Codes with 000, MMM, XXX, YYY, or ZZZ have no follow-up days. Codes with 010 include all follow-up care for the 10 days after surgery and codes with 090 include all follow-up care for the 90 days following surgery. The charges for the follow-up office and hospital visits were included in the value of the original procedure. Physicians may, however, charge for supplies furnished by the office over and above those usually supplied with the service. If the length of follow-up care goes

Commented [CO4]: If approved, add Telehealth icon to footer on rate table tables

beyond the number of follow-up days indicated, the physician is allowed to charge for office/hospital visits.

Surgical Assistant

The *Medical Services Provider Manual* uses established CMS designations and rules for determining whether an assistant surgeon service is covered. CMS uses the following numeric designations to indicate the payment status for assistant surgeon services:

- 0 = Assistant surgeon allowed only with supporting documentation to establish medical necessity
- 1 = Assistant surgeon is not allowed
- 2 = Assistant surgeon is allowed
- 9 = Concept does not apply

Telemedicine

Telemedicine is the use of electronic information and telecommunication technologies to provide care when the provider and patient are in different locations. Technologies used to provide telemedicine include telephone, video, the internet, mobile app and remote patient monitoring. Services provided by telemedicine are identified by the use of location code 02 (telemedicine) and Modifier 95, Synchronous Telemedicine Service, on the bill.

Certain services that are eligible for reimbursement under the South Carolina Medical Services Provider Manual when provided by telehealth during the COVID-19 pandemic emergency are identified with an asterisk (*) in the rate tables. Telemedicine may not be used for emergent conditions. The maximum payment for telemedicine services is 100% of the billed charge, not to exceed the non-facility maximum allowable payment (MAP) listed in the rate tables. Service level adjustment factors are applicable based on the licensure of the healthcare professional providing the telemedicine service.

Additional services may be provided via telemedicine with pre-authorization by the payer.

The location for the telemedicine service is defined as the location of the patient/injured worker. Providers must be licensed to practice in South Carolina and telemedicine services may be provided by physicians, physician assistants, psychologists, nurse practitioners, physical therapists, occupational therapists, speech therapists and social workers. Telemedicine activities provided by physical therapy assistants and occupational therapy assistants must be supervised and directed by a physical therapist or occupational therapist, as appropriate, whose license is in good standing in South Carolina.

The South Carolina Workers' Compensation Commission will determine the expiration date of this policy, which will be aligned with the suspension of the COVID-19 Pandemic emergency.

If the pandemic emergency is lifted prior to March 31, 2022, telemedicine services may be provided with pre-authorization through March 31, 2022.

Part II Organization

Part II, the fee schedule, is organized as follows:

SECTION 1. Evaluation and Management Services includes services such as office visits, hospital visits, and consultations, CPT codes 99202-99499;

SECTION 2. Anesthesia includes anesthesiology and anesthetic injection services, CPT codes 00100-01999 and 99100-99140;

SECTION 3. Surgery includes CPT codes 10004-69990;

SECTION 4. Radiology including diagnostic ultrasound, and nuclear medicine, CPT codes 70010-79999;

SECTION 5. Pathology and Laboratory includes CPT codes 80047-89398 and HCPCS codes G0480-G0483 and G0659. HCPCS codes applicable to Pathology and Laboratory are also included in Section 9. HCPCS Level II;

SECTION 6. Medicine and Injections includes CPT codes 90281-95830, 95836, 95857-96999, 97151-97158, 97597-97610, 97802-97849, 98972, and 99500-99607. HCPCS codes applicable to Medicine and Injections are included in Section 9. HCPCS Level II;

SECTION 7. Physical Medicine includes CPT codes 95851-95852, 97010-97150, 97161-97546, 97750-97799, and osteopathic/ chiropractic manipulation treatment codes 98925-98943;

SECTION 8. Special Reports and Services including medical testimony, CPT codes 99070-99091 and 99151-99199, SC001-SC006;

SECTION 9. HCPCS Level II includes codes A0021-V5364. Codes applicable to air and ground ambulance are A0021-A0999 and S9960-S9961; and

SECTION 10. Pharmacy.

Services Not Listed in this Schedule

The Schedule does not include fees for general dental services, glasses and contact lenses, inpatient or outpatient hospital charges, vocational or occupational rehabilitation (except for physical or occupational therapy codes). This manual should not be used to determine payments for these services. According to South Carolina State Regulation 67-1302D providers of general dental services, pharmaceuticals, durable medical equipment, and other medical products and services not covered by the *Medical Services Provider Manual* shall bill at

the provider's usual and customary charge. Payment for services not included in this Manual should be based on usual and customary charges or negotiated between the provider and payer.

The CPT codes and descriptions are developed and maintained by the American Medical Association and updated annually in the CPT book. Should there be any question or dispute regarding a CPT code description, refer to the [2020-2021](#) CPT book for clarification. In the event of a dispute between a provider and a reviewer that cannot be resolved, the matter may be referred to the Medical Services Division for resolution.

Medically Unlikely Edits (MUEs)

Medically unlikely edits (MUEs) are applied according to the provider type. If the supply is provided in the physician office use the physician MUE; if the medical service is provided in the inpatient or outpatient facility, we use the facility MUE. For DME supply only, a Medicare-approved provider is not required to dispense the DME. The place of service (physician or facility) MUE schedule would be referenced for coverage. Significant supplies dispensed in the physician office may be reimbursed according to the guidelines in this Fee Schedule even if the MUE is 0. (See Part I Chapter IV, Paying for Supplies for more details regarding reimbursing supplies.)

Section 1. Evaluation and Management (E/M) Services

This section stipulates the policies and procedures that are unique to Evaluation and Management Services. Additional policies and procedures that apply to all providers are found in Part I of this *Medical Services Provider Manual*.

LEVELS OF E/M SERVICES¹

Evaluation and Management codes are grouped into broad categories such as office visits, hospital visits and consultations. Most of the categories are further divided into two or more subcategories of services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital visits (initial and subsequent). The subcategories of E/M services are further classified into levels of services that are identified by specific codes. This classification is important because the nature of physician work varies by type of service, place of service, and the patient's status.

The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified. Third, the content of the service is defined, for example, comprehensive history and comprehensive examination. Fourth the nature of the presenting problem(s) usually associated with a given level is described, and fifth, the time typically required to provide the service is specified.

Documentation must support the level of E/M service reported.

For complete instructions on identifying and billing E/M services, please refer to the Evaluation and Management Services Guidelines of the [2020-2021 CPT book](#).

E/M service descriptors have seven components. These components are: history, examination, medical decision-making, counseling, coordination of care, nature of presenting problem, and time. The appropriate level of E/M service is based on the level of medical decision making defined for each service or the total time spent on E/M services on the date of service.

1. Adapted from CPT 2020, pp 4-10.

Evaluation and Management Time

Beginning in 2021, time alone may be used to select the appropriate code level of office or other outpatient evaluation and management services. This applies to codes 99202-99205 and 99212-99215. The times listed in the code descriptors are averages. Actual time spent by the provider may be slightly higher or lower depending upon the actual clinical circumstances; however, providers should select the CPT code that best describes the amount of time actually spent. For office visits and other outpatient visits, time is based on the amount of time spent face to face with the patient and not the time the patient is in an examining room. For inpatient hospital care, time is based on unit floor time. This includes the time the physician is present on the patient's hospital unit and at the bedside rendering services. This also includes time spent reviewing the patient's chart, writing additional notes, and communicating with other professionals and/or the patient's family.

Additional codes may be reported with the office or other outpatient visit codes to indicate a prolonged visit or a visit of unusual complexity.

Time is used as the controlling factor to select a level of service when more than 50 percent of the patient encounter is spent in counseling and coordination of care. Time spent counseling and the extent of the counseling and/or coordination of care must be documented.

Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the *other* E/M services when counseling and/or coordination of care dominates the service. The appropriate time should be documented in the medical record when it is used as the basis for code selection.

New and Established Patient

A new patient is one who has not received professional face-to-face services from the provider or another provider of the same specialty in the same practice for three years. A new patient is also defined as a patient who is being seen and evaluated for a new workers' compensation related illness or injury. An established patient has been seen within the last three years by the same provider or a provider of the same

specialty in the same practice within the last three years.

Refer to the decision tree in the CPT book to help determine if the patient is new or established.

Preoperative Evaluation and Management Services

The E/M service where the decision was made to perform surgery is billable. This visit can be identified with modifier 57 Decision for surgery. Subsequent visits for the express purpose of completing the facility-required history and physical are not separately reported.

NON-PHYSICIAN PRACTITIONERS

When authorized by the employer or insurance carrier, a nurse practitioner or physician assistant may provide services to injured workers. Payment to these non-physician practitioners is determined by multiplying the maximum allowable payment (MAP) amounts listed in the Schedule by a service level adjustment factor (SLAF) of .85. For example, to bill for a basic evaluation (CPT code 99212 value \$59.00 in the non-facility setting) performed by a nurse practitioner or physician assistant, payment would be calculated as follows:

$$\$59.00 \times .85 = \$50.15$$

When a service is provided by a nurse practitioner, physician assistant, or certified nurse specialist, the service must be reported by adding state-specific modifier AL to the appropriate CPT code. All services provided by nurse practitioners, physician assistants, or certified nurse specialists are subject to the SLAF. Incident-to guidelines are not applicable to services rendered under the [2020-2021 South Carolina Workers' Compensation Medical Services Provider Manual](#).

CONSULTATION SERVICES

A consultation includes services rendered by a physician whose opinion or advice is requested by another physician or other appropriate source for the further evaluation and/or management of the patient. A consultant may initiate diagnostic or therapeutic services at the request of the attending physician. There must be documentation to the attending physician of the recommended course of action and that the treatment has been initiated upon the attending physician's request. A copy of a consultation report must be submitted with the bill in order for payment to be made.

Payment for a consultation includes payment for the report. When a physician performs consultative services and subsequently becomes the treating physician for either total or partial care, payment for the consultative services should not be denied by the carrier. The subsequent services must be billed and paid under the appropriate visit codes, not consultation codes.

Consultation with a Nurse Case Manager

A consultation with a nurse case manager may be billed and paid only when the consultation service meets all requirements listed in the descriptor of the CPT consultation code billed. The medical record pertaining to the consultation must specify the time spent in consultation and must be included with the claim for payment.

Physician consultations with a nurse case manager of less than 30 minutes must be reported with the appropriate CPT

code (99366–99368) and modifier 52. The reimbursement may be reduced to the lesser of billed charges or 80 percent of the MAP to represent a service that is less than the code description of “30 minutes or more.”

HOSPITAL DISCHARGE DAY MANAGEMENT

Payment must not be made for this service in addition to another hospital visit billed by the same physician on the same day for the same patient.

PHYSICAL THERAPY SERVICES

A treating physician who sees an injured worker for the single purpose of monitoring the outcome of physical therapy may be paid for only one E/M service per week. If the E/M office note can substantiate that a separately identifiable service was provided, the provider may be paid. An E/M service may be provided on the same day as the therapeutic modality application. Physical and occupational therapists must not be paid for E/M services. (See Part II Section 7 of this *Medical Services Provider Manual* and codes 97161–97168.)

INJECTABLE PHARMACEUTICALS

If the injection is part of an office visit where other services are provided and an office visit is billed, the physician will be paid only for the cost of the pharmaceutical but not for the injection fee. The injectable pharmaceutical must be billed using the appropriate HCPCS A, C, J, or Q code as listed in Section 9. HCPCS Level II.

If the single purpose of an office visit is for the injection, the physician may be paid for the cost of the injectable pharmaceutical plus a fee for the injection but cannot be paid for an office visit. (See *Injectable Pharmaceuticals* in Section 6. Medicine, for complete information on billing for injections.)

ADMINISTRATION KITS

Administration kits packaged by the manufacturer and assigned a single National Drug Code (NDC) may be reimbursed the Average Wholesale Price (AWP) of the kit without additional markup. Kits packaged by the provider or other source are considered to be part of the administration of the pharmaceutical and are not separately reimbursed even if reported with an NDC or HCPCS Level II code. Only those supplies and materials over and above those usually provided in the office of the physician or other qualified health care professional may be reported in addition to the pharmaceutical drug and administration as discussed above and in Part I Chapter III of the [2020-2021 Medical Services Provider Manual](#).

Commented [C05]: Update when 2021 rates are finalized

Commented [AB6]: Update when CF/MAP is approved

CHIROPRACTORS

In addition to payments for physical medicine and x-ray services, a chiropractor who is the treating medical provider may also be paid for one office visit per week. Office visit codes may not be substituted for manipulation codes.

TRAVEL REIMBURSEMENT

Physicians may be reimbursed for travel associated with depositions or other medical testimony. Travel by public transportation, subsistence, and lodging are reimbursed at actual cost. Travel by personal auto is paid per mile. (See the South Carolina Workers' Compensation Commission (SCWCC) website for the current travel reimbursement amount:

<https://wcc.sc.gov/claims/compensation-rates>

SUPPLIES AND MATERIALS (CPT 99070)

Supplies and materials provided by the physician over and above those usually included with the office visit may be paid. Use the appropriate code from Part II Section 9. HCPCS Level II, to report the supply. In the event that a supply cannot be identified using the codes listed in Section 9, use CPT code 99070 and price the item at actual cost plus 20 percent. (See Chapter III. Billing Policy and Chapter IV. Payment Policy for complete details.)

IMPAIRMENT RATINGS

When a treating physician determines that the injured worker has reached maximum medical improvement (MMI), where the injured worker's condition is not likely to be improved by further treatment, the treating physician must rate the level of permanent impairment sustained by the injured worker. The results of the impairment rating must be forwarded to both the Commission and the insurance carrier or self-insured employer. The impairment rating may be indicated in the office notes and need not be a separate report.

If an E/M service is necessary in determining an impairment rating it may be billed using CPT code 99455 or the E/M code that best represents the level of service rendered.

INDEPENDENT MEDICAL EVALUATION (IME)

An Independent Medical Evaluation is an objective medical or chiropractic evaluation of the injured employee's medical condition and work status which is requested by the insurance carrier, self-insured employer, an attorney, or a Workers' Compensation Commissioner. An IME includes the review of available records and test reports, examination of

the patient, and a written report regarding the medical condition and work status of the injured worker.

The employer or carrier may schedule an IME with a medical provider of its choice to assist in determining the status of an injured employee's condition. Acceptable reasons for conducting an IME include, but are not limited to:

1. Instances when the authorized treating physician has not provided current medical reports;
2. Determining whether a change in medical provider is necessary;
3. Determining whether treatment is necessary or the employee appears not to be making appropriate progress in recuperation;
4. Determining whether over-utilization by a medical provider has occurred.

The medical provider performing the IME may not be the medical provider selected to provide the treatment or follow-up care, unless the carrier or self-insurer and the employee agree to this, or unless an emergency exists.

Before performing an IME, a physician must have a written request from the Commission, the employer/insurance carrier, the injured worker or his/her attorney, or other appropriate third party. To report an IME, use CPT code 99456. Payment for this service varies and is based on individual consideration (IC) or negotiation between the carrier and provider.

ALTERNATING PHYSICIANS

When physicians of similar skills alternate in the care of a patient, e.g., partners or group practice members covering for a physician on weekends and vacations, each physician must bill individually for the services he/she personally rendered.

FOLLOW-UP DAYS

When a service listed in the *Medical Services Provider Manual* is assigned a number of follow-up days, no payment will be made for office or hospital visits provided by the surgeon or his/her representative during the follow-up period. The charges for the follow-up office and hospital visits were included in the value of the original procedure. Physicians may, however, charge for supplies furnished by the office. If the length of follow-up care goes beyond the number of follow-up days indicated, the physician is allowed to charge for office/hospital visits. Emergency department visits, consultations, and further treatment referrals for care to another provider are not part of the follow-up days and should be separately paid.

MODIFIERS

The following modifiers are used when reporting evaluation and management services. (See *CPT 2020-2021* Appendix A for a full list of CPT modifiers.)

CPT Modifiers

24 Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period

The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see **Evaluation and Management Services Guidelines** for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. **Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

57 Decision for Surgery

An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

HCPCS Modifiers

XE Separate encounter, a service that is distinct because it occurred during a separate encounter.

XP Separate practitioner, a service that is distinct because it was performed by a different practitioner.

XS Separate structure, a service that is distinct because it was performed on a separate organ/structure.

XU Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.

South Carolina State-Specific Modifier

AL Nurse Practitioner, Physician Assistant, or Certified Nurse Specialist

When the service was provided by a nurse practitioner, physician assistant, or certified nurse specialist, the AL modifier must be added to the CPT code for the service rendered.

EVALUATION AND MANAGEMENT (E/M)

992021-99499

Medical Fee Schedule

Effective April 1, 2020

2021

INSERT RATE TABLES HERE

Section 2. Anesthesia

This section stipulates the policies and procedures that are unique to Anesthesia services. Additional policies and procedures that apply to all providers are found in Part I of this Manual.

GENERAL INFORMATION AND OVERVIEW

Payment for anesthesia includes all usual pre- and postoperative visits, the anesthesia care during the procedure, and the administration of fluids and/or blood incidental to the anesthesia or surgery and usual monitoring procedures. Specialized forms of monitoring (e.g., central venous (CPT® 36555–36556, 36568–36569, 36580, 36584) and Swan-Ganz (CPT 93503) may be billed separately. No additional payment is made for qualifying circumstances (CPT codes 99100–99140).

Unlike other services in the Schedule, anesthesiology maximum allowable payment (AMAP) is determined by combining the Basic MAP amount with the Time Value Amount (TVA) representing the actual time of service. The two amounts added together equal the AMAP for the service.

Anesthesia services may be provided by an anesthesiologist who personally performs the service or by a Certified Registered Nurse Anesthetist (CRNA) who performs the service under the medical direction of a physician.

ANESTHESIA MAXIMUM ALLOWABLE PAYMENT (AMAP)

Calculating the AMAP for each service requires two value components: a Basic MAP amount and a time value amount (TVA). The basic value is determined by identifying the appropriate CPT code and corresponding MAP amount in the Schedule portion of this section. The TVA is determined by identifying the number of minutes of service and locating the appropriate value on the Time Value Chart at the end of this section. The total MAP, or AMAP, is determined by adding these two amounts:

$$\text{Basic MAP amount} + \text{TVA} = \text{AMAP}$$

Determining the Basic MAP Amount

The Basic MAP for each service is listed by CPT code in the Schedule. When multiple surgical procedures are performed

during an operative session, use the CPT code which has the highest Basic MAP.

Determining the Time Value Amount (TVA)

The time value amount (TVA) is determined by consulting the Time Value Chart at the end of this section, or by multiplying the appropriate conversion factor by the appropriate time units (as listed below). To locate the TVA on the Time Value Chart, locate the number of minutes of service with the range listed in the Minutes column on the chart. The TVA is listed in the adjacent column.

Anesthesia time starts when the anesthesiologist or CRNA begins to prepare the patient for the induction of anesthesia and ends when the personal attendance of the anesthesiologist or CRNA is no longer required and the patient can be safely placed under the customary postoperative supervision. Actual anesthesia time in minutes must be reported on the claim form.

The amounts listed in the Time Value Chart were determined by multiplying a conversion factor by the time units. Time units are calculated by dividing the reported anesthesia time by fifteen. When converting minutes into time units, round up to the highest unit. The conversion factor for anesthesia is \$30.00 per unit.

SERVICES RENDERED BY A CRNA

When a physician supervises a CRNA who administers anesthesia, the total payment for the service must not exceed the Basic MAP plus the time value amount (TVA). When the physician and the CRNA bill separately, each is entitled to the lesser of billed charges or 50 percent of the total payment amount. In all instances, a modifier must be used to identify the service rendered by the CRNA. The modifiers for anesthesia are listed below.

CPT CODES FOR ANESTHESIA SERVICES

When billing for anesthesia services, use CPT codes 00100 through 01999 as listed in this section. Do not use the surgical procedure code to report anesthesia services. Anesthesia codes must be used and the time indicated in minutes on the claim form to ensure proper payment. The Commission, insurance carriers, and review agencies have

the option of returning for correction any claim where surgery codes were used to bill for anesthesia services.

Do not use anesthesia procedure codes to bill for diagnostic or therapeutic nerve blocks. Refer to Section 3. Surgery, subsection Diagnostic or Therapeutic Nerve Blocks.

ANESTHESIA BY SURGEON

When the physician performing the surgical procedure administers a regional block (e.g., lower extremity) that service may be billed and paid in addition to the surgical procedure. Billing is done by listing the surgical code twice and adding the modifier 47 to the second code. The payment is the lesser of \$90.00 or the provider's charge.

Additional payment is not made when infiltration, digital block, or topical anesthesia is provided. (Refer to Section 3. Surgery, subsection Global Payment.)

CPT CODES FOR MEDICAL OR SURGICAL SERVICES

Anesthesia services include charges for the usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood incidental to the anesthesia or surgery, and the usual monitoring procedures. When an anesthesiologist or CRNA is required to participate in and be responsible for the patient, monitoring the general care of the patient during surgery, but does not administer anesthesia, such professional services must be billed and paid as though an anesthetic were administered, that is basic anesthesia plus time.

MODIFIERS

The following modifiers are used when reporting anesthesia services. (See *CPT 2020-2021* Appendix A for a full list of CPT modifiers.)

CPT Modifiers

47 Anesthesia by Surgeon

Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia) **Note:** Modifier 47 would not be used as a modifier for the anesthesia procedures.

HCPCS Modifiers

AA Anesthesia services performed personally by anesthesiologist

AD Medical supervision by a physician; more than 4 concurrent anesthesia procedures

G8 Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedures

G9 Monitored anesthesia care for patient who has a history of severe cardiopulmonary condition

GC This service has been performed in part by a resident under the direction of a teaching physician

QK Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals

QS Monitored anesthesiology care services (can be billed by a qualified nonphysician anesthetist or a physician)

QX Qualified nonphysician anesthetist with medical direction by an anesthesiologist

QY Medical direction of one *qualified non-physician* anesthetist by an anesthesiologist

QZ CRNA *without* medical direction by a physician

TIME VALUE CHART

Time Units	Minutes	TVA (\$)
1	0–15	30
2	16–30	60
3	31–45	90
4	46–60	120
5	61–75	150
6	76–90	180
7	91–105	210
8	106–120	240
9	121–135	270
10	136–150	300
11	151–165	330
12	166–180	360
13	181–195	390
14	196–210	420
15	211–225	450

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Time Units	Minutes	TVA (\$)
16	226–240	480
17	241–255	510
18	256–270	540
19	271–285	570
20	286–300	600
21	301–315	630
22	316–330	660
23	331–345	690
24	346–360	720
25	361–375	750
26	376–390	780
27	391–405	810
28	406–420	840
29	421–435	870
30	436–450	900
31	451–465	930
32	466–480	960
33	481–510	990
34	511–525	1020

Time Units	Minutes	TVA (\$)
35	526–540	1050
36	541–555	1080
37	556–570	1110
38	571–585	1140
39	586–600	1170
40	601–615	1200
41	616–630	1230
42	631–645	1260
43	646–660	1290
44	661–675	1320
45	676–690	1350
46	691–705	1380
47	706–720	1410
48	721–735	1440
49	736–750	1470
50	751–765	1500

ANESTHESIA

00100-01999, 99100-99140

Medical Fee Schedule

Effective April 1,

~~2020~~2021

INSERT RATE TABLES HERE

Section 3. Surgery

This section stipulates the policies and procedures that are unique to Surgery. Additional policies and procedures that apply to all providers are found in Part I of the *Medical Services Provider Manual*.

GENERAL

The schedule of maximum allowable payment (MAP) for surgery lists services by CPT code, including a narrative description of the service, the MAP amount, number of follow-up days, and whether an assistant surgeon is allowed. For certain procedures a distinction is made in the maximum allowable price based on the setting of the service. In these cases, prices are set for both office and facility settings. This distinction is based on the higher costs to the physician in providing the service in the office (non-facility) setting. Facility settings include hospitals, ambulatory surgical centers, and skilled nursing facilities. Both the facility and non-facility amounts will be displayed.

Payment for all surgical procedures includes the surgery, local infiltration, and digital block or topical anesthesia when used. Supplies and materials furnished by the physician over and above those normally required for the procedure performed may be reported separately using the appropriate code from Section 9. HCPCS Level II. If a code does not exist for the supply, use CPT code 99070 and price the supply no higher than actual cost plus 20 percent.

Follow-up days listed for individual services are those determined by the Centers for Medicare and Medicaid Services (CMS). During the follow-up period no payment will be made for hospital or office visits provided by the surgeon, since these services are included in the charge for the surgical procedure. The day after the service was rendered is considered day 1 of the follow-up period.

A claim for an operative procedure is considered incomplete unless accompanied by an operative report. If a procedure is listed with an "IC" rather than a dollar amount in the MAP column, payment will be based on a review of the hospital operative report or similar office record for non-hospital care that must be submitted to substantiate the charges (see Determining Payment for Services Listed as Individual Consideration in Part I Chapter IV, for complete details). Copies of the operative report are required documentation for billing and will not be paid for separately.

(See Part I Chapter II, Authorization to Treat, for more information regarding prior authorization.)

GLOBAL PAYMENT

The payment allowances for surgical procedures are based on a global payment concept that covers the basic service and the normal range of care required before and after surgery. Additionally, global payment requires that the service(s) performed be identified and billed using the fewest possible CPT codes.

Global payment for a surgical procedure includes:

1. the immediate preoperative care including the initial exam by the surgeon whether performed in the hospital or elsewhere, completion of hospital records (including history and physical), and initiation of the treatment program;
2. local anesthesia, such as infiltration, digital block, or topical anesthesia;
3. the surgical procedure;
4. normal, uncomplicated follow-up care for the time periods indicated in the follow-up days column in the Schedule. The number in that column establishes the days during which no additional payment is allowed for the usual care provided by the surgeon following surgery.

Exceptions to the global payment policy will be considered on a case-by-case basis. An exception may be made when:

1. a preoperative visit by the surgeon is the initial visit, as in some emergency situations, and when prolonged detention or evaluation is necessary to establish the need for a particular type of surgery;
2. the preoperative visit is a consultation;
3. preoperative services are provided that are not part of the usual preparation for the particular surgical procedure, e.g., performing a myelogram prior to a laminectomy;
4. medical necessity requires that a procedure be performed in a hospital that, under normal

circumstances, would be performed in an outpatient facility;

5. it is necessary to treat complications, exacerbations, recurrences, or other diseases and injuries. In these situations, documentation substantiating the medical necessity of the additional services rendered must be submitted with the claim form; or
6. the postoperative service is provided in an emergency department, is a consultation, or is a referral for care by another provider.

When an additional surgery is performed during the postoperative period of another surgical procedure, each procedure carries its own follow-up day period. Charges for normal postoperative care must be paid according to the separate follow-up day periods that will run concurrently.

ANESTHESIA BY SURGEON

When the physician performing the surgical procedure administers regional or general anesthesia, that service may be billed and paid in addition to the surgical procedure. Billing is done by listing the surgical code twice and adding modifier 47 to the second code. The payment is \$90.00 or the provider's charge, whichever is less.

Payment is not made when infiltration, digital or topical anesthesia is provided. (See Global Payment, this section.)

SURGICAL SUPPLIES

When services are provided in a physician's office, supplies and materials provided over and above those usually included in the procedure may be billed using the appropriate code from Section 9. HCPCS Level II. If no code exists to describe the supply, use CPT code 99070 and price the supply no higher than actual cost plus 20 percent.

MULTIPLE PROCEDURES

When multiple procedures are performed, i.e., more than one procedure performed in a single operative session, the major or highest valued procedure must be billed with the applicable CPT code with no modifier and will be paid at the lesser of the billed amount or the MAP amount. The additional or lesser procedure(s) must be billed using modifier 51. Payment for the additional procedures will be made at the lesser of the billed amount or 50 percent of the listed MAP amount, except for those procedures listed under "Exceptions" below. Also, exceptions to the 50 percent rule may be made on a case-by-case basis for situations involving complex traumatic procedures.

The multiple surgery rule also applies to independent multiple or bilateral surgical procedures performed by separate surgical teams at the same operative session, and to multiple operative procedures performed at the same session in separate operative fields and through separate incisions.

This same concept applies for multiple procedures involving a surgical assistant. The surgical assistant will be paid the lesser of billed charges or 20 percent of the MAP amount for the initial or highest valued procedure and 10 percent for subsequent procedures. (See Surgical Assistant in this section.)

Exceptions

Certain procedures are not subject to the multiple procedures policy. These procedures are performed only in conjunction with other surgical procedures or that otherwise do not fit into the concept of multiple surgery. As a general rule, the description will contain the words "each additional" or "list separately" in its CPT descriptor and will be identified with the + icon. These services are also known as "add-on" procedures. These codes will be an exception to the multiple procedures policy and are reported using the CPT code with no modifier. Payment for these services will be made at the lesser of billed charges or 100 percent of the MAP amount. A listing of CPT codes that are exempt from the multiple procedures policy is found in Appendix B of the *Medical Services Provider Manual*.

Separate Procedures

The descriptor for many CPT codes includes a parenthetical statement that the procedure presents a "separate procedure." The inclusion of this statement indicates that the procedure, while possible to perform separately, is generally included in a more comprehensive procedure, and the service is not to be billed when a related, more comprehensive, service is performed. When a related procedure from the same section, subsection, category, or subcategory is performed, a code with the designation of "separate procedure" is not to be billed with the primary procedure. (See Part I Chapter IV. Payment Policy, National Correct Coding Initiative.)

Distinct Procedural Services

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifiers 59, XE, XP, XS, or XU are used to identify procedures and services that are not normally reported together but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or separate injury or area of injury in extensive

injuries. These modifiers should be used only if no other more descriptive modifier is available.

Bilateral Procedures

When a CPT code for a bilateral procedure, pertaining to two sides and requiring separate incisions, is not available, report the bilateral procedure by using the CPT code for the primary procedure and add modifier 50. Payment will be made at the lesser of 150 percent of the MAP amount or the provider's charge. If the bilateral procedure is performed in addition to another procedure and is not the primary procedure, then payment is made at the lesser of billed charges or 75 percent of the MAP amount.

SERVICES RENDERED BY MORE THAN ONE PHYSICIAN

Consultant Services: When a patient's condition requires the services of a consultant in addition to the services of the attending physician, the consultant's continuing services may be paid only for as long as they are medically necessary.

Surgical Assistant: When medically necessary and approved by the employer or carrier, a surgical assistant may be paid separately for assisting at surgery. The surgical assistant must submit a separate claim that includes a copy of the operative report and must identify his/her services by using the appropriate modifier(s) as described below.

Assistant Surgeon: When a physician assists at surgery, payment will be made at the lesser of the billed charges or 20 percent of the MAP amount for the applicable surgical procedure. Modifier 80 must be added to the surgical procedure code to identify the surgical assistant.

Certified Physician Assistant, Nurse Practitioner, or Certified Nurse Specialist as Surgical Assistant: When a certified physician assistant assists at surgery payment will be made at the lesser of billed charges or 17 percent of the MAP for the applicable surgical procedure (85 percent of the amount allowed for a physician assisting at surgery) or the provider's charge, whichever is less. Modifier AS must be added to the surgical procedure code to identify the certified physician assistant, nurse practitioner, or certified nurse specialist.

TWO SURGEONS

Under certain circumstances, two surgeons (usually with different skills) may be required in the management of a specific surgical procedure. Under such circumstances, the separate services may be identified by adding modifier 62 to the procedure code used by each surgeon for reporting the procedure(s). Each surgeon must submit an individual billing form for the services rendered along with an operative

report documenting the specific surgical procedure(s) provided. Payment must not be made to either surgeon until the carrier has received each surgeon's individual operative report and claim form.

Payment for co-surgeons follows the same logic as for a surgeon-assistant surgeon team except that the payment will be divided equally among the two surgeons. When co-surgeons perform a single procedure, each will be paid the lesser of billed charges or 60 percent of the MAP for the procedure.

SURGERY BY A RESIDENT IN A TEACHING SETTING

Because there are a number of teaching hospitals in South Carolina where residents are trained in surgery under the direction and supervision of an attending physician, it may occur that an injured worker undergoes surgery by a resident-attending physician team. This practice is permissible under the following conditions:

1. the attending physician must be fully qualified for the specialty in which the resident is being trained;
2. prior to surgery, authorization must be obtained from the employer or insurance carrier for the surgery to be performed by a resident under the supervision of an attending physician;
3. the attending physician must participate in the surgery, which includes direct supervision and control of the procedure; or
4. the operative note must identify the resident surgeon as a resident and must indicate in the narrative that the attending surgeon was present during the entire procedure.

When the surgery is performed by a resident-attending physician team under these conditions, the attending physician may bill and be paid for the surgery. Modifier GC or GR should be appended in this circumstance.

NON-PHYSICIAN PRACTITIONERS

When authorized by the employer or insurance carrier, a nurse practitioner or physician assistant may provide services to injured workers. Payment to these non-physician practitioners is determined by multiplying the maximum allowable payment (MAP) amounts listed in the Schedule by a service level adjustment factor (SLAF) of .85. Incident-to guidelines are not applicable to services rendered under the [2020-2021 Medical Services Provider Manual](#).

When a service is provided by a nurse practitioner, physician assistant, or certified nurse specialist, the service must be

reported by adding state-specific modifier AL to the appropriate CPT code. Use modifier AS when the nurse practitioner, physician assistant, or certified nurse specialist acts as an assistant surgeon.

WOUND REPAIR AND SUTURE REMOVAL

Payment for wound repair includes the evaluation, routine debridement, materials normally required to perform the procedure (e.g., suture tray), and suture removal. In the rare event that the suture removal is performed by another physician not associated with the initial physician, that physician may be paid for the office visit at the appropriate level of service.

The following policies for reporting wound repairs were adapted from the American Medical Association's CPT book.

Wound repairs are classified as simple, intermediate, or complex.

Simple Repair: When a wound involves only the skin and/or superficial tissues and requires simple suturing. (For closure with adhesive strips, only the appropriate office visit is paid.)

Intermediate Repair: When a wound involves deeper layers and requires layer closure.

Complex Repair: When a wound is more complicated and requires more than layered closure.

The repaired wound(s) should be measured and recorded in centimeters, regardless of configuration such as curved, angular or stellate.

When multiple wounds of the same classification (see above) and anatomic grouping are repaired, add together the lengths of those wounds and report them as a single repair. When multiple wounds of more than one classification or anatomic grouping are repaired, list the more complicated repair as the primary procedure; report the less complicated repair as the secondary procedure by listing it separately and adding modifier 51.

Debridement is considered a separate procedure only when gross contamination requires:

- prolonged cleansing not normally encountered;
- when appreciable amounts of devitalized or contaminated tissue are removed from the wound; or
- when debridement is provided without other definitive procedures.

For extensive debridement of soft tissue and/or bone, see CPT codes 11042–11047.

Report repair of nerves, blood vessels and tendons using codes from the appropriate system (Nervous, Cardiovascular, Musculoskeletal). The repair of these structures includes wound repair unless it qualifies as a complex wound, in which case modifier 51 should be appended as appropriate.

BURNS, LOCAL TREATMENT

1. Procedure code 16000 must be used when billing for treatment of first degree burns when no more than local treatment of the burned surfaces is required.
2. Procedure codes 16020–16030 must be used only when billing for treatment of second and third degree burns.

Major debridement of foreign bodies, grease, epidermis, or necrotic tissue may be billed separately using CPT codes 11000–11047.

In order to accurately identify the proper CPT code (codes 16020–16030) and substantiate the descriptor for billing, the exact percentage of the body surface involved and the degree of the burn must be specified in the proper section on the billing form. Percentage of body surface burned is defined as follows:

- “Small” means less than 5 percent of the body area
- “Medium” means 5–10 percent of the body area (e.g., whole face or whole extremity)
- “Large” means greater than 10 percent of the body area (e.g., more than one extremity)

Any claim submitted that does not indicate the degree of burn and exact percentage of body area involved must be returned to the physician for completion. Grafting of burned areas must be billed separately under the appropriate skin grafting procedures. (See procedure codes 15050–15261.)

MUSCULOSKELETAL SYSTEM

Application of Casts and Strapping

The casting and strapping codes are reported:

- for initial treatment to stabilize or protect a fracture, injury, or dislocation;
- when additional restorative treatment is not performed at that visit;
- replacement of cast or strapping; or
- patient comfort.

Restorative treatment or procedure(s) rendered by another physician following the application of the initial cast/splint/strap may be reported with a treatment of fracture and/or dislocation code.

A physician who applies the initial cast, strap, or splint and provides all fracture, dislocation, or injury care cannot separately report the application of casts and strapping codes. The first cast/splint or strap application is included in the treatment of a fracture and/or dislocation. Preoperative care does not include temporary casting/splinting and is not separately reported. Significantly identifiable evaluation and management services provided at the time of the cast application or strapping may be reported.

Casting or strapping without other definitive treatment is reported in addition to the documented level of evaluation and management. The casting or strapping supplies may be reported with the appropriate HCPCS Level II code from Section 9 or code 99070.

Casting and strapping codes include removal of cast or strapping.

DIAGNOSTIC OR THERAPEUTIC NERVE BLOCKS

When a nerve block is performed for diagnostic or therapeutic purposes, select the appropriate code from CPT codes 62320–62327 or 64400–64530.

MICROSURGICAL PROCEDURES

When a magnifying loupe or magnifying binoculars are used during a surgical procedure, no additional payment will be made for the use of the magnifying instrument. Only microsurgical techniques requiring the use of operating microscopes may be paid. See CPT code 69990.

MODIFIERS

The following modifiers are used when reporting surgical services. (See *CPT 2020-2021* Appendix A for a full list of CPT modifiers.)

CPT Modifiers

26 Professional Component

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

47 Anesthesia by Surgeon

Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia) **Note:** Modifier 47 would not be used as a modifier for the anesthesia procedures.

54-50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session, should be identified by adding modifier 50 to the appropriate 5 digit code.

South Carolina Specific Instruction: *The second (bilateral) procedure is identified by adding modifier 50 to the procedure code.*

52-51 Multiple Procedures Bilateral

When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s).

Note: This modifier should not be appended to designated “add-on” codes.

South Carolina Specific Instruction: *This modifier may be used to report multiple medical procedures performed at the same session, as well as a combination of medical and surgical procedures, or several surgical procedures performed at the same operative session. The second and each subsequent procedure should be valued at the lesser of billed charges or 50 percent of its listed MAP value.*

53 Discontinued Procedure

Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (modifiers approved for ASC hospital outpatient use).

58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy

following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the operating/procedure room (eg, unanticipated clinical condition), see modifier 78.

59 Distinct Procedural Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.

62 Two Surgeons

When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s)) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

South Carolina Specific Instruction: Each provider is reimbursed at the lesser of billed charges or 60 percent of the MAP for a total of 120 percent of the MAP.

66 Surgical Team

Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians

or other qualified health care professionals, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the “surgical team” concept. Such circumstances may be identified by each participating individual with the addition of modifier 66 to the basic procedure number used for reporting services.

76 Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a procedure or service was repeated by the same physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 76 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

77 Repeat Procedure by Another Physician or Other Qualified Health Care Professional

It may be necessary to indicate that a basic procedure or service was repeated by another physician or other qualified health care professional subsequent to the original procedure or service. This circumstance may be reported by adding modifier 77 to the repeated procedure or service. **Note:** This modifier should not be appended to an E/M service.

78 Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period

It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76.)

79 Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period

The individual may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79. (For repeat procedures on the same day, see modifier 76.)

80 Assistant Surgeon

Surgical assistant services may be identified by adding modifier 80 to the usual procedure number(s).

HCPSC Modifiers

AS Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery

South Carolina Specific Instruction: When a certified physician assistant, nurse practitioner, or certified nurse specialist acts as a surgical assistant, the service must be identified by adding the modifier AS in addition to the modifier 80 to the surgery procedure code. Reimbursement is made at the lesser of the billed charges or 17 percent of the MAP amount.

GC This service has been performed in part by a resident under the direction of a teaching physician

GR This service was performed in whole or in part by a resident in a department of Veterans Affairs medical center or clinic, supervised in accordance with VA policy

TC Technical Component

Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number.

XE Separate encounter, a service that is distinct because it occurred during a separate encounter.

XP Separate practitioner, a service that is distinct because it was performed by a different practitioner.

XS Separate structure, a service that is distinct because it was performed on a separate organ/structure.

XU Unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.

South Carolina State-Specific Modifier

AL Nurse practitioner, physician assistant, or certified nurse specialist

When the service was provided by a nurse practitioner, physician assistant, or certified nurse specialist, modifier AL must be added to the CPT code for the service rendered.

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Effective April 1, [2020](#)~~2021~~

SURGERY
Medical Fee Schedule

INSERT RATE TABLES HERE

Section 4. Radiology

This section stipulates the policies and procedures that are unique to Radiology services. Additional policies and procedures that apply to all providers are found in Part I of the *Medical Services Provider Manual*.

GENERAL INFORMATION

Radiology services include diagnostic radiology (diagnostic imaging, diagnostic ultrasound and nuclear medicine). Most radiology services are comprised of a professional component and a technical component. The professional component is the physician's interpretation of the procedure and the technical component is the equipment, supplies, and technician's services used to perform the procedure. These are discussed in greater detail later in this section.

SEPARATE PROCEDURES

A procedure designated as "separate procedure" in its CPT descriptor is commonly performed as a component of a larger procedure and, as such, is not paid as a separate service. However, when a separate procedure is performed independently of, and not immediately related to, other services, it may be billed and paid.

CONTRAST MEDIA

Complete procedures, interventional radiological procedures or diagnostic studies involving injection of contrast media include all usual pre- and post-injection services, e.g., necessary local anesthesia, placement of needle catheter, injection of contrast media, supervision of the study, and interpretation of results. Providers must determine whether the use of ionic or non-ionic contrast media is appropriate for the individual patient. No additional payment will be made for the use of non-ionic contrast media.

X-RAY CONSULTATION (CPT 76140)

CPT code 76140 Consultation on x-ray examination made elsewhere, written report, will be paid only when there is a documented need for the service and when performed by a radiologist or physician who is certified to perform radiological services. Payment for the review of x-rays will not be made when:

1. The physician, during the course of an office visit, consultation, or Independent Medical Evaluation (IME), reviews x-rays that were not taken by that physician's office;
2. The treating or consulting physician reviews x-rays at an emergency room or hospital visit.

BILLING RADIOLOGY SERVICES

Number of Views

When a CPT code descriptor indicates a minimum number of views, the number listed indicates the minimum number of views required for that service, not the maximum. No additional payment will be made for views in excess of the minimum number.

Billing a Total Procedure (Professional and Technical Component)

To bill for a total procedure in which both the professional and technical components were performed by the physician, use the appropriate CPT code with no modifier.

Billing the Professional Component (Modifier 26)

To bill for the professional component of a procedure, such as the reading of a radiology service provided by a hospital or diagnostic center, use the appropriate CPT code and the modifier 26.

Payment for professional services will not be made when:

1. The physician, during the course of an office visit, consultation, or Independent Medical Evaluation (IME), reviews x-rays that were not taken by the physician's office;
2. The treating or consulting physician reviews x-rays at an emergency room or hospital visit.

Billing the Technical Component (Modifier TC)

When the technical component is provided by a health care provider other than the physician providing the professional component, the health care provider bills for the technical component only by appending modifier TC to the applicable radiology code.

BILLING FOR RADIOLOGICAL SUPERVISION AND INTERPRETATION

When a radiologist and a clinician work together as a team, e.g., when the clinician injects contrast media and the radiologist supervises and interprets the procedure, each must bill separately for services rendered.

To bill for the service rendered by the clinician in this case, use the applicable surgical injection procedure code. Payment for the injection includes all the usual physician services for injections, e.g., pre- and post- injection services, local anesthesia, placement of needle or catheter, and the injection itself.

To bill for the service rendered by the radiologist, use the applicable radiology procedure code with a descriptor that specifies "supervision and interpretation only."

Note that some procedure codes in the surgical section of the CPT book include the injection and radiology service in the description. In these circumstances only one code is reported.

PAYMENT

Payment for professional services (modifier 26) will not be made when x-rays taken elsewhere are reviewed during an Independent Medical Evaluation (IME), medical visit, or consultation; or when the treating or consulting physician reviews x-rays at an emergency room or hospital visit. Such review is included in the payment for the evaluation and will not be paid as professional component or as x-ray consultation (CPT 76140).

Should the provider fail to add modifier 26 to a radiology procedure provided in a hospital, ambulatory surgical center, or similar facility, payment will be made only for the professional component.

If the MAP is listed as "IC" (individual consideration), the provider's payment will be determined by the carrier based on a review of the documentation submitted with the claim. If the listed amount is listed "NC" (not covered) the service should not be billed or reimbursed.

Certain radiology studies have procedure codes that list complete body areas, as well as the individual sections of body areas, as separate entities. When x-rays of multiple

sections of a body are billed separately, the total payment must not exceed the MAP of the complete body area study.

MODIFIERS

The following modifiers are used when reporting radiology services. (See [CPT 2020-2021](#) Appendix A for a full list of CPT modifiers.)

CPT Modifiers

26 Professional Component

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

53 Discontinued Procedure

Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (modifiers approved for ASC hospital outpatient use).

HCPCS Modifier

TC Technical Component

Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number.

Radiology

70010-79999

Effective April 1, ~~2020~~

Medical Fee Schedule

RADIOLOGY

~~2020~~
2021

INSERT RATE TABLES HERE

Section 5. Pathology and Laboratory Services

This section stipulates only those policies and procedures that are unique to Pathology and Laboratory services. Additional policies and procedures that apply to all providers can be found in Part I of this *Medical Services Provider Manual*.

PATHOLOGY AND LABORATORY CODES

Pathology and laboratory codes may be billed by a clinical laboratory or, in some instances, by a physician's office. Some pathology and laboratory services may require interpretation by a physician. In this case, there may be a separate bill for the technical and professional components of the procedure. The technical component is the use of the laboratory equipment and technician's services, and the professional component is the physician's interpretation and report. When billing for the professional or the technical component, use the appropriate modifier. When billing for the total procedure, no modifier is required.

Outpatient lab testing needs to be related to the treatment. Testing not directly related to treatment, routine health screening, or standing order laboratory testing, will require preauthorization for outpatient coverage (see Part I Chapter II, Authorization to Treat, for more information). Examples of laboratory testing requiring preauthorization include, but are not limited to:

— Routine laboratory panels

- Vitamin levels
- Hormone levels (estrogen, progesterone, testosterone, growth)

• Evocative/suppression testing

- Vitamin levels
-
- Molecular pathology testing
- Cytogenetic/chromosome analysis
- Infertility/reproductive testing
- Testing related to chronic conditions not affecting current care

DRUG SCREENING

Drug screening services must be reported using service codes 80305, 80306 and 80307 for presumptive drug testing. Definitive testing is reported with codes G0480–G0483 dependent upon the number of drug classes included in the testing or G0659 when identifying individual drugs and distinguishing between structural isomers.

Code 80305 is used for presumptive testing read by direct optical observation including dipsticks, cups, cards, and cartridges. Code 80306 is used for presumptive testing where instrument assisted optical observation is used to read the dipsticks, cups, cards, and cartridges. Code 80307 is used to report presumptive testing by instrumented chemistry analysis. All of these codes are reported only once per date of service. Only one of these codes per day may be reported according to the Centers for Medicare and Medicaid Services (CMS) and CPT guidelines.

Codes G0480–G0483 are used to report definitive testing and the specific code is selected dependent upon the number of drug classes included in the testing. Code G0659 is used when utilizing a method to identify individual drugs and distinguishing between structural isomers. Only one definitive testing code may be reported per day.

Drug classes for which testing is performed, should reflect only those likely to be present, based on the patient's medical history, current clinical presentation, and illicit drugs that are in common use. It is NOT medically necessary or reasonable to routinely test for substances (licit or illicit), which are not used in the patient treatment programming. Focused drug screens may be more useful for immediate or temporary clinical decision making to support continuation or discontinuation of a treatment plan.

CMS in its final determination chose to create HCPCS codes G0480–G0483 and will not price the laboratory codes 80320–80377. Providers should utilize 80305–80307 and G codes G0480–G0483 and G0659 for reporting of services.

Drug screening will be in accordance with Medicare's Local Coverage Determination (LCD) L35724 Controlled Substance Monitoring and Drugs of Abuse Testing revision 19 (R19) and Local Coverage Article A54799. At the time of publication this LCD is available from the following Medicare website:

<https://www.cms.gov/medicare-coverage-database/search/document-id-search-results.aspx?Date=01/01/2020&DocID=L35724&bc=iAAAA&AAAA&> and the Local Coverage Article is available at: <https://www.cms.gov/medicare-coverage-database/search/document-id-search-results.aspx?Date=01/01/2020&DocID=A54799&bc=hAAAA&AAAA&>

MODIFIERS

The following modifiers are used when reporting pathology and laboratory services. See *CPT 2020-2021* Appendix A for a full list of CPT modifiers.

CPT Modifiers

26 Professional Component

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

90 Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting physician or other qualified health care professional, the procedure may be identified by adding modifier 90 to the usual procedure number.

91 Repeat Clinical Diagnostic Laboratory Test

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. **Note:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

92 Alternative Laboratory Platform Testing

When laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the usual laboratory procedure code (HIV testing 86701–86703, and 87389). The test does not require permanent dedicated space, hence by its design may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of the testing is not in itself determinative of the use of this modifier.

HCPCS Modifier

TC Technical Component

Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number.

80047–89398, G0480-G0483, G0659

PATHOLOGY AND LABORATORY SERVICES

Effective April 1, ~~2020~~

2021

Medical Fee Schedule

INSERT RATE TABLES HERE

Section 6. Medicine and Injections

This section stipulates only those policies and procedures that are unique to this Medicine and Injections section. Additional policies and procedures that apply to all providers are listed in Part I of this *Medical Services Provider Manual*.

NON-PHYSICIAN PROVIDERS (NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS)

Physician assistants and nurse practitioners who treat injured workers are not paid at the full maximum allowable payment (MAP) amounts listed in the Schedule. Payments to these non-physician providers must not exceed 85 percent of the MAP amounts. To determine the maximum allowable payment for these providers, multiply the MAP amount listed in the *Medical Services Provider Manual* fee schedule by .85.

When a service is provided by a nurse practitioner, physician assistant, or certified nurse specialist, the service must be reported by adding modifier AL to the appropriate CPT code. All services provided by nurse practitioners, physician assistants, or certified nurse specialists are subject to the service level adjustment factor (SLAF). Incident-to guidelines are not applicable to services rendered under the [2020-2021 Medical Services Provider Manual](#).

SEPARATE PROCEDURES

A procedure designated as “separate procedure” in its CPT descriptor is commonly performed as a component of a larger procedure and, as such, is not paid as a separate service. However, when a separate procedure is performed independently of, and not immediately related to, other services, it may be billed and paid. (See National Correct Coding Initiative in Chapter IV. Payment Policy.)

TRAVEL REIMBURSEMENT

Regulation 67-1601 A (1) provides the expenses incurred for travel to receive medical attention, which shall be reimbursed to the claimant, for mileage to and from a place of medical attention, which is more than five miles away from home in accordance with the amount allowed state employees for mileage. Injured workers may submit a brief request for reimbursement to the insurance carrier indicating the date, miles, and destination of travel.

See the South Carolina Workers’ Compensation Commission (SCWCC) website for the current travel reimbursement amount:

<https://wcc.sc.gov/claims/compensation-rates>

INDEPENDENT MEDICAL EVALUATION

An Independent Medical Evaluation (IME) is an objective medical or chiropractic evaluation of the injured employee’s medical condition and work status which is requested by the insurance carrier, self-insured employer, an attorney, or a Workers’ Compensation Commissioner. An IME includes the review of available records and test reports, examination of the patient, and a written report regarding the medical condition and work status of the injured worker.

The employer or carrier may schedule an IME with a medical provider of its choice to assist in determining the status of an injured employee’s condition. Acceptable reasons for conducting an IME include, but are not limited to:

1. Instances when the authorized treating physician has not provided current medical reports;
2. Determining whether a change in medical provider is necessary;
3. Determining whether treatment is necessary or the employee appears not to be making appropriate progress in recuperation;
4. Determining whether over-utilization by a medical provider has occurred.

The medical provider performing the IME may not be the medical provider selected to provide the treatment or follow-up care, unless the carrier or self-insurer and the employee agree to this, or unless an emergency exists.

Before performing an IME, a physician must have a written request from the Commission, the employer/insurance carrier, the injured worker, his/her attorneys, or other appropriate third party. To report an IME, use CPT code 99456. Payment for this service varies and is based on individual consideration (IC) or negotiation between the carrier and provider.

CHIROPRACTORS AND OSTEOPATHS

See Section 7. Physical Medicine for further guidelines regarding chiropractors, osteopaths, and manipulation services.

AUDIOLOGIC FUNCTION TESTS

The audiometric tests (procedure codes 92550–92596) require the use of calibrated electronic equipment. Other hearing tests (such as whispered voice or tuning fork) are considered part of the general otorhinolaryngologic services and are not paid separately. All descriptors refer to testing of both ears. Use modifier 52 if a test is applied to one ear only. When modifier 52 is used in conjunction with an audiological functioning test, payment will be made at the lesser of billed charges or 80 percent of the MAP amount (MAP x .80 = payment).

PSYCHOLOGICAL SERVICES

Psychological services may be paid when ordered by a physician and authorized by the employer or insurance carrier.

Payment for psychiatric diagnostic interview (CPT codes 90791 and 90792) includes history and mental status determination, development of a treatment plan when necessary, and the preparation of a written report that must be submitted with the required billing form.

Payment for psychological testing includes administering and scoring the test, interpreting test results, and preparing the written report. In order for appropriate payment to be made, each test must be specifically identified on the claim form with the appropriate procedure code and descriptor.

Psychotherapy (CPT codes 90832–90853) must be billed under the CPT code most closely approximating the length of the session. The codes for individual therapy services designate whether the service can be reported in addition to medical evaluation and management services. Only a medical doctor or other qualified health care provider can legally provide medical evaluation. Consequently, only a medical doctor or other qualified health care provider may be paid for codes 90833, 90836, and 90838. (See *CPT 2020-2021* page [xiii-xiv](#) for definition of other qualified health care provider.)

Services Rendered by a Clinical Social Worker

When authorized by the employer or insurance carrier, a clinical social worker may provide services to injured workers. When billing for diagnostic testing services (CPT codes 96138–96139), a clinical social worker may be paid the lesser of billed charges

or the MAP amount in the Schedule. However, when providing therapeutic or diagnostic services other than diagnostic tests, a service level adjustment factor (SLAF) of .75 must be applied to the MAP amount. For example, to determine the maximum allowable payment for thirty minutes of individual psychotherapy (CPT code 90832 at the non-facility rate of \$94.50) the MAP amount must be multiplied by the SLAF of .75.

$$\$94.50 \times .75 = \$70.88$$

Billing

Clinical psychologists must add modifier AH, and clinical social workers must add modifier AJ to the applicable CPT codes when billing for services. Services are paid at the lesser of the provider's usual charge or the MAP amount.

Psychologists are not subject to the SLAF reduction.

BIOFEEDBACK

Biofeedback training (CPT codes 90901, 90912 and 90913) may be provided when it is medically necessary and is approved by the employer/carrier. See Part I Chapter II, Authorization to Treat. Payment for biofeedback is limited to providers currently licensed or certified to provide biofeedback services. Providers include physicians, physical therapists, and psychologists currently licensed in South Carolina, who are certified by, or meet minimum certification requirements of, the Biofeedback Certification Institute of America. CPT code 90901, Biofeedback training for any modality, may be billed only once per date of service. CPT code 90912, Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes, may be billed once per date of service. Add-on code 90913 Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 15 minutes, may be billed up to three times per date of service in conjunction with the primary procedure.

OVER-THE-COUNTER PREPARATIONS

Over-the-counter preparations dispensed by the provider must be preauthorized prior to dispensing. CPT code 99070 must be used to bill for over-the-counter (proprietary) preparations. The name of the preparation, dosage, and package size must be listed either on the claim form or in the attached office report. The charge must not exceed actual cost plus 20 percent. Payment will not be made for nutrient preparations and other dietary supplements.

CONSULTATION SERVICES

See Section 1. Evaluation and Management, for consultation services.

Commented [C07]: Update when 2021 rate is finalized

Commented [C08]: Update example when 2021 rates is finalized

NEUROLOGY AND NEUROMUSCULAR SERVICES

Neurologic services are typically consultation services and any of the five levels of consultation may be appropriate.

Diagnostic studies (nerve conduction tests, electromyograms, electroencephalograms, etc.) may be paid in addition to the office visit or consultative service. A diagnostic study includes both a technical component (equipment, technical personnel, supplies, etc.) and a professional component (interpreting test results, written report, etc.).

When the professional and technical components are performed separately, use modifier 26 to indicate the professional component, or modifier TC to indicate the technical component. Billing the CPT neurological and neuromuscular service codes with no modifier indicates that the complete service (professional and technical components) was provided.

When diagnostic services are provided at a hospital or ambulatory surgical center (ASC) that will be billing for the technical component, the professional service must be billed with the modifier 26. The physician will be paid only for the professional component.

EXTREMITY TESTING, MUSCLE TESTING, AND RANGE OF MOTION (ROM) MEASUREMENTS

See Section 7, Physical Medicine, for complete details.

ELECTROMYOGRAPHY (EMG)

Payment for electromyography (EMG) services includes the initial set of electrodes and all supplies necessary to perform the service. Additional sets of electrodes and supplies and materials provided by the physician over and above those usually included with the service may be paid. Use the appropriate code from Section 9, HCPCS Level II, to report the supply. In the event that a supply cannot be identified using the codes listed in Section 9, use CPT code 99070 and price the item at actual cost plus 20 percent. (See Part I Chapter III, Injectable Pharmaceuticals, Supplies, and Durable Equipment and Chapter IV, Paying for Supplies for additional information.)

When a physician provides only the interpretation of an EMG performed in a hospital or other facility that will be billing for the technical services, modifier 26 must be added to the service code signifying that the physician is billing only for the professional component of the procedure.

Physicians may be paid for both an initial (new patient) visit or consultation and an EMG performed on the same day.

When an EMG is performed on the same day as a follow-up (established patient) visit or consultation, payment may be made for the visit only when documentation of medical necessity substantiates the need for the E/M services in addition to the EMG.

NERVE CONDUCTION STUDIES (CPT CODES 95905-95913)

A nerve conduction study is the assessment of the motor and sensory functions of a nerve in an extremity. Nerve conduction studies may include comparison studies when documented as medically necessary.

Providers may be paid for all procedures that are necessary to complete a single nerve conduction study.

Physicians may be paid for both an initial (new patient) visit/consultation and nerve conduction studies performed at the same visit. When a nerve conduction study is performed on the same day as a follow-up (established patient) visit/consultation, payment for the visit/consultation may be made only when documentation of medical necessity substantiates the need for the visit services in addition to the nerve conduction study.

OPHTHALMOLOGICAL SERVICES

Ophthalmological services cover numerous highly specialized procedures for the treatment of workers with on-the-job injuries or work-related illnesses. Included are prescriptive and diagnostic services and specific supplies and materials that may be required in treatment.

If the service provided does not equal the scope of the descriptor for a specific ophthalmology service code, the provider should use a general medicine service code or surgical service code that more clearly describes the service provided.

Payment of Ophthalmologic Supplies

The provision of spectacles or contact lenses, including the prescription, the fitting, and the supply of materials, may be paid only when the spectacles/contacts were damaged or lost as the result of an on-the-job injury or accident, or are required for the treatment of an on-the-job injury or work-related illness. The provision of replacement frames is limited to frames of comparable quality to the original frames.

INJECTABLE PHARMACEUTICALS

Payment for injection codes includes the supplies usually required to perform the procedure, but not the medications. Injections are classified as subcutaneous, intramuscular, or

intravenous. Subcutaneous (SC) injections and intramuscular (IM) injections are billed using CPT code 96372; intravenous (IV) injections are billed using CPT code 96374. Each of these CPT codes has been assigned a basic MAP amount, as listed in the *Medical Services Provider Manual*.

When an injection is given during an E/M service, the cost of providing the injection is included in the payment for the E/M service and must not be billed or paid separately. The cost of the injectable pharmaceutical may be billed using the appropriate HCPCS code listed in this section. If a HCPCS code for the injectable pharmaceutical does not exist, use CPT code 99070 and price the drug at its average wholesale price (AWP) as contained in the current edition of *Medi-Span* published by Wolters Kluwer Health.

When the injection is provided without an E/M service, and only the injection will be billed for that date of service, the injection and the medication should be listed separately on the claim form. Report the injection by entering the appropriate CPT injection code, and report the medication as described in the paragraph above. The reimbursement for the injection is the lesser of billed charges or the MAP amount. The charge for the injectable pharmaceutical is determined by the HCPCS code or the average wholesale price (AWP) as published in the current edition of *Medi-Span*. Total reimbursement for the injection is the lesser of billed charges or the basic MAP amount plus the cost of the pharmaceutical.

Anesthetic agents such as Xylocaine and Carbocaine used for local infiltration are included in the payment for the procedure and will not be paid separately.

ADMINISTRATION KITS

Administration kits packaged by the manufacturer and assigned a single National Drug Code (NDC) may be reimbursed the Average Wholesale Price (AWP) of the kit without additional markup. Kits packaged by the provider or other source are considered to be part of the administration of the pharmaceutical and are not separately reimbursed even if reported with an NDC or HCPCS Level II code. Only those supplies and materials over and above those usually provided in the office of the physician or other qualified health care professional may be reported in addition to the pharmaceutical drug and administration as discussed above and in Part I Chapter III of the *2020-2021 Medical Services Provider Manual*.

MODIFIERS

The following modifiers are used when reporting medicine services. See *CPT 2020-2021* Appendix A for a full list of CPT modifiers.

CPT Modifiers

26 Professional Component

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

53 Discontinued Procedure

Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (modifiers approved for ASC hospital outpatient use).

HCPCS Modifiers

AH Clinical Psychologist

South Carolina Specific Instruction: When the service was rendered by a clinical psychologist or other non-Ph.D. provider, the modifier AH must be added to the CPT code for the service rendered.

AJ Clinical Social Worker

South Carolina Specific Instruction: When the service was rendered by a clinical social worker, the modifier AJ must be added to the CPT code for the service rendered.

AS Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist Services for Assistant at Surgery

South Carolina Specific Instruction: When a certified physician assistant, nurse practitioner, or certified nurse specialist acts as a surgical assistant, the service must be identified by adding modifier AS. Reimbursement is made at 17 percent of the MAP.

TC Technical Component

Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure number.

South Carolina State-Specific Modifier

AL Nurse Practitioner, Physician Assistant, or Certified Nurse Specialist

When the service was provided by a nurse practitioner, physician assistant, or certified nurse specialist, the AL modifier must be added to the CPT code for the service rendered.

MEDICINE & INJECTIONS 90281–~~95830~~, 95836, 95857–96999, 97151–97158, 97597–97610, 97802–97814, [98970–98972](#),
99500–99607
Medical Fee Schedule Effective April 1,
~~2020~~[2021](#)

INSERT RATE TABLES HERE

Section 7. Physical Medicine

This section stipulates only those policies and procedures that are unique to Physical Medicine. Additional policies and procedures that apply to all providers are listed in Part I of the *Medical Services Provider Manual*.

ELIGIBLE PROVIDERS

Licensed chiropractors, physicians, osteopaths, physical therapists, physical therapy assistants, occupational therapists, and occupational therapy assistants may be paid for manipulations and physical therapy services rendered under workers' compensation. Physical therapy will be paid when the therapy provided is likely to restore function and is specific to the improvement of the patient's condition.

Physicians, osteopaths, and chiropractors who act as the treating medical provider and who provide therapy in their office may be paid for an office visit one time per week in addition to therapy services. Evaluation and management (E/M) services will also be paid in addition to manipulation services when the office notes substantiate a separate E/M service. Physical and occupational therapists and physical and occupational therapy assistants must not be paid for E/M services. (See codes 97161–97168.)

Upon request, physicians must submit to the insurance carrier documentation substantiating the medical necessity of therapies prescribed. (See Chapter II for more information.)

CHIROPRACTORS AND OSTEOPATHS

Chiropractors and osteopaths who act as the treating medical provider may use E/M codes in addition to the physical medicine codes and x-ray procedure codes. Only one office visit per week will be paid, that is, once every Sunday through Saturday time period unless otherwise agreed. Office visit codes may not be substituted for manipulation codes. Chiropractors and osteopaths may use the osteopathic manipulative treatment codes listed in Section 7, Physical Medicine, as appropriate.

OSTEOPATHIC MANIPULATIVE TREATMENT (OMT)

Osteopathic Manipulative Treatment (OMT) is a form of manual treatment applied by a chiropractor or physician to eliminate or alleviate somatic dysfunction and related

disorders. This treatment may be accomplished by a variety of techniques. Additional evaluation and management services may be reported separately using modifier 25, if the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual pre- and postservice work associated with the procedure. Only one office visit may be billed each week. Osteopathic manipulation is reported based on the number of body regions involved in the manipulation treatment.

For purposes of billing osteopathic manipulative treatment, the body's regions are: head region, cervical region, thoracic region, lumbar region, sacral region, pelvic region, lower extremities, upper extremities, rib cage region, abdomen, and viscera region.

CHIROPRACTIC MANIPULATIVE TREATMENT (CMT)

Chiropractic manipulative treatment (CMT) is a form of manual treatment to influence joint and neurophysiological function. This treatment may be accomplished by a variety of techniques. The chiropractic manipulative treatment codes include a premanipulation patient assessment. Additional evaluation and management services may be reported separately using modifier 25, if the patient's condition requires a significant separately identifiable E/M service, above and beyond the usual pre- and post-service work associated with the procedure. Only one office visit may be billed each week.

For purposes of billing chiropractic manipulative treatment, the five spinal regions referred to are: cervical region, thoracic region, lumbar region, sacral region, and pelvic region. The five extraspinal regions referred to are: head region, lower extremities, upper extremities, rib cage, and abdomen.

AUTHORIZATION TO TREAT

Medical providers must receive authorization from the insurance carrier or, if the employer is self-insured, from the employer prior to providing treatment. All treatment must be medically necessary. If an insurance carrier/employer has reason to believe that the proposed treatment is not medically necessary to the employee's work-related injury, the insurance carrier/employer is not obligated to approve the treatment.

PLAN OF CARE

An initial plan of care must be developed and filed with the insurance carrier/employer by the physician or practicing therapist. The plan of care must include, at a minimum, the potential degree of restoration and measurable goals, the specific therapies to be provided, including the frequency and duration of each, and the estimated duration of the therapeutic regimen. The plan of care must be updated at least every thirty days and the revised plan must be signed by the physician or therapist and submitted to the insurance carrier/employer. All therapies and services must be authorized prior to the provision of those services.

INITIAL ASSESSMENT

Therapists may use CPT codes 97161–97163 Physical therapy evaluation, or 97165–97167 Occupational therapy evaluation, to bill for their initial evaluation as documented and meeting the code description. Only one reassessment (CPT code 97164 or 97168) may be paid during the course of treatment for any one injury.

FUNCTIONAL CAPACITY ASSESSMENT

To report a functional capacity assessment (or key functional assessment) use CPT code 97750 and bill the time up to a maximum of twelve (12) units. Code 97750 is subject to the multiple procedure reduction of 75 percent for the second and subsequent units. Total payment for a functional capacity assessment must not exceed \$434.75 (1 unit at \$47.00 plus 11 units totaling \$385.75 ($\$47.00 \times .75 \times 11$)). A copy of the reports and service notes must accompany the claim. (See Multiple Procedure Reduction in this section for more information.)

WORK HARDENING AND WORK CONDITIONING

Work hardening and work conditioning are goal-oriented therapies designed to prepare injured workers, at the end of their therapy, for their return to work. The injured worker should be at the point of resolution of the initial or principal injury so that participation in work hardening would not be prohibited. Use CPT codes 97545 and 97546 to report these services. Use 97545 to bill for the initial two hours and 97546 to bill for each additional hour. Additional hours must be billed as units rounded to the nearest hour (e.g., the final unit should not be counted unless it represents at least 31 minutes of service beyond the previous full hour). Total payment for work hardening or work conditioning must not exceed eight hours of treatment or \$517.99 per date of service. (One unit of 97545 and six units of 97546 ($\$129.49 + (6 \times \$64.75) = \$517.99$)).

ELECTRICAL NERVE STIMULATION

Electrical Nerve Stimulation may be provided by the therapist when ordered by the physician and authorized by the carrier. Payment for electrical stimulation therapy is limited to four sessions per injury.

Use CPT codes 97014 or 97032 to report electrical stimulation therapy.

HOT AND COLD PACKS

Payment for the application of hot or cold packs (CPT code 97010) is included in the payment for the various physical therapy modalities. A separate payment is not made for this service.

MEDICAL SUPPLIES

Medical supplies are not routinely used in the course of physical and occupational therapy. However, dressings that must be removed before treatment and replaced after treatment may be billed and paid. Use the appropriate code from Section 9. HCPCS Level II, to report the supply. In the event that a supply cannot be identified using the codes listed in Section 9, use CPT code 99070 and price the item at actual cost plus 20 percent. (See Part I Chapter III, Injectable Pharmaceuticals, Supplies, and Durable Equipment and Chapter IV, Paying for Supplies for complete details.)

BILLING GUIDELINES

Physical Medicine Therapies (CPT codes 97032–97150, 97530–97542, and 97750–97763) are paid according to time, billed in units of 15 minutes. These services will be paid the lesser of billed charges or the specified MAP for each 15 minute block of time. When determining the correct number of units for billing or payment, additional minutes of service beyond the “initial minutes” specified in the CPT service descriptor must be rounded to the nearest fifteen minute block (e.g., CPT code 97110 at 15–22 minutes = 1 Unit, and at 23–30 minutes = 2 Units).

CPT codes 97012 through 97028 are Physical Medicine Modalities for a single (one) modality or procedure and are paid per service only. They are not billed according to units or minutes of service. When billing for more than one body area, the service notes must be attached so that the body areas can be identified by the claim reviewer.

Use of a back machine (whether mechanical or computerized) is reported using code 97750. A copy of the written request from the referring physician must accompany the claim when billing these services.

Commented [CO9]: Update example based on 2021 rate

Commented [CO10]: Update based on 2021 rates

CPT code 97750 must be used to report testing performed by means of mechanical equipment. Payment for testing is limited to one test every two weeks. The printout of test results is considered part of the service and will not be paid separately.

For muscle testing, range of joint motion, or electromyography, use CPT codes 95851–95875 and 95885–95887, 97161–97172. (See Section 6, Medicine, for more information.) For biofeedback training by EMG use code 90901 (Section 8, subsection Psychological and Biofeedback Services).

PHYSICAL THERAPY AND OCCUPATIONAL THERAPY ASSISTANTS

When a physical therapy assistant (PTA) or occupational therapy assistant (OTA) provide patient care, the services are reported with the addition of modifiers CO or CQ. PTA services are reported with modifier CQ and OTA services are reported with modifier CO. The service level adjustment factor (SLAF) for PTAs and OTAs is 85 percent. Reimbursement is the lesser of the amount billed or 85 percent of the MAP for physical and occupational therapy assistants.

MULTIPLE PROCEDURE REDUCTION

Multiple procedure reduction guidelines apply to the codes in the Physical Medicine section. The highest valued procedure is reported first and is not subject to multiple procedure reduction. It is appropriate to report the additional or subsequent physical medicine codes with modifier 51 to reduce the MAP amount for second and subsequent procedures reported on the same date of service. The reduction for second and subsequent procedures is 75 percent of the MAP amount. Reimbursement will be the lesser of MAP x 75 percent or billed amount.

The codes subject to the multiple procedure reduction are listed below.

92507	92508	92521	92522	92523	92524	92526
92597	92607	92609	96125	97012	97016	97018
97022	97024	97026	97028	97032	97033	97034
97035	97036	97110	97112	97113	97116	97124
97140	97150	97161	97162	97163	97164	97165
97166	97167	97168	97530	97533	97535	97537
97542	97750	97755	97760	97761	97763	G0281
G0283	G0329					

For services by physical and occupational therapy assistants, the service level adjustment factor (SLAF) is applied after the multiple procedure reduction. Second and subsequent services performed by the PTA or OTA are reimbursed at the lesser of billed charges or 0.6375 percent of the MAP ($\text{MAP} \times .85 \times .75 \text{ (SLAF)} = .6375$).

MODIFIERS

The following modifiers are used when reporting physical medicine services. (See *CPT 2020-2021* Appendix A for a full list of CPT modifiers.)

CPT Modifiers

51 Multiple Procedures

When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s).

Note: This modifier should not be appended to designated “add-on” codes.

South Carolina Specific Instruction: Therapy services second and subsequent procedures should be valued at the lesser of billed charges or 75 percent of its listed MAP value. (CPT codes 92507–92508, 92521–92526, 92597, 92607, 92609, 96125, 97012, 97016–97028, 97032–97036, 97110–97124, 97140–97150, 97161–97168, 97530–97542, 97750–97763, G0281, G0283, and G0329.)

52 Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

53 Discontinued Procedure

Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. **Note:** This modifier is not used to report the

elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (modifiers approved for ASC hospital outpatient use).

96 Habilitative Services

When a service or procedure that may be either habilitative or rehabilitative in nature is provided for habilitative purposes, the physician or other qualified health care professional may add modifier 96 to the service or procedure code to indicate that the service or procedure provided was a habilitative service. Habilitative services help an individual learn skills and functioning for daily living that the individual has not yet developed, and then keep and/or improve those learned skills. Habilitative services also help an individual keep, learn, or improve skills and functioning for daily living.

97 Rehabilitative Services

When a service or procedure that may be either habilitative or rehabilitative in nature is provided for rehabilitative purposes, the physician or other qualified health care professional may add modifier 97 to the service or procedure code to indicate that the service or procedure provided was a rehabilitative service. Rehabilitative services help an individual keep, get back, or improve skills and functioning for daily living that have been lost or impaired because the individual was sick, hurt, or disabled.

HCPCS Modifiers

CO Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant

CQ Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant

95851–95852, 97010–97150, 97161–97546, 97750–97799, 98925–98943

PHYSICAL MEDICINE

Effective April 1, 2020

2021

Medical Fee Schedule

INSERT RATE TABLES HERE

Section 8. Special Reports and Services

This section stipulates the policies and procedures that are unique to Special Reports and Services. Additional policies and procedures that apply to all providers are found in Part I of this *Medical Services Provider Manual*.

SPECIAL REPORTS

A special report may be billed and paid when the provider furnishes information above and beyond that which is required by Commission policy or by the laws and regulations of the South Carolina Workers' Compensation Act. [Special Reports](#), CPT® code 99080, [special reports](#), should not be used to bill for completing a report which is included in the CPT descriptor of the service provided. ~~or for reporting the results of an impairment rating made during and E/M service~~ However, CPT code 99080 may be billed in conjunction with, and in addition to, CPT code 99455, [work related or medical disability examination, to report the results of an impairment rating developed during the examination.](#)

Payment for a special report is \$55.00 for a checklist-type report which requires a review of the medical record, and \$70.00 for a written report or for completing the Commission's Form 14B. Prepayment for form or report completion is prohibited.

The purpose of WCC Form 14B Physician's Statement is to consolidate medical information, already existing in the patient's medical file, onto a single, easily referenced document. The Form 14B is a summary of information generated from the patient's previous medical exams, including the diagnosis, date of maximum medical improvement, permanent impairment, work restrictions, retained hardware, and need for future medical care and treatment. [The Form 14B must be signed by the treating physician, who is a qualified physician or surgeon.](#)

The Form 14B is required to be submitted when an employer's representative requests an informal conference to approve settlement on a Form 16A pursuant to R.67-802(A)(1)(a); when an employer's representative requests a Form 16A be approved in accordance with R.67-802(A)(2)(a); and when an employer's representative requests an informal conference to approve settlement on a full and final, clincher basis in accordance with R.67-803(B)(1)(a).

The Workers' Compensation Act provides that "...a physician or hospital may not collect a fee from an employer or insurance carrier until the physician or hospital has made the reports required by the Commission in connection with the case." S.C. Code Ann. § 42-15-90(A) (1976, as amended).

COPIES OF REPORTS AND RECORDS

Providers are required to include supporting documentation when submitting claims, or when required by an insurance carrier, self-insured employer, or the Commission to submit substantiating documentation, and may not charge for these required reports. (See Regulation 67-1302 B(2).) However, when the records or reports are not for the purposes listed above, providers may charge for copying costs. Copying charges are \$0.65 per page for the first 30 pages provided in ~~Print or Electronic format~~, and \$0.50 per page thereafter, ~~provided in an electronic format, which may not exceed \$150.00 per request~~, plus a clerical and handling fee of \$25.00 plus tax and actual postage costs. Providers must respond to a request for copies within 14 days of receipt or face a penalty of up to \$200.00. Section 42-15-95 of the S.C. Code, which governs charges for copies, can be found in Appendix A. [Providers are entitled to charge for the cost of copying records and reports except when such documents are requested by the Commission or for the purpose of substantiating a charge and/or medical necessity.](#)

Providers are required to include supporting documentation when submitting claims, or when required by an insurance carrier, self-insured employer, or the Commission to submit substantiating documentation, and may not charge for these

required reports. (See Regulation 67-1302 B(2).) However, when the records or reports are not for the purposes listed above, providers may charge for copying costs. Copying charges are \$0.65 per page for the first 30 *printed* pages, and \$0.50 per *printed* page thereafter, *which may not exceed \$200.00 per request*, plus a clerical and handling fee of \$25.00 plus tax and actual postage costs. Providers must respond to a request for copies within 14 days of receipt or face a penalty of up to \$200.00. Section 42-15-95 of the S.C. Code, which governs charges for copies, can be found in Appendix A. Providers are entitled to charge for the cost of copying records and reports except when such documents are requested by the Commission or for the purpose of substantiating a charge and/or medical necessity.

Providers who use a medical records company to make and provide copies of medical records must ensure that neither the Commission nor the reviewer is billed for the cost of copies when the purpose of the copies is to substantiate a charge and/or medical necessity.

Note: Providers do not need to obtain authorization from the injured worker to release medical records relating to a workers' compensation claim. An employee who seeks treatment under the provisions of the Workers' Compensation Act is considered to have given consent for the release of medical records relating to the examination or treatment.

TRAVEL REIMBURSEMENT

Physicians may be reimbursed for travel associated with depositions or other medical testimony. Travel by public transportation, subsistence and lodging are reimbursed at actual cost. Travel by personal auto is paid per mile.

See the South Carolina Workers' Compensation Commission (SCWCC) website for the current travel reimbursement amount:

<https://wcc.sc.gov/claims/compensation-rates>

MEDICAL TESTIMONY

Medical testimony by personal appearance of a physician, whether before a Commissioner or in a court of law, is reported using CP4South Carolina specific codes SC001 and SC002. Payment is based on the time spent "in court" only. Time for preparation or travel is not considered when determining payment. Use CP4South Carolina specific code 99075-SC001 to report the initial hour, and South Carolina specific code 99076-SC002 to report each additional quarter hour of medical testimony by personal appearance by a physician. For all other providers, use South Carolina specific code 99077-SC003.

Medical testimony by deposition of a physician is reported using South Carolina specific service codes 99072-SC004 and 99073-SC005. Use South Carolina specific code 99072-SC004 to report the initial hour and code 99073-SC005 to report each additional quarter hour of medical testimony by deposition of a physician. Time is measured based on the actual time spent in deposition. Time spent reviewing records is not considered when determining payment. For all other providers, use South Carolina specific code 99074-SC006.

SPECIAL REPORTS AND SERVICES
Medical Fee Schedule

99070-99091, 99151-99199
Effective April 1, 2021

INSERT RATE TABLES HERE

Section 9. HCPCS Level II

This section stipulates only those policies and procedures that are unique to HCPCS Level II codes for Supplies and Durable Medical Equipment. Additional policies and procedures that apply to all providers are listed in Part I of *Medical Services Provider Manual*. This Manual does not include codes for ambulance and dental services.

BILLING

Supplies and materials provided by the physician over and above those usually included with the office visit may be paid. Use the appropriate code to report the supply. In the event that a supply cannot be identified using the codes listed in this section, use CPT code 99070 and price the item at actual cost plus 20 percent. (See Part I Chapter III, Injectable Pharmaceuticals, Supplies, and Durable Equipment and Chapter IV, Paying for Supplies for complete details.)

CODING

The codes used in this section are Healthcare Common Procedure Coding System (HCPCS) Level II codes. These codes are developed and maintained for use with Medicare and Medicaid services. They are used nationally by many insurance programs. The full HCPCS code descriptions are used in this Manual. Should there be any question or dispute regarding a description, refer to the [2020-2021 HCPCS book](#).

AIR / GROUND AMBULANCE TRANSPORTATION SERVICE

The Commission will follow the Centers for Medicare and Medicaid Services (CMS) guidelines and Ambulance Fee Schedule for air and ground ambulance transportation services. All non-emergency ground and air ambulance service provided to workers' compensation claimants shall be pre-certified. Emergency ground and air ambulance services shall be retro-certified within 72 hours of the service or within three (3) business days. All ground and air ambulance services shall be medically necessary and appropriate. Documentation and trip sheets shall be submitted with the bill that state the condition that indicates the necessity of the air and ground ambulance service provided. It should readily indicate the need for transport via this mode rather than another less expensive

form of transportation. The service billed shall be supported by the documentation submitted for review. Billing shall be submitted to the employer or carrier on a properly completed CMS 1500 claim form or electronic 837p format by HCPCS code. Hospital based or owned providers must submit charges on a CMS 1500 form or electronic 837p format by HCPCS code.

Reimbursement shall be based upon the lesser of the submitted charge or the current Medicare rate. To the extent permitted by federal law, the rates determined in the preceding sentence shall also apply to air ambulance services. No additional conversion factors will be applied to these services. The CMS Ambulance Fee Schedule can be found at:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/index.html>

MEDICALLY UNLIKELY EDITS (MUES)

Medically unlikely edits (MUEs) are applied according to the provider type. If the supply is provided in the physician office use the physician MUE; if the medical service is provided in the inpatient or outpatient facility, use the facility MUE. For DME supply only, a Medicare-approved provider is not required to dispense the DME. The place of service (physician or facility) MUE schedule would be referenced for coverage. Significant supplies dispensed in the physician office may be reimbursed according to the guidelines in this Fee Schedule even if the MUE is 0. (See Part I Section IV for more details regarding reimbursing supplies.)

ADMINISTRATION KITS

Administration kits packaged by the manufacturer and assigned a single National Drug Code (NDC) may be reimbursed the Average Wholesale Price (AWP) of the kit without additional markup. Kits, packaged by the provider or other source, are considered to be part of the administration of the pharmaceutical and are not separately reimbursed even if reported with an NDC or HCPCS Level II code. Only those supplies and materials over and above those usually provided in the office of the physician or other qualified health care professional may be reported in addition to the pharmaceutical drug and administration as

discussed above and in Part I Chapter III of the [2020-2021 Medical Services Provider Manual](#).

MODIFIERS

Modifiers augment codes to more accurately describe the circumstances of services provided. When applicable, the circumstances should be identified by a modifier code; a two-character identifier placed after the usual procedure code. The following modifiers are used when reporting physical medicine services. (See CPT [2020-2021](#) Appendix A for a full list of CPT modifiers.)

CPT Modifiers

26 Professional Component

Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

HCPCS Modifiers

Many durable medical equipment items can be purchased in new or used condition, or rented. Therefore, modifiers are used to identify each of these transactions. The applicable modifiers are:

AU Item furnished in conjunction with a urological, ostomy, or tracheostomy supply

AV Item furnished in conjunction with a prosthetic device, prosthetic or orthotic

AW Item furnished in conjunction with a surgical dressing

KC Replacement of special power wheelchair interface

KL DMEPOS item delivered via mail

NU New equipment

RR Rental (use the RR modifier when DME is to be rented)

TC Technical Component

Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances the technical component charge is identified by adding modifier TC to the usual procedure code.

UE Used durable medical equipment

Level II

A0021–V5364

Effective April 1, ~~2020~~

Medical Fee Schedule

~~2020~~ 2021

HCPCS

INSERT RATE TABLES HERE

Section 10. Pharmacy

This section stipulates only those policies and procedures that are unique to Pharmacy. Additional policies and procedures that apply to all providers are listed in Part I of this *Medical Services Provider Manual*.

PRESCRIPTION DRUG MONITORING PROGRAM

Treating physicians prescribing medication or drugs must comply with the requirements of Act 91 enacted by the SC General Assembly May 31, 2017.

REIMBURSEMENT

Payment for prescription drugs is limited to the lesser of the amount established by the following formula, or by the pharmacist's or health care provider's usual and customary charge. The formula applies to both brand name and generic drugs. However, all prescriptions must be filled using generic drugs, if available, unless the authorized treating physician directs that it be dispensed as written. Opioids/scheduled controlled substances that are prescribed for treatment shall be provided through a pharmacy. The dispensing provider shall keep a signature on file indicating the injured worker or his/her authorized representative has received the prescription.

Average Wholesale Price + \$5.00

All bills under this section shall be itemized for proper reimbursement. Bills submitted for reimbursement shall be based on the original manufacturer's Average Wholesale Price (AWP) of the drug product on the date the drug was dispensed, and must include the National Drug Code (NDC) of the product dispensed. Medi-Span, published by Wolters-Kluwer Health, or IBM Micromedex RED BOOK, shall be used as the source for determining the average wholesale price (AWP). Where the AWP of a medication is not published by Medi-Span or RED BOOK, any nationally published pharmacy price index may be used as a secondary source. In case of a dispute on AWP values for a specific NDC, the parties should take the lower of their referenced published values. If published AWP data becomes unavailable, substitute Wholesale Acquisition Cost (WAC) + 20%. Any issue arising as to the source of average wholesale price may be administratively reviewed by the Commission's Medical Services Division.

Any medication or drugs not specifically prescribed

by the treating physician shall not be reimbursed. In the event the treating physician recommends and/or prescribes a particular drug or medication that can be purchased over-the-counter (without a prescription), and the injured employee pays for the drug or medication, the injured employee is entitled to reimbursement for the purchase upon submission of the appropriate receipts to the employer/insurance carrier.

The price determined by the formula will be the maximum allowable payment a provider can be paid under the Workers' Compensation Act. In instances where the pharmacy's charge is lower than the maximum allowable payment, or where the pharmacy has agreed by contract with an employer, insurance carrier, or their agent to a contractual amount that is lower than the maximum allowable amount, reimbursement shall be made at the lower amount in accordance with the terms of the contract.

REPACKAGED DRUGS

The entity packaging two or more products together makes an implied claim that the products are safe and effective when used together and shall be billed as individual line items identified by their original AWP and NDC. Bills for repackaged drug products must include the original manufacturer or distributor's stock package NDC used in the repackaging process. Reimbursement for a drug that has been repackaged or relabeled shall be calculated by multiplying the number of units dispensed times the per-unit AWP set by the original manufacturer for the underlying drug, plus a \$5.00 single dispensing fee of \$5.00, except where the carrier/payer has contracted for a different amount. A repackaged NDC Number shall not be used and shall not be considered the original manufacturer's NDC Number.

If the original manufacturer's or distributor's stock package NDC information is not provided or is unknown, the payer shall select the most reasonable and closely associated AWP to use for reimbursement of the repackaged drug. In no case shall the repackaged or relabeled drug price exceed the amount otherwise payable had the drug not been repackaged or relabeled. Supplies are considered integral to the package and are not separately reimbursable. Manufacturers of a repackaged or relabeled drug shall not be considered an "original manufacturer."

COMPOUND DRUGS

All medications must be reasonably needed to cure and relieve the injured worker from the effects of the injury.

Compound drugs must be preauthorized for each dispensing and shall be billed by listing each drug included in the compound by NDC, and calculating the charge for each drug separately. Any compounded drug product billed by the compounding pharmacy or dispensing physician shall be identified at the ingredient level and the corresponding quantity by their original manufacturer's National Drug Code (NDC) when submitted for reimbursement. Payment for compounded prescription drugs shall be based on the sum of the average wholesale price by gram weight fee for each ingredient, plus a single dispensing fee of \$5.00. If the NDC for any compounded ingredient is a repackaged medication NDC, reimbursement for the repackaged ingredient(s) shall be calculated as provided above. No payment shall be required for an ingredient not identified by an NDC. A compounded NDC Number shall not be used and shall not be considered the original manufacturer's NDC Number. Any component ingredient in a compound medication for which there is no NDC shall not be reimbursed. Any component ingredient in a topical compound medication that is not FDA approved for topical use shall not be reimbursed.

PRESCRIPTION STRENGTH TOPICAL COMPOUNDS

In order to qualify as a compound under this section, the medication must require a prescription; the ingredients must be combined, mixed, or altered by a licensed pharmacist or a pharmacy technician being overseen by a licensed pharmacist, a licensed physician, or, in the case of an outsourcing facility, a person under the supervision of a licensed pharmacist; and it must create a medication tailored to the needs of an individual patient. All ingredient materials must be listed by quantity used per prescription. Continued use (refills) may require documentation of effectiveness including functional improvement. Category fees include materials, shipping and handling, and time. Regardless of how many ingredients or what type, compounded drugs cannot be reimbursed higher than the Category III fee. The 30-day Maximum Fee Schedule value shall be fractioned down to the prescribed and dispensed amount given to the injured worker. Automatic refilling is not allowed. All topical compounds shall be billed using the South Carolina Worker's Compensation Commission code corresponding with the applicable category as follows:

Category I SC0801, \$80.00 per 30-day supply

Any anti-inflammatory medication or any local anesthetic single agent.

Category II SC0802, \$160.00 per 30-day supply

Any anti-inflammatory agent or agents in combination with any local anesthetic agent or agents.

Category III SC0803, \$240.00 per 30-day supply

Any agent(s) other than anti-inflammatory or local anesthetic agents, either alone, or in combination with other anti-inflammatory or local anesthetic agents.

ADMINISTRATION KITS

Administration kits packaged by the manufacturer and assigned a single National Drug Code (NDC) may be reimbursed the Average Wholesale Price (AWP) of the kit without additional markup. Kits packaged by the provider or other source are considered to be part of the administration of the pharmaceutical and are not separately reimbursed even if reported with an NDC or HCPCS Level II code. Only those supplies and materials over and above those usually provided in the office of the physician or other qualified health care professional may be reported in addition to the pharmaceutical drug and administration as discussed above and in Part I Chapter III of the *2020-2021 Medical Services Provider Manual*.

Part III

Appendix A. Workers' Compensation Medical Laws and Regulations Referenced

The following laws and regulations pertinent to medical services are excerpted from the South Carolina Code of Laws, Title 42, Workers' Compensation, and from the regulations of the South Carolina Workers' Compensation Commission. For access to a complete copy of Title 42, see <http://www.sccode.com/code/statmast.php>. For access to a complete copy of all workers' compensation regulations, see <http://www.sccode.com/coderegs/statmast.php>.

LAWS

Section

- 42-9-360 Assignment of compensation; exemptions from claims of creditors and taxes.
- 42-15-20 Notice of accident shall be given employer.
- 42-15-40 Time for filing claim
- 42-15-60 Medical treatment and supplies shall be furnished.
- 42-15-65 Compensation for damage to prosthetic device, eyeglasses, or hearing aid.
- 42-15-70 Liability of employer for medical treatment.
- 42-15-80 Physical exam facts not privileged.
- 42-15-90 Fees of physicians and hospitals approved by commission.
- 42-15-95 Availability of information by treatment facility.
- 42-17-30 Commission may appoint doctor to examine employee.
- 42-19-10 Employers' records and reports of injuries.

REGULATIONS

- 67-1301 Medical Reports.
- 67-1302 Maximum Allowable Payments to Medical Practitioners.
- 67-1305 Medical Bill Review.
- 67-1307 Rehabilitation Professionals.
- 67-1308 Communication Between Parties And Health Care Providers.
- 67-1601 Expenses Incurred in Receiving Medical Treatment, Reimbursement.

LAWS

SECTION 42-9-360. Assignments of compensation; exemptions from claims of creditors and taxes.

(A) No claim for compensation under this title shall be assignable and all compensation and claims therefor shall be exempt from all claims of creditors and from taxes.

(B) It shall be unlawful for an authorized health care provider to actively pursue collection procedures against a workers' compensation claimant prior to the final adjudication of the claimant's claim. Nothing in this section shall be construed to prohibit the collection from and demand for collection from a workers' compensation insurance carrier or self insured employer. Violation of this section, after written notice to the provider from the claimant or his representative that adjudication is ongoing, shall result in a penalty of five hundred dollars payable to the workers' compensation claimant.

(C) Any person who receives any fee or other consideration or any gratuity on account of services so rendered, unless the consideration or gratuity is approved by the commission or the court, or who makes

it a business to solicit employment for a lawyer or for himself in respect of any claim or award for compensation is guilty of a misdemeanor and, upon conviction, must, for each offense, be fined not more than five hundred dollars or imprisoned not more than one year, or both.

(D) Payment to an authorized health care provider for services shall be made in a timely manner but no later than thirty days from the date the authorized health care provider tenders request for payment to the employer's representative, unless the commission has received a request to review the medical bill.

HISTORY: 1962 Code Section 72-187; 1952 Code Section 72-187; 1942 Code Section 7035-24; 1936 (39) 1231; 1996 Act No. 424, Section 7, eff June 18, 1996.

SECTION 42-15-20. Notice to employer of accident or repetitive trauma.

(A) Every injured employee or his representative immediately shall on the occurrence of an accident, or as soon thereafter as practicable, give or cause to be given to the employer a notice of the accident and the employee shall not be entitled to physician's fees nor to any compensation which may have accrued under the terms of this title prior to the giving of such notice, unless it can be shown that the employer, his agent, or representative, had knowledge of the accident or that the party required to give such notice had been prevented from doing so by reason of physical or mental incapacity or the fraud or deceit of some third person.

(B) Except as provided in subsection (C), no compensation shall be payable unless such notice is given within ninety days after the occurrence of the accident or death, unless reasonable excuse is made to the satisfaction of the commission for not giving timely notice, and the commission is satisfied that the employer has not been prejudiced thereby.

(C) In the case of repetitive trauma, notice must be given by the employee within ninety days of the date the employee discovered, or could have discovered by exercising reasonable diligence, that his condition is compensable, unless reasonable excuse is made to the satisfaction of the commission for not giving timely notice, and the commission is satisfied that the employer has not been unduly prejudiced thereby.

HISTORY: 1962 Code Section 72-301; 1952

Code Section 72-301; 1942 Code Section 7035-25; 1936 (39) 1231; 1974 2265; 2007 Act No. 111, Pt I, Section 25, eff July 1, 2007, applicable to injuries that occur on or after that date.

SECTION 42-15-40. Time for filing claim; filing by registered mail.

The right to compensation under this title is barred unless a claim is filed with the commission within two years after an accident, or if death resulted from the accident, within two years of the date of death. However, for occupational disease claims the two year period does not begin to run until the employee concerned has been diagnosed definitively as having an occupational disease and has been notified of the diagnosis. For the death or injury of a member of the South Carolina National Guard, as provided for in Section 42-7-67, the time for filing a claim is two years after the accident or one year after the federal claim is finalized, whichever is later. The filing required by this section may be made by registered mail, and the service within the time periods set forth in this section constitutes timely filing. For a "repetitive trauma injury" as defined in Section 42-1-172, the right to compensation is barred unless a claim is filed with the commission within two years after the employee knew or should have known that his injury is compensable but no more than seven years after the last date of injurious exposure. This section applies regardless of whether the employee was aware that his repetitive trauma injury was the result of his employment.

HISTORY: 1962 Code Section 72-303; 1952 Code Section 72-303; 1942 Code Section 7035-27; 1936 (39) 1231; 1955 (49) 319; 1974 (58) 2265; 1978 Act No. 522 Section 6; 1979 Act No. 194 Part III Section 6; 1990 Act No. 612, Part II, Section 15C, eff June 13, 1990 (became law without the Governor's signature); 2007 Act No. 111, Pt I, Section 26, eff July 1, 2007, applicable to injuries that occur on or after that date.

SECTION 42-15-60. Time period medical treatment and supplies furnished; refusal to accept treatment; settled claims; total and permanent disability.

(A) The employer shall provide medical, surgical, hospital, and other treatment, including medical and surgical supplies as reasonably may be required, for a period not exceeding ten weeks from the date of an injury, to effect a cure or give relief and for an additional time as in the judgment of the commission will tend to lessen the period of disability as evidenced by expert medical evidence stated to a reasonable degree of medical certainty. In addition to it, the original artificial members as reasonably may be necessary must be provided by the employer. During any period of disability resulting from the injury, the employer, at his own option, may continue to furnish or cause to be furnished, free of charge to the employee, and the employee shall accept, an attending physician and any medical care or treatment that is considered necessary by the attending physician, unless otherwise ordered by the commission for good cause shown. The refusal of an employee to accept any medical, hospital, surgical, or other

treatment or evaluation when provided by the employer or ordered by the commission bars the employee from further compensation until the refusal ceases and compensation is not paid for the period of refusal unless in the opinion of the commission the circumstances justified the refusal, in which case the commission may order a change in the medical or hospital service. If in an emergency, on account of the employer's failure to provide the medical care as specified in this section, a physician other than provided by the employer is called to treat the employee, the reasonable cost of the service must be paid by the employer, if ordered by the commission.

(B)(1) When a claim is settled on the commission's Agreement for Permanent Disability/Disfigurement Compensation form, the employer is not required to provide further medical treatment or medical modalities after one year from the date of full payment of the settlement unless the form specifically provides otherwise.

(2) Each award of permanency as ordered by the single commissioner or by the commission must contain a finding as to whether or not further medical treatment or modalities must be provided to the employee. If the employee is entitled to receive such benefits, the medical treatment or modalities to be provided must be set forth with as much specificity as possible in the single commissioner's order or the commission's order.

(3) In no case shall an employer be required to provide medical treatment or modalities in any case where there is a lapse in treatment of the employee by an authorized physician in excess of one year unless:

- (a) the settlement agreement or commission order provides otherwise; or
- (b) the employee has made reasonable attempts to obtain further treatment or modality from an authorized physician, but through no fault of the employee's own, is unable to obtain such treatment or modalities.

HISTORY: 1962 Code Section 72-305; 1952 Code Section 72-305; 1942 Code Section 7035-28; 1936 (39) 1231; 1972 (57) 2339; 1980 Act No. 445; 2007 Act No. 111, Pt I, Section 27, eff July 1, 2007, applicable to injuries that occur on or after that date.

SECTION 42-15-65. Compensation for damage to prosthetic device, eyeglasses, or hearing aid.

Damage to a prosthetic device of an injured employee as the result of an injury by accident arising out of and in the course of the

employment entitles the employee to compensation ensuring that the prosthetic device is repaired or replaced.

Damage to eye glasses or a hearing aid used by an injured employee as the result of an injury by accident arising out of and in the course of the employment entitles the employee to compensation ensuring that the eye glasses or the hearing aid is repaired or replaced.

HISTORY: 1992 Act No. 329, Section 1, eff May 4, 1992.

SECTION 42-15-70. Liability of employer for medical treatment; effect of malpractice.

The pecuniary liability of the employer for medical, surgical and hospital service or other treatment required, when ordered by the commission, shall be limited to such charges as prevail in the community for similar treatment of injured persons of a like standard of living when such treatment is paid for by the injured person and the employer shall not be liable in damages for malpractice by a physician or surgeon furnished by him pursuant to the provisions of this section, but the consequences of any such malpractice shall be deemed part of the injury resulting from the accident and shall be compensated for as such.

HISTORY: 1962 Code Section 72-306; 1952 Code Section 72-306; 1942 Code Section 7035-29; 1936 (39) 1231.

SECTION 42-15-80. Submission to physical examinations; admissibility of communications to physician; autopsy; role of rehabilitation professionals.

(A) After an injury and so long as he claims compensation, the employee, if so requested by his employer or ordered by the commission, shall submit himself to examination, at reasonable times and places, by a qualified physician or surgeon designated and paid by the employer or the commission. The employee has the right to have present at the examination any qualified physician or surgeon provided and paid by him. A fact communicated to or otherwise learned by any physician or surgeon who may have attended or examined the employee, or who may have been present at any examination, is not privileged, either in hearings provided for by this title or any action at law brought to recover damages against an employer who may have accepted the compensation provisions of this title. If the employee refuses to submit himself to or in any way obstructs the examination requested by and provided for by the employer, his right to compensation and his right to take or prosecute a proceeding under this title must be suspended until the refusal or objection ceases and compensation is not payable at any time for the period of suspension unless in the opinion of the commission the circumstances justify the refusal or obstruction. The employer or the commission may require in any case of death an autopsy at the expense of the person requesting it.

(B) The commission shall promulgate regulations establishing the

role of rehabilitation professionals and other similarly situated professionals in workers' compensation cases with consideration given to these persons' duties to both the employer and the employee and the standards of care applicable to the rehabilitation professional or other similarly situated professional as the case may be.

HISTORY: 1962 Code Section 72-307; 1952 Code Section 72-307; 1942 Code Section 7035-30; 1936 (39) 1231; 2007 Act No. 111, Pt I, Section 28, eff July 1, 2007, applicable to injuries that occur on or after that date.

SECTION 42-15-90. Fees of attorneys and physicians and hospital charges approved by commission.

(A) Attorney fees, physician fees, and hospital charges for services under this title are subject to the approval of the commission, but a physician or hospital may not collect a fee from an employer or insurance carrier until the physician or hospital has made the reports required by the commission in connection with the case.

(B)(1) A person may not:

- (a) receive a fee, gratuity, or other consideration for a service rendered pursuant to this title unless the fee, gratuity, or other consideration is approved by the commission or a court of competent jurisdiction; or
- (b) make it a business to solicit employment for an attorney or himself with respect to a claim or award for compensation under this title.

(2) A violation of this section constitutes a misdemeanor and, upon conviction, each offense is subject to a fine of not more than five hundred dollars, imprisonment for not more than one year, or both.

(C)(1) The commission may adopt criteria to establish a new fee schedule or adjust an existing fee schedule to establish maximum allowable payments for medical services provided by medical practitioners exclusive of hospital inpatient services and hospital outpatient services and ambulatory surgery centers based in whole or in part on the requirements of a federally funded program, but if it adopts adjustments to an existing fee schedule, it must adopt these adjustments on an annual basis and the adjustments may not exceed the percentage change indicated by the federally funded program. The commission shall conduct an evidentiary hearing to review a proposed adjustment to increase or reduce these fees by

more than ten percent annually to determine whether to:

- (a) increase or reduce the proposed adjustment as the commission considers appropriate; or
 - (b) accept the proposed adjustment.
- (2)(a) A decision of the commission to increase or reduce a fee schedule to establish maximum allowable payments for medical services provided by medical practitioners exclusive of hospital inpatient services and hospital outpatient services and ambulatory surgery centers by more than ten percent is reviewable by expedited appeal to the Administrative Law Court pursuant to the Administrative Procedures Act.
- (b) On appeal, the court may:
- (i) accept the increase or decrease;
 - (ii) impose a lesser increase or decrease;
 - (iii) revert the fee schedule as it was immediately prior to the annual adjustment;
 - (iv) adjust the appropriate conversion factors as necessary; or
 - (v) make other adjustments the court considers reasonable.
- (c) The court shall issue a decision within ninety days after it receives the appeal.
- (d) During the pendency of this appeal, the portion of the fee schedule under review must remain the same as it was immediately prior to the proposed changes, but all other portions of the fee schedule or conversion factors are effective and remain unchanged.

HISTORY: 1962 Code Section 72-19; 1952 Code Section 72-19; 1942 Code Section 7035-67; 1936 (39) 1231; 198 Act No. 318, Section 3; 2012 Act No. 183, Section 1, eff June 7, 2012.

SECTION 42-15-95. Release of medical records; communication of medical history by health care provider.

(A) Any employee who seeks treatment for any injury, disease, or condition for which compensation is sought under the provisions of this title shall be considered to have given his consent for the release of medical records relating to such examination or treatment under any applicable law or regulation. All information compiled by a health care facility, as defined in Section 44 7 130, or a health care provider licensed pursuant to Title 40 pertaining directly to a workers' compensation claim must be provided to the insurance carrier, the employer, the employee, their respective attorneys or certified rehabilitation professionals, or the South Carolina Workers' Compensation Commission, within fourteen days after receipt of written request. A health care facility and a health care provider may charge a fee for the search and duplication of a medical record in

accordance with regulations promulgated by the Workers' Compensation Commission. Fee schedules established through regulations of the Workers' Compensation Commission shall apply only to claims under Title 42. If a health care provider fails to send the requested information within thirty days after receipt of the request, the person or entity making the request may apply to the commission for an appropriate penalty payable to the commission, not to exceed two hundred dollars.

(B) A health care provider who provides examination or treatment for any injury, disease, or condition for which compensation is sought under the provisions of this title may discuss or communicate an employee's medical history, diagnosis, causation, course of treatment, prognosis, work restrictions, and impairments with the insurance carrier, employer, their respective attorneys or certified rehabilitation professionals, or the commission without the employee's consent. The employee must be:

- (1) notified by the employer, carrier, or its representative requesting the discussion or communication with the health care provider in a timely fashion, in writing or orally, of the discussion or communication and may attend and participate. This notification must occur prior to the actual discussion or communication if the health care provider knows the discussion or communication will occur in the near future;
- (2) advised by the employer, carrier, or its representative requesting the discussion or communication with the health care provider of the nature of the discussion or communication prior to the discussion or communication; and
- (3) provided with a copy of the written questions at the same time the questions are submitted to the health care provider. The employee also must be provided with a copy of the response by the health care provider.

Any discussion or communication must not conflict with or interfere with the employee's examination or treatment.

Any discussions, communications, medical reports, or opinions obtained in accordance with this section will not constitute a breach of the physician's duty of confidentiality.

(C) Any discussions, communications,

medical reports, or opinions obtained in violation of this section must be excluded from any proceedings under the provisions of this title.

HISTORY: 1980 Act No. 318, Section 1; 1989 Act No. 186, Section 1, eff June 8, 1989; 1990 Act No. 476, Section 1, eff May 14, 1990; 1994 Act No. 468, Section 5, eff July 14, 1994; 2007 Act No. 111, Pt I, Section 29, eff July 1, 2007, applicable to injuries that occur on or after that date.

SECTION 42-17-30. Commission may appoint doctor to examine injured employee; compensation.

The commission or any member thereof may, upon the application of either party or upon its own motion, appoint a disinterested and duly qualified physician or surgeon to make any necessary medical examination of any employee and to testify in respect thereto. The physician or surgeon must be allowed traveling expenses and a reasonable fee in accordance with a fee schedule set by the commission. The commission may allow additional reasonable amounts in extraordinary cases. The commission or any member thereof has the discretion to order either party to pay the fees and expenses of the physician or surgeon, or the commission or any member thereof may order the parties to share responsibility for payment of the fees and expenses.

HISTORY: 1962 Code Section 72-353; 1952 Code Section 72-353; 1942 Code Section 7035-66; 1936 (39) 1231; 1990 Act No. 407, Section 1, eff April 11, 1990.

SECTION 42-19-10. Employers' records and reports of injuries.

Every employer shall keep a record of all injuries, fatal or otherwise, received by his employees in the course of their employment on forms approved by the commission.

If the injury requires minimal medical attention at a cost not to exceed an amount specified by regulation of the

- (1) Compensation Commission must be reported annually on a form and at a time prescribed by the commission.
- (2) An injury involving compensable lost time, medical attention in excess of the limit established by commission regulation in item (1), or the possibility of permanency must be reported within ten business days after the occurrence and knowledge of it, as provided in Section 42-15-20, on a form or in an electronic format prescribed by the commission.

However, for the injury of a South Carolina National Guard member as provided for in Section 42-7-67, the reporting periods must be counted from the date the employer, the South Carolina National Guard, has knowledge that the federal government has denied benefits to the injured guard member or that benefits or additional benefits may be due under the provisions of Title 42.

HISTORY: 1962 Code Section 72-501; 1952 Code Section 72-501; 1942 Code Section 7035-69; 1936 (39) 1231; 1955

(49) 459; 1980 Act No. 318, Section 7; 1989 Act No. 197, Section 1, eff June 20, 1989; 1990 Act No. 612, Part II, Section 15D, eff June 13, 1990 (became law without the Governor's signature); 1996 Act No. 424, Section 8, eff June 18, 1996.

REGULATIONS

67-1301 Medical Reports.

A. A medical practitioner or treatment facility shall furnish upon request all medical information relevant to the employee's complaint of injury to the claimant, the employer, the employer's representative, or the Commission. Payment for services rendered may be withheld from any medical practitioner or treatment facility who fails to comply with a request for this information.

B. The employer's representative shall submit to the Commission a report indicating the claimant's final rating of permanent impairment.

C. A health care facility and a health care provider may charge a fee for the search and duplication of a medical record not to exceed the fee published in the Medical Services Provider Manual.

HISTORY: Added by State Register Volume 14, Issue No. 9, effective September 2, 1990. Amended by State Register Volume 17, Issue No. 4, eff April 23, 1993; State Register Volume 21, Issue No. 6, Part 2, eff June 27, 1997; State Register Volume 34, Issue No. 2, eff February 26, 2010.

67-1302 Maximum Allowable Payments to Medical Practitioners.

A. The Commission shall establish maximum allowable payments for medical services provided by medical practitioners based on a relative value scale and a conversion factor set by the Commission.

(1) The maximum allowable payments and any policies governing the billing and payment of services provided by medical practitioners shall be published in a medical services provider manual.

(2) The Commission may review and update the relative values and/or the conversion factor as needed.

B. Medical practitioners submit claims for payment to the employer or insurance carrier on the Form 14A.

(1) The Commission recognizes the Health Care

Financing Administration Form 1500 (HCFA 1500) as its Form 14A for medical practitioners.

(2) Any narrative records or reports pertaining to the services rendered must be attached to the Form 14A and supplied at no charge to the employer or carrier.

C. An employer or insurance carrier may not pay, and a medical practitioner may not accept, more than the maximum allowable payment amounts listed in the provider manual.

D. Providers of general dental services, pharmaceuticals, durable medical equipment, and other medical products and services not covered by the medical services provider manual shall bill at the provider's usual and customary charge.

HISTORY: Added by State Register Volume 14, Issue No. 9, effective September 2, 1990. Amended by State Register Volume 17, Issue No. 4, eff April 23, 1993; State Register

Volume 21, Issue No. 6, Part 2, eff June 27, 1997.

67-1305 Medical Bill Review.

A. Upon receipt of a medical claim, the employer or carrier shall review the bill for compliance with the policies and maximum payments set forth by the Commission

(1) An employer or insurance carrier who reviews medical claims for payment must apply to the Commission for approval to review and reduce medical bills. An employer who is not an approved reviewer may solicit the services of an approved bill reviewer, but may not rely on the Commission for bill review services.

(2) In cases where the billing involves unusual or complex circumstances the bill may be sent to the Commission's Medical Services Division for initial review.

(3) Whenever a charge is reduced to the Commission's maximum allowable payment, the reviewer shall include on the explanation of benefits (EOB) form a statement which explains the reduction and indicates the provider's right to appeal the reduction as outlined in subsections B and C.

B. A medical provider who disagrees, based on Commission payment policy, with a reduction may appeal the decision directly to the payer/reviewing entity.

C. If the disagreement cannot be resolved between the provider and the payer/reviewer, the matter may then be referred to the Commission's Medical Services Division for review and resolution.

(1) A provider or reviewer may request a review by submitting to the Medical Services Division:

(a) A cover letter outlining the dispute and stating the requesting party's position regarding the correct payment;

(b) A copy of the bill;

(c) A copy of the explanation of benefits (EOB); and

(d) Any supporting documentation.

Laws

- (2) The Medical Services Division shall review the bill and supporting documentation, using its medical consultant as needed, and shall make a determination regarding correct payment.
- (3) The decision of the Medical Services Division shall be final.
- D. Any medical provider who discovers an incorrect payment within two years of the original billing date may resubmit the claim to the payer for the correct payment.
- E. Any payer who discovers an overpayment made to a provider within two years of the original billing date may request a refund from that provider.

HISTORY: Amended by State Register Volume 21, Issue No. 6, Part 2, eff June 27, 1997.

67-1307 Rehabilitation Professionals.

A. Rehabilitation professionals are coordinators of medical rehabilitation services, including but not limited to state, private, or carrier based, whether on site, telephonic, in or out of state.

B. The role of a rehabilitation professional is to ensure the primary concern and commitment in each workers' compensation case is to advance the medical rehabilitation of the injured worker.

C. A rehabilitation professional must comply with S.C. Section 42-15-95 and R.67-1308 when communicating with a health care provider who provides examination or treatment for any injury, disease, or condition for which compensation is sought. A rehabilitation professional shall possess one of the following certifications:

- (1) Registered Nurse RN;
- (2) Certified Rehabilitation Counselor CRC;
- (3) Certified Registered Rehabilitation Nurse CRRN;
- (4) Certified Disability Management Specialist CDMS;
- (5) Certified Occupational Health Nurse COHN; or
- (6) Certified case manager CCM.

D. Rehabilitation professionals shall be subject to the requirements, rules, regulations, and Code of Ethics specific to their license and certification.

HISTORY: Added by State Register Volume 34, Issue No. 2, eff February 26, 2010.

67-1308 Communication Between Parties And Health Care Providers.

A. A health care provider who provides examination or treatment for any injury, disease or condition for which compensation is sought under the provisions of this title may discuss or communicate an employee's medical history, diagnosis, causation course of treatment, prognosis, work restrictions, and impairments with the insurance carrier, employer, their respective attorneys or certified rehabilitation professionals or the Commission without the employee's consent.

B. The claimant must be:

- (1) Notified by the employer, carrier or its representative requesting the discussion or communication with the health care provider in a timely fashion, but no less than ten days notice unless the parties agree otherwise. Notification may be oral or in writing.
- (2) Allowed to attend and participate, along with claimant's attorney, if any.
- (3) Advised by the employer, carrier or its representative requesting the discussion or communication prior to the discussion or communication.
- (4) Provided a copy of the written questions at the same time the questions are submitted to the health care provider and provided a copy of the response by the health care provider.

HISTORY: Added by State Register Volume 34, Issue No. 2, eff February 26, 2010.

67-1601 Expenses Incurred in Receiving Medical Treatment, Reimbursement.

A. The expenses incurred for travel to receive medical attention which shall be reimbursed to the claimant are:

- (1) Mileage to and from a place of medical attention which is more than five miles away from home in accordance with the amount allowed state employees for mileage; and
- (2) Actual cost of expenses incurred in using public transportation; and
- (3) Actual cost of reasonable overnight lodging and subsistence.

B. The claimant shall receive reimbursement from the employer's representative.

Appendix B. Exceptions to the Multiple Surgical Procedures Policy

The following CPT codes are exempt from the multiple surgical procedures policy. Payment for these services is not subject to a 50 percent reduction. Modifier 51 should not be appended to these codes. Administrators should continue to rely on the National Correct Coding Initiative (NCCI) coding edits for payment guidance.

20697	44500	93602	93612	93618	99151
20974	61107	93603	93615	94610	99152
20975	93600	93610	93616	95905	

Appendix C. Reviewer Approval

CRITERIA

Approved reviewers must demonstrate and maintain compliance with the following criteria.

1. The reviewing entity must abide by the policies established by the South Carolina Workers' Compensation Commission (Commission) and must ensure that all employees conducting bill review understand, and have access to, both the *Medical Services Provider Manual* and the *Hospital and Ambulatory Surgical Center Payment Manual*.
2. The reviewing entity must generate an explanation of benefits (EOB) for the provider whenever payment is made in an amount different from the charge on the provider's bill. The EOB must meet the criteria outlined in Chapter IV, Payment Policy, Explanation of Benefits of the *Medical Services Provider Manual*.
3. The reviewing entity must abide by the Medical Services Division's decision when a dispute between the reviewing entity and a medical provider is referred to the Medical Services Division for resolution. (See *Medical Services Provider Manual*, Chapter IV, Payment Policy, Disputed Payments subsection.)

4. The reviewing entity must maintain an accuracy rate of at least 97 percent. Any reviewing entity that is deficient in this area shall have its approval rescinded and must reapply to have that approval reinstated. The Commission may at any time conduct a random audit to review the accuracy of bills reviewed by the reviewing entity. The reviewing entity must comply with any request for audit materials.

APPROVAL

To initiate approval to conduct bill review, the reviewing entity must demonstrate compliance with the above criteria by submitting to the Medical Services Division a request for approval that includes the following:

1. A written statement indicating that the reviewing entity has reviewed and agrees to comply with the above four criteria.
2. An example of the review entity's EOB form.
3. The name, address, and telephone number of an individual who will serve as the primary contact for matters relating to bill review.

Appendix D. Abbreviations

AMA	American Medical Association	MMI	Maximum Medical Improvement
AMAP	Anesthesiology Maximum Allowable Payment	MUE	Medically Unlikely Edits
AWP	Average Wholesale Price	NC	Not Covered
CMS	Centers for Medicare and Medicaid Services	NCCI	National Correct Coding Initiative
CMT	Chiropractic Manipulative Treatment	NON-FAC	Non-facility, services rendered in an office or other non-facility setting
CPT®	Current Procedural Terminology	NPI	National Provider Identifier
CRNA	Certified Registered Nurse Anesthetist	NUCC	National Uniform Claim Committee
DME	Durable Medical Equipment	OMT	Osteopathic Manipulative Treatment
E/M	Evaluation and Management	PC	Professional Component
EOB	Explanation of Benefits	RBRVS	Resource Based Relative Value Scale
FAC	Facility, services rendered in a facility setting	RVU	Relative Value Unit
FEIN	Federal Employer Identification Number	SCWCC	South Carolina Workers' Compensation Commission
FUD	Follow-up Days	SLAF	Service Level Adjustment Factor
HCPCS	Healthcare Common Procedure Coding System	SSN	Social Security Number
IC	Individual Consideration	TC	Technical Component
IME	Independent Medical Evaluation	TVA	Time Value Amount
MAP	Maximum Allowable Payment		