State of South Carolina

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Workers' Compensation Commission

ADVISORY NOTICE

Medical Services Provider Manual Updates

March 15, 2021

At the Business Meeting on March 15, 2021 the SC Workers' Compensation Commission approved changes to the Medical Services Provider Manual (MSPM) for 2021. New text is underlined and deleted text is marked with a ~~strikethrough.~~

The Commission approved a Conversion Factor of $51.50 for the 2021 MSPM.

The changes will be effective April 1, 2021.

To purchase a copy of the 2021 MSPM go to the following link on the Commission's website:
https://wcc.sc.gov/insurance-and-medical-services/medical-services-division/medical-fee-schedules

Chapter II. General Policy

COPIES OF RECORDS AND REPORTS (page 9 of 2020 MSPM)
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 *printed* pages, and $0.50 per *printed* page thereafter, *which may not exceed $200.00 per request*, ~~plus~~ inclusive of 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.

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Part II: Fee Schedule

Icons (page 31 of the 2020 MSPM)

∞ 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 of 2020 MSPM, to be inserted after Surgical Assistant section)

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.

Section 1: Evaluation and Management (E/M) Services (Page 33 of 2020 MSPM)

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.~~

Section 3: Surgery (Page 69 of the 2020 MSPM)

~~51~~ 50 Bilateral Procedure
~~52~~ 51 Multiple Procedures

Section 8: Special Reports and Services

Special Reports (Page 483 of the 2020 MSPM)
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.

COPIES OF REPORTS AND RECORDS (Page 483 of the 2020 MSPM)

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~~ inclusive of 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.

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MEDICAL TESTIMONY (Page 484 of the 2020 MSPM)

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 ~~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.

Section 10: Pharmacy (Page 691 of the 2020 MSPM)

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. Schedule II-III 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, the IBM Micromedex RED BOOK may be used as a secondary source. When an AWP is not published by either Medi-Span or RED Book, any nationally published pharmacy price index may be used as a secondary source. 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.

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 at the individual

ingredient level utilizing the 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 reasonable and medically necessary 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.

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.*