State of South Carolina

1333 Main Street Suite 500
P.O. Box 1715
Columbia, S.C. 29202-1715

Workers' Compensation Commission

Public Notice

Commission Special Meeting

March 8, 2021

The South Carolina Workers' Compensation Commission will conduct a Special Meeting on Monday March 8, 2021 at 11:00 AM to discuss Medical Service Provider Manual. The meeting will be conducted electronically via Zoom with the Commissioners participating from different locations. The meeting agenda was posted prior to the meeting and proper advance notice was made in compliance with requirements in the Freedom of Information Act. Individuals who want to attend the meeting may use the following link to join the Zoom meeting

https://us02web.zoom.us/j/81662524017?pwd=MmlQdWd1Y3F2U05tTEF1RnpkMnJ5UT09
Meeting ID: 816 6252 4017
Passcode: 392684

The agenda for the Special Business Meeting follows:

1. Call to Order	Chairman Beck
2. Review of Rate Analysis	Christine O'Donnel, Fair Health
3. Review Summary of Changes for 2021	Christine O'Donnel, Fair Health
4. Review of Stakeholder Feedback	Christine O'Donnell, Fair Health Gary Cannon, WCC
5. Review of Fair Health License Fee Request	Donna Smith, Fair Health
6. Adjournment	Chairman Beck

For information about this notice contact:

Gary M. Cannon
Executive Director
GCannon@wcc.sc.gov

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

MEMORANUM

TO: **COMMISSIONERS**

FROM: **Gary Cannon**
Executive Director

DATE: **March 8, 2021**

RE: **Medical Services Provider Manual – Briefing Session**

The Briefing Session to discuss Medical Services Provider Manual Conversion Factor, Proposed Policy Changes and Stakeholder comments will be conducted via Zoom Monday March 8 at 11:00 a.m. The link for the meeting is
https://us02web.zoom.us/j/81662524017?pwd=MmlQdWd1Y3F2U05tTEF1RnpkMnJ5UT09
Meeting ID: 816 6252 4017
Passcode: 392684

Attached are documents for the meeting.

- Fee Schedule Analysis 2021
- Fair Health Summary of Stakeholder Comments, with WCC Staff Comments
- Summary of Changes to the 2021 Medical Services Provider Manual
- Fair Health MSPM User License Fee

Members of the project team from Fair Health, Christine O'Donnell, Dr. Joel Brill, Linda Stelmach, Lydia Muna and Donna Smith, will be in attendance. Christine O'Donnell, project team leader will lead the discussion on the Fee Schedule Analysis 2021 to include the Conversion Factor, Summary of the Stakeholder Comments, and Summary of Policy Changes to the 2021 MSPM. Donna Smith will be in attendance to respond to any questions concerning the proposed change to the User License Fee.

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.

Chris O'Donnell
Executive Director, Business Operations
codonnell@fairhealth.org
212-257-2367 (office)
212-710-0646 (mobile)

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.

~~51~~ 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 ~~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.

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.*

Summary of Stakeholder Feedback

For discussion by the Commissioners

Feedback was received from 11 organizations and individuals about potential changes to the fee schedule. Most of the feedback was related to changes to the pharmacy section of the MSPM. Additional feedback was provided by Walmart on parts of the MSPM that were not proposed for change in 2021 and some general changes and longer-term studies were also proposed.

Section 10: Pharmacy (begins on page 691 of the 2020 MSPM)

1. Opioid dispensing

Original Proposed Change in the 2021 MSPM 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.

Background

Many states restrict physicians from dispensing opioids and other controlled substances for several reasons, including to:

- control expenses related to higher drug costs when dispensed by physicians rather than pharmacies
- limit the dispensing of addictive drugs to pharmacies that are set up to track and report these drugs
- minimize potential abuse

The United States Drug Enforcement Agency (DEA) classifies controlled substances as follows:

- **Schedule I:** drugs, with no currently accepted medical use and a high potential for abuse.
    - Examples include: heroin, lysergic acid diethylamide (LSD), marijuana (cannabis), 3,4-methylenedioxymethamphetamine (ecstasy), methaqualone, and peyote
    - These drugs are illegal and would not be covered by the fee schedule under any circumstances

- **Schedule II:** drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence. These drugs are also considered dangerous.
    - Examples include: (Vicodin), cocaine, methamphetamine, methadone, hydromorphone (Dilaudid), meperidine (Demerol), oxycodone (OxyContin), fentanyl, Dexedrine, Adderall, and Ritalin
- **Schedule III:** drugs with a moderate to low potential for physical and psychological dependence. Schedule III drugs abuse potential is less than Schedule I and Schedule II drugs but more than Schedule IV.
    - Examples include: Tylenol with codeine, ketamine, anabolic steroids, testosterone
- **Schedule IV:** drugs with a low potential for abuse and low risk of dependence
    - Examples include: Xanax, Soma, Darvon, Darvocet, Valium, Ativan, Talwin, Ambien, Tramadol
- **Schedule V:** drugs with lower potential for abuse than Schedule IV and consist of preparations containing limited quantities of certain narcotics, generally used for antidiarrheal, antitussive, and analgesic purposes
    - Examples include: cough preparations with less than 200 milligrams of codeine or per 100 milliliters (Robitussin AC), Lomotil, Motofen, Lyrica, Parepectolin

Proposed Language from Stakeholder Comments

Alternative 1: Two organizations representing physicians provided feedback that they would like no change to the fee schedule to maintain the ability to dispense drugs to provide medications to injured workers faster and to make it easier on patients who may find it difficult to make a separate trip to the pharmacy to obtain their medications.

- **No change to current language** – do nothing

Alternative 2: There were suggestions from two stakeholders to revise the language to preserve the ability to dispense Schedule IV and V drugs, while requiring Schedule II and III medications to be dispensed by a pharmacy.

- **Proposed change:**
  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~~ 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.

FAIR Health Comments

The change proposed under Alternative 2 restricts the dispensing of opioids and other Schedule II and III drugs that have a high to moderate potential for abuse to pharmacies. However physicians

could to continue to dispense medications with low potential for abuse and/or low risk of dependence that are classified under Schedules IV and V.

Staff Comments and Recommendation:

Staff concurs with Fair Health's comments concerning Alternative 2 and recommends the policy be amended to require Schedule II and III drugs be dispensed by pharmacies. The physician's justification to allow dispensing Schedule II and Schedule drugs in office is based upon the premise the patient receiving the medication sooner than having the pharmacy dispense the medication. Two comments were submitted by the Pain Society of the Carolinas and the Physician's Research Institute opposing the change.

2. Red Book

Background

The MSPM designates Medi-Span, published by Wolters-Kluwer Health, as the source for determining average wholesale price (AWP) for prescription drugs. A change was proposed to add an additional source, REDBOOK.

Original Proposed Change in the 2021 MSPM

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.

Stakeholder Comments

A stakeholder suggested that adding an additional source of AWP to the MSPM could create situations where there is a disparity in AWP as published by Med-Span and the RED BOOK and result in disputes. Stakeholders suggested that no change be made and that the RED BOOK language should be struck:

Proposed Language from Stakeholder Comments

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 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.

FAIR Health Comments

This change was originally proposed to provide flexibility for stakeholders who may have access to RED BOOK and not Medi-Span. However, as stakeholders suggest, this could set up potential disputes. Another alternative to consider could be to use RED BOOK when Medi-Span does not contain an AWP for a particular drug. Alternative language is:

Fair Health's Alternative Language *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. 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.*

Staff Comments and Recommendation:

Staff concurs with Fair Health's comments and supports the alternative language offered by Fair Health.

3. Repackaged drugs

Background

Repackaging describes when two or more drugs are packaged together without altering any of the individual drugs included in the package.

Original Proposed Change in the 2021 MSPM

*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.

Stakeholder Comments

A clarification to the language was proposed replacing "as individual line items identified by their original AWP and NCD" with "at the individual ingredient level utilizing the original AWP and NDC":

Proposed Language from Stakeholder Comments

*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~~ 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.*

FAIR Health Comments

The proposed change does not alter the intent of the original change. Using the terminology "individual ingredient level" as proposed may help to clarify the meaning of the phrase.

Staff Comments and Recommendation:Staff concurs with Fair Health's comments and supports the proposed language using the terminology "individual ingredient level".

4. Compound drugs

Background

A compound drug is a combination of multiple active ingredients that are specially mixed, prepared and/or altered for the specific needs of the patient.

Original Proposed Change in the 2021 MSPM

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.

Stakeholder Comments

A stakeholder proposed replacing "reasonably needed" with "reasonable and medically necessary":

Proposed Language from Stakeholder Comments

All medications must be ~~reasonably needed~~ 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.

FAIR Health Comments

The proposed change serves to strengthen the intent of the revised language that was presented to stakeholders.

Staff Comments and Recommendation:

Staff concurs with Fair Health's comments and supports the language offered by Fair Health to strengthen the intent of the original proposed language.

5. Topical compounds - preauthorization

Background

Topical compounds are compounded medications often in cream, ointment or lotion form that are applied to the skin. Topical compounds are often prescribed to manage pain.

Original Proposed Change in the 2021 MSPM

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:

Stakeholder Comments

A stakeholder proposes to repeat a sentence from the prior paragraph in the Compound Drug section as the first sentence in the Prescription Strength Topical Compounds Section. Include the following sentence from in the Compound Drugs section and in the Prescription Strength Topical Compounds section: Compound drugs must be preauthorized for each dispensing.

Proposed Language from Stakeholder Comments

PRESCRIPTION STRENGTH TOPICAL COMPOUNDS
Compound drugs must be preauthorized for each dispensing. 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:

FAIR Health Comments

The addition of the sentence to this section reinforces that pre-authorization applies to both compound drugs and to prescription strength topical compounds.

Staff Comments and Recommendation:

Staff concurs with Fair Health's comments and supports the addition of the sentence in this section to reinforce pre-authorization applies to both compound drugs and prescription strength topical compounds.

6. Topical compounds – state-specific codes

Background

To better control costs for prescription strength topical compounds, a change was proposed to reimburse based on the category the medication falls in, rather than based on the sum of the individual ingredients of the compound.

Original Proposed Change in the 2021 MSPM

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.

Stakeholder Feedback

This topic received more feedback than any other proposed change to the fee schedule. No commenters objected to the categorization of the medications, nor to the proposed maximum payment amounts. However, several stakeholders challenged the use of state-specific codes SC0801, SC0802 and SC0803 to report these medications because current claims and billing systems would have to be updated to facilitate automated reporting. Manual reporting can be expensive and time consuming, cause delays and add to the administrative burden of providers and payors.

Several stakeholders suggested that the categories and payment amounts could be supported using the current NDC codes for the ingredients of topical compounds that are used to report these medications. In this scenario, the NDC codes for the individual active ingredients would

be reported but reimbursement would be based on the category the topical compound drug falls into.

FAIR Health Comments

FAIR Health appreciates the complexity of adding codes that are not part of the standard code set and that manual processing places additional administrative burden on payors and providers.

FAIR Health contacted the Colorado Division of Workers' Compensation about their experience with state-specific codes they have been using since 2011 and similar payment categories that have been in use since 2012. The changes were implemented in Colorado 8 years ago and currently the Colorado Division reports that their impression is that it is working well for both compounding pharmacies and payors. While they have occasionally heard "grumbling" about crosswalking NDC codes to the Colorado categories for topical compounds, they currently see "little to no payment disputes".

Separately, FAIR Health has reached out to Paul Wilson at the National Council for Prescription Drug Programs (NCPDP) as recommended by Lee Ann Stember, President and CEO of NCPDP, in the feedback letter she submitted to the South Carolina Commission. We inquired about:

- The time frame necessary to establish South Carolina state-specific codes for this purpose, given that a similar structure has already been implemented for Colorado; and
- If South Carolina adopted the same codes currently in use by Colorado, whether that would eliminate the need for manual processing.

NCPDP provided a detailed response about the complexities and limitations of supporting state-specific codes and the need to do further study before implementing such a change.

In addition, on March 3, FAIR Health met with a worker's compensation expert with expertise in opioid prescribing guidelines and drug formularies recommended by the Colorado Division to gain additional feedback about the use of state-specific codes for this purpose. This expert shared experience from other states and offered ideas for additional solutions that could potentially meet the Commission's goals that might merit further study.

Four alternatives for reimbursement of prescription strength topical compounds are outlined below:

1. Make no change at this time. Topical compounds would continue to be reimbursed based on the AWP of the individual ingredients used to create the compound. The Commission could continue to study this issue and research the options for establishing state-specific codes and payment amounts.
2. As stakeholders suggested, create the three categories of topical compounds and align the payment rates as proposed above. However, topical compounds would still be reported based on the component NDC codes. The disadvantage to this alternative is that payors would be required to have knowledge of the medications so combinations of NDC codes could be identified as topical compounds and then assigned to the appropriate category for payment. This solution would work in some cases but would leave significant room for error and potential overpayment.
3. Implement the policy according to the original proposal using state-specific codes that are not yet recognized by automated payment systems. This would require manual

processing and administrative burden and likely result in payment delays. NCPDP advises that the process for adding new state-specific codes may take years and could still result in some manual processing. NCPDP does not support the use of state-specific codes.

4. Implement the policy according to the original proposal using the same codes (Z0790, Z0791, Z0792) that are currently in use in Colorado. While Colorado is not experiencing payment disputes, NCPDP reports that some pharmacies are still processing these claims manually. NCPDP pointed out that there are significant hurdles using any state specific codes and does not recommend their use in South Carolina.

Staff Comments and Recommendation

Staff concurs with the intent of controlling cost of prescription strength topical compounds by changing the reimbursement basis to the category the medication falls in, rather than based on the sum of the individual ingredients of the compound. However, staff further understands the stakeholder comments implementing state-specific codes not yet recognized by automated payment systems would require manual processing and administrative burden and likely result in payment delays. Therefore, staff recommends not changing the language at this time and continue to research other alternatives.

Stakeholder Comments on Current Policies, Conversion Factors, Administrative Burden and NegotiatedPayments

Walmart provided the following feedback on current policies that were not anticipated to be updated for the 2021 MSPM.

- Require a time frame of one year from date of service for a provider to submit a bill and one year from original denial or payment for reconsideration. Under current state policy, a provider has two years from original billing to submit for reconsideration.

- Services provided out of state to be paid based on other state's fee schedule when there is one. If not, then negotiate as under current policy.

- Remove language that maximum reimbursement is based on Medicare guidelines and methodologies.

- Include all modifiers (e.g., Modifier 54 for only surgical portion of the service, excluding pre- and post-op.)

Certain items such as payments for services provided out of state and the Medicare basis for guidelines and methodologies cannot be changed without a change to the law. Others such as inclusion of modifiers require additional review and have been added to areas to research for the 2022 MSPM.

The following more general comments were provided and do not require action for the 2021 MSPM.

- Do not use a budget neutral conversion factor approach as it doesn't allow for reasonable increases in medical costs and providers may decide not to see workers' comp patients.

    - *Note that the Commission reviews a budget neutral conversion factor as part of the conversion factor analysis that is provided each year. However, that is not the standard that is used to set the South Carolina conversion factor. By statute, the professional conversion factor must be the same for all service areas except anesthesia. The Commission typically sets a conversion factor that is approximately equal to 140% of the Medicare professional conversion factor. This is based on preference – not a mandate.*

- Set up an advisory committee to review ways in which the administrative burden on providers could be reduced.

- Do a competitive assessment of South Carolina fees compared to other state workers' compensation programs.

- Allow for the opportunity to negotiate rates above fee schedule MAPs when payors/employers agree that the value-add is worth it.

Staff Comments and Recommendation

The comments presented by Walmart and others were not considered in the MSPM update for 2021. To implement the requests will require further research and a statutory or regulatory change.

FAIR Health User License fee

Definition and User Fees for downloading South Carolina's fee schedule

Definition:

Licensing fee schedules is based on the number of users in your organization. A User is an individual who uses information from the ground rules and/or rate tables to make decisions about, to charge or to pay for services related to claims for injured workers.

Examples:

- A physician practice using the fee schedule to bill for services provided to a patient who was injured at work
- Anyone adjudicating a bill whereby the fee schedule is used to price services
- A business analyst interpreting rules and regulations for automation into a software program for bill adjudication, analysis, reporting or other needs
- A claims processor at an insurer/TPA/bill review agency or employer who is reviewing a workers' compensation bill to evaluate appropriate review or payment for medical services
- Reviewing a bill for the purposes of adjusting or completing a potential re-evaluation due to errors, a state or hearing directive or a provider dispute
- Reviewing the fee schedule information for purposes of preparing litigation, attending a hearing or arbitration

The following example would NOT be considered Users of the fee schedule:

- IT staff who load the fee schedule to a company's computer system or software program for use by claims processors or bill reviewers, running reports or other IT functions

2021 User Fees:

2021 South Carolina **Medical/facility fee schedule**	**Fee per order type**
Hardcopy Book printed	$ 150
PDF downloadable format	$ 150
per add'l user	$ 50
Electronic file format	$ 350
per add'l user	$ 50