State of South Carolina

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Workers' Compensation Commission

March 21, 2019

Medical Services Provider Manual
Proposed Changes
Effective April 1, 2019

At the Business Meeting on March 18, 2019 the Commission approved the following text changes to the Medical Services Provider Manual (MSPM), the 2019 CPT and HCPCS Codes approved by the Center for Medicare and Medicaid Services (CMS), a MSPM Conversion Factor of $50, and a $30 maximum allowable payment of $30 per 15-minute unit for anesthesia services. The effective date of the updated fee schedule is April 1, 2019. To purchase an updated Manual click on the following link: https://www.optum360coding.com/Product/48308/

A summary of the text changes to the MSPM follows.

1. **Overview Section Chapter V. Completing and Submitting Claims** - Update instructions for Element number 9 on the CMS 1500 Claims Form.

   9. **Other Insured's Name:** Not applicable

2. **Section 1. Evaluation and Management (E/M) Services & Section 6. Medicine and Injections** – The Commission has not adopted a telemedicine policy at this time, therefore codes and services specific to telemedicine, will be changed from a MAP to an "IC" and negotiated between parties.

3. **Section 7. Physical Medicine** – CMS adopted two new therapy modifiers to be paid at 85% of MAP (one for PT Assistants (PTA) and another for OT Assistant (OTA)) when services are furnished in whole or in part by a PTA or OTA. Proposed verbiage and insertion point within the MSPM is shown below:

   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

Physical Therapy and Occupational Therapy Assistants

When the services of 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. Reimbursement is the lesser of the amount billed or 85 percent of the MAP.

Sections affected: Billing Guidelines and each Section where Modifiers are referenced.

4. **Section 8. Special Reports and Services – Copies of Reports and Records**

Section 8. Special Reports and Services
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 sixty-five cents per page for the first thirty pages *provided in an electronic format*, and fifty cents per page thereafter *provided in an electronic format*, *which may not exceed one hundred fifty dollars per request*, plus a clerical and handling fee of $15.00 plus tax and actual postage costs. Providers must respond to a request for copies within fourteen 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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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.5.

Section 9. HCPCS Level II & Section 10. Pharmacy - Address issue of physicians' billing, pharmacy dispensing companies, and DME suppliers who are combining two or more products

together as “Drug/Supply Kits”. These packaged kits should be valued based on the individual products contained in the package that have an assigned CPT/HCPCS code with relative value (RV) amounts or non-payable supplies (bundled items) which are part of practice expense (PE) and are not separately billable supply items. The proposed verbiage and suggested insertion points within the MSPM are shown below:

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 mark-up. 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 physician or other qualified health care professional office may be reported in addition to the pharmaceutical drug and administration as discussed above and in Part I of the 2019 South Carolina Workers’ Compensation Medical Services Provider Manual.

Sections affected: Injectable Pharmaceuticals, Supplies, and Durable Equipment, HCPCS Modifiers and Compound Drugs.

6. **Section 9. HCPCS Level II** – Physicians’ routine office supplies are included their services and some of these have a zero value even for the physician. However, other valid supplies that are provided should be reimbursed. The proposed verbiage and suggested insertion points within the MSPM are shown below:

Medically unlikely edits (MUE’s) 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 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. Payment Policy for more details regarding reimbursing supplies.

Sections affected: Injectable Pharmaceuticals, Supplies, and Durable Equipment, Services Not Listed in this Schedule and Air/Ground Ambulance Transportation Service.