State of South Carolina

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Workers' Compensation Commission

Advisory Notice

2024 Medical Services Provider Manual

February 2, 2024

At the Business Meeting on January 18, 2024, the Commission received the Summary of Proposed Changes, the Analysis of Anesthesia Conversion Factor and the Fee Schedule Analysis for the update of the Medical Services Provider Manual for 2024. The Commissioners scheduled a Hearing to receive public comment on the proposed changes at the Business Meeting, on Monday, February 12, 2024, in Hearing Room A at the Commission's office, 1333 Main Street, Suite 500, Columbia, SC 29201.

The documents are provided with this notice.

Interested parties may submit written comments by email to Gary Cannon at gcannon@wcc.sc.gov.

The Commission will consider final approval of the 2024 Medical Services Provider Manual at the March 11, 2024 Business Meeting. The effective date of the 2024 Manual will be April 1, 2024.

For additional information contact:

Gary M Cannon
Executive Director
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Summary of Proposed Changes

2024 Medical Services Provider Manual

January 18, 2024

FAIR Health reviewed the policies in the Medical Services Provider Manual (MSPM) under the direction of the South Carolina Workers' Compensation Commission (WCC). This is a preliminary version of the summary and will be updated when final changes are approved.

The codes in the provider manual will be made current by including codes established for 2024 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, code ranges, numerical examples and URL links, substantive changes to the text, which are outlined below, are included in the proposed version of the 2024 Medical Services Provider Manual (MSPM). Page numbers refer to the pages in the South Carolina MSPM effective April 1, 2023.

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

Part I

Chapter I. Overview and Guidelines: Healthcare Common Procedure Coding System

Page 1 – Healthcare Common Procedure Coding System

- Language was updated to recognize that CPT occasionally uses alpha-numeric codes.

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

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

Page 2 – Providers Covered by the Manual, 3. Non-Physician Practitioners

- Included Mental Health Counselors, to align with the Centers for Medicaid & Medicare Services' (CMS) changes to expand access to care for mental health services.

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

Page 2 – Service Level Adjustment Factor

- Added adjustment factor for reimbursement for Mental Health Counselors.

  Mental Health Counselors: .75 for therapeutic and diagnostic services other than diagnostic tests; no adjustment is necessary for diagnostic tests.

Chapter II. General Policy

Page 7 – Copies of Records and Reports

- Added reference to the appendix for consistency with other sections of the provider manual.

  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. (See Appendix A for S.C. Code Section 42-15-95 and Regulation 67-1308.)

Chapter III. Billing Policy

Page 10 – Medically Unlikely Edits (MUES)
Note: Repeated on pages 14, 33 and 459

- Edited to align with updates in the National Correct Coding Initiative (NCCI) language.

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

Page 10 – Modifiers

- Added language to clarify that the modifier only applies to the service code appended and not to the entire bill.

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

Chapter IV. Payment Policy

Page 14 – Medically Unlikely Edits
Note: Repeated on pages 10, 33 and 459

- Edited to align with updates in the National Correct Coding Initiative (NCCI) language.

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Page 14 – Add-on Code Edits

- Language modified to provide clarification and consistency with updated NCCI language.

  CMS has adopted add-on code edits. An add-on code describes a service that can only be performed in addition to a primary service by the same practitioner. Add-on codes can be identified by a **+** in the CPT book and the Medical Services Provider Manual. ~~These~~ The CMS edits identify the primary procedure that should be reported with the add-on code, or those codes that do not specify a primary procedure. Add-on codes are identified as a type ~~I~~1, ~~II~~2, or ~~III~~3.

  - Type ~~I~~1 has a limited number of identifiable primary procedure codes;
  - Type ~~II~~2 does not have a specific list of primary procedure codes; and
  - Type ~~III~~3 has a list of some, but not all, primary procedure codes identified

~~For example,~~ There is one exception for Type 1 edits. Add-on code guidelines indicate that code 99292 may be reported by a provider who does not report 99291 if another provider of the same specialty from the same group reports 99291 ~~on the same day~~. The add-on code edits have been recognized by Medicare since 2013, and followed by state Medicaid programs and health insurance carriers. More information about the add-on code edits can be found at: **http://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits.html**

Part II

Fee Schedule

Page 32 – Telemedicine

- Added place of service code 10 and descriptions of the place of service codes for clarification.
- Removed pandemic emergency language due to expiration of the public health emergency.
- Added mental health counselors.

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 place of service code 02, ~~(telemedicine)~~ (telehealth provided other than in the patient's home) or 10 (telehealth provided in the patient's home) and Modifier 95, Synchronous Telemedicine Service, or Modifier 93, Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System 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 a star (★) in the rate tables. Telemedicine may not be used for emergent conditions. The maximum payment for telemedicine services is 100 percent 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 place of service 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, mental health counselors 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.

Page 33 – Medically Unlikely Edits (MUEs)
Note: Repeated on pages 10, 14 and 459

- Edited to align with updates to the National Correct Coding Initiative (NCCI) language.

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

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

Page 35 – Documentation must support the level of E/M service reported.

- Removed the link to AMA guidelines. In 2023 there were significant changes to E/M services and the AMA made an exception and provided a link to access the guidelines at no cost. This link is no longer active.

For complete instructions on identifying and billing E/M services, please refer to the Evaluation and Management Services Guidelines of the 2024 CPT book, ~~or https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf~~

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.

Page 39 – South Carolina State-Specific Modifier
Note: Repeated on pages 71 and 387

- Appropriate was added before CPT code for consistency with other sections

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

Section 3. Surgery

Page 65 – General

- Provided language to clarify that services covered by follow-up days only apply to services related to the original procedure.

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

Page 66 – Exceptions

- Language was updated to clarify the difference between add-on codes and Modifier 51 exempt codes.

  Certain procedures are not subject to the multiple procedures policy. These procedures are performed only in conjunction with other surgical procedures or ~~that otherwise~~ do not fit into the concept of multiple surgery.

  ~~As a general rule, the description will~~ Add-on codes contain the words “each additional” or “list separately” in ~~it's the~~ CPT descriptor and ~~will be~~ are identified with the **+** icon in the rate tables. ~~These services are also known as “add-on” procedures.~~ These codes ~~will be~~ are an exception to the multiple procedures policy and are reported using the CPT code with no modifier. Payment for these services will be made at the lesser of billed charges or 100 percent of the MAP amount.

  Modifier 51 exempt codes ~~have not been~~ are identified with the ⃠ icon in the rate tables. These codes are an exception to the multiple procedures policy and are reported using the CPT code with no modifier. Payment for these services will be made at the lesser of billed charges or 100 percent of the MAP amount. A list~~ing~~ of CPT codes that are exempt from ~~the multiple procedures policy~~ modifier 51 is found in Appendix B of the Medical Services Provider Manual ~~and these codes are identified with a ⃠ icon in the rate tables.~~

Page 67 – Non-Physician Practitioners

- Certified nurse specialist was added for consistency with other sections of the MSPM.

  When authorized by the employer or insurance carrier, a nurse practitioner, ~~or~~ physician assistant, or certified nurse specialist may provide services to injured workers. Payment to these non-physician practitioners is determined by multiplying the maximum allowable payment (MAP) amounts listed in the Schedule by a service level adjustment factor (SLAF) of .85. Incident-to guidelines are not applicable to services rendered under the 2024 Medical Services Provider Manual.

Page 71– South Carolina State-Specific Modifier
Note: Repeated on pages 39 and 387

- Appropriate was added before CPT code for consistency with other sections

AL Nurse practitioner, physician assistant or certified nurse specialist

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

Section 6. Medicine and Injections

Page 383 – Non-Physician Providers (Nurse Practitioners and Physician Assistants)

- Certified nurse specialist was added for consistency with other sections of the provider manual.

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

Page 384 – Services Rendered by a Clinical Social Worker

- Updated section title to reflect a broader recognition of social workers and to include the addition of Mental Health Counselors.

Services Rendered by a Mental Health Counselor, or a Medical or Clinical Social Worker

Page 384 – Billing

- Update section to clarify the inclusion of medical social workers and to add mental health counselors

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

Page 387 – HCPCS Modifiers

- Updated modifier description to clarify the inclusion of medical social workers and to add mental health counselors

AJ Medical or Clinical Social Worker, or Mental Health Counselors
South Carolina Specific Instruction: *When the service was rendered by a medical or clinical social worker, or a mental health counselor, the modifier AJ must be added to the CPT code for the service rendered.*

Page 387– South Carolina State-Specific Modifier
Note: Repeated on pages 39 and 71

- Appropriate was added before CPT code for consistency with other sections

AL Nurse practitioner, physician assistant or certified nurse specialist

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

Section 9. HCPCS Level II

Page 459 – Medically Unlikely Edits (MUES)
Note: Repeated on pages 10, 14 and 33

- Edited to align with updates in the National Correct Coding Initiative (NCCI) language.

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

Analysis of Anesthesia Conversion Factor

January 5, 2024

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

FAIR Health reviewed the anesthesia conversion factor from several aspects:

- Comparison to Medicare
- Comparison to private health insurance
    - Billed charges
    - Allowed amounts
- Comparison to other states' workers' compensation fee schedules

NOTE: The American Society of Anesthesiologists (ASA) no longer surveys anesthesia providers about conversion factors and does not publish the conversion factor study that was previously used for comparison in this report.

The Commission increased the anesthesia conversion factor from $30.00 to $32.85 in the 2023 South Carolina Medical Services Provider Manual (MSPM) . The anesthesiology maximum allowable payment (AMAP) is the sum of the Basic MAP amount plus the Time Value Amount payment. The Basic MAP amount is set in the fee schedule based on the conversion factor x base units. The Time Value amount is calculated based on the $32.85 conversion factor x each 15-minute time unit.

For example:
CPT 01380 – anesthesia for all closed procedures on knee joint

	60-Minute Surgery (4 Time Units)	120-Minute Surgery (8 Time Units)
Basic MAP (3 base units)	$ 98.55	$ 98.55
Time Value Amount	$ 131.40	$ 262.80
Total AMAP	$ 229.95	$ 361.35

Medicare

CMS reduced the Medicare anesthesia conversion factor slightly in 2024 to maintain budget neutrality for professional fees. The South Carolina anesthesia conversion factor was increased from $30.00 to $32.85 in 2023 and is currently 161% of the national CMS anesthesia conversion factor. The comparison below is based on the Medicare conversion factor published in the 2024 Final Rule.

	National Comparison Anesthesia	South Carolina Comparison Anesthesia	South Carolina Comparison Other Professional Services
South Carolina 2023 Conversion Factor	$32.85	$32.85	$51.50
2024 Medicare Conversion Factor	$20.4349 (National)	$19.91 (Adjusted by CMS for South Carolina)	$32.7442
Ratio	161%	165%	157%

Private Health Insurance

FAIR Health collects data for anesthesia services from private payors (more than 50 payors contribute data for services performed in South Carolina) and uses this data to develop benchmarks, including benchmarks for anesthesia conversion factors. Insurers and administrators that participate in the FAIR Health Data Contribution Program are required to submit all of their data; they cannot selectively choose which data to contribute to FAIR Health. We are providing benchmarks for anesthesia conversion factors in two different ways:

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

The benchmarks below are based on anesthesia services in the FAIR Health database provided in the state of South Carolina. Charge benchmarks (Billed Anesthesia) are based on claims from July 2022 through June 2023 and allowed benchmarks (Allowed Anesthesia) are based on allowed amounts from claims incurred from January through December 2022. These are the latest releases available at the time of developing this report.

		Conversion Factor Percentile									
Type	Release	Average	5th	10th	15th	20th	25th	30th	35th	40th	45th
Billed Anesthesia	Nov-2023	144.24	60.25	78.31	93.45	100.79	109.52	115.60	121.13	130.76	141.20
Allowed Anesthesia	Aug-2023	57.12	22.40	26.56	29.84	33.75	38.45	43.27	48.99	54.00	56.97

		Conversion Factor Percentile									
Type	Release	50th	55th	60th	65th	70th	75th	80th	85th	90th	95th
Billed Anesthesia	Nov-2023	147.56	155.73	161.26	164.36	168.59	173.15	178.64	186.77	195.86	214.44
Allowed Anesthesia	Aug-2023	60.00	60.87	64.80	68.94	71.59	73.79	75.44	78.70	84.91	86.00

The benchmarks for allowed anesthesia, representing rates contracted with network providers under private health insurance, may be used to compare to the South Carolina conversion factor. It aligns to what is being paid for services provided to workers' compensation patients.

In this analysis, the current $32.85 conversion factor falls between the15th and 20th percentiles of allowed values for private insurance. That means that between 80% and 85% of the allowed values in the FAIR Health database are equal to or greater than $32.85. The 50th percentile (conversion factor of $60.00) is the median conversion factor value in the private insurance data and the average allowed conversion factor benchmark is $57.12.

State Workers' Compensation Fee Schedules

FAIR Health reviewed anesthesia conversion factors documented in state workers' compensation fee schedules effective in 2023.

State	Conversion Factor (per 15-minute time unit)
South Carolina	**$32.85**
Alabama	$63.41
Arizona	$61.00
Colorado	$44.00
Florida	$29.49
Georgia	$64.44
Kentucky	$78.53
Louisiana	$50.00
Maryland	$22.81
Mississippi	$75.00
North Carolina	$58.20 – first 60 min $30.75 – after 60 min
North Dakota	$70.86
Ohio	$41.71
Oklahoma	$54.00
Tennessee	$75.00
Virginia (6 regions)	$51.48 - $82.59

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

Summary

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

- The current South Carolina anesthesia conversion factor is $32.85 or 165% of the 2024 Medicare conversion factor for South Carolina and 161% of the national Medicare conversion factor.
- The ratio of the South Carolina workers' compensation anesthesia conversion factor to the Medicare conversion factor is slightly greater than 157% ratio of the conversion factor for other professional services ($51.50) in comparison to Medicare ($32.7442). However, the MAP amounts in the MSPM may also be limited by the +/- 9.5 percent cap on increases or decreases each year, and the formula-based conversion factors for professional services other than anesthesia would not be applicable to those services.
- South Carolina's conversion factor of $32.85 is low when compared to other states' workers' compensation programs.

Fee Schedule Analysis

January 5, 2024

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 (2022 dates of service) provided by the National Council on Compensation Insurance, Inc. (NCCI) and South Carolina maximum allowable payment (MAP) amounts to review conversion factors and propose MAP values for the 2024 fee schedule.

FAIR Health received paid amounts from NCCI for the 2022 calendar year, aggregated at the procedure code/modifier level. FAIR Health used the data to:

1. Compare 2022 actual spending to projected amounts based on 2022 fee schedule MAPS.
2. Project spending for 2023.
3. Project spending for 2024 based on multiple conversion factor alternatives.

2022 Paid Data and Frequencies

The following is a summary of the 2022 data received from NCCI:

NCCI Data – 2022 Calendar Year (Before Validation)

Service Type	Total Paid	Total Charged	Transactions	Units
Ambulance*	$ 2,500,474	$ 4,687,537	14,186	246,888
Anesthesia**	$ 1,474,681	$ 8,351,439	4,842	525,110
CPT (Less Anesthesia)	$ 54,654,210	$ 121,138,777	626,963	870,602
HCPCS (Less Ambulance)	$ 19,772,098	$ 28,942,157	69,027	594,559
Total	**$ 78,401,463**	**$ 163,119,910**	**715,018**	**2,237,159**

*Assumes most units are miles
**Assumes most units are minutes

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 2022 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.

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  - 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 (e.g., assistant surgeon modifiers 80-82 and AS) were projected based on 2022 occurrences and adjusted MAP amounts.

2022 Spending

Actual spending from 2022 based on the NCCI data was compared to projected spending based on 2022 fee schedule MAP values.

Category	Frequency	Payments (NCCI)	Fee Schedule Projections	Ratio of Payments to Fee Schedule
Evaluation and Management	110,175	$ 13,833,309	$ 15,689,598	88.17%
HCPCS Level II	311,655	$ 5,690,827	$ 7,312,593	77.82%
Medicine and Injections	12,073	$ 1,304,497	$ 1,306,085	99.88%
Pathology and Laboratory Services	10,356	$ 377,167	$ 424,810	88.78%
Physical Medicine	653,279	$ 21,849,419	$ 30,689,457	71.20%
Radiology	45,703	$ 4,408,667	$ 4,322,895	101.98%
Special Reports and Services	1,065	$ 62,776	$ 63,418	98.99%
Surgery	29,309	$ 11,176,380	$ 11,923,361	93.74%
Total	**1,173,615**	**$ 58,703,042**	**$ 71,732,218**	**81.84%**

2023 Projections

- Total dollar amounts were projected based on 2022 occurrences and 2023 relative value units (RVUs).
- Using these frequencies and RVUs, FAIR Health projected the estimated spending based on 2023 fee schedule MAP values, including the 9.5% cap on MAP increases and decreases compared to the prior year, where applicable.
- Ambulance data is paid at 100% of Medicare and is not included in this analysis.
- Please see the separate analysis for anesthesia.

Category	Frequency	Total RVUs	2023 Fee Schedule Projections
Evaluation and Management	110,175	324,918	$ 16,626,494
HCPCS Level II	256,689	151,966	$ 7,602,825
Medicine and Injections	12,073	25,622	$ 1,308,679
Pathology and Laboratory Services	10,356	8,396	$ 433,253
Physical Medicine	653,279	606,431	$ 31,164,634
Radiology	45,703	84,241	$ 4,342,886
Special Reports and Services	1,065	1,240	$ 63,861
Surgery	29,309	235,483	$ 12,110,026
Total	**1,118,649**	**1,438,297**	**$ 73,652,658**

2024 Projections and Alternate Conversion Factors

- The projections of paid amounts for the 2024 fee schedule are based on 2022 frequencies and 2024 RVUs, to which the current conversion factor of 51.5 is applied. Projections based on other conversion factors: 50, 51, 52 and 53 are also provided. The cap of +/- 9.5% of the prior year's MAP value for each service was applied, when appropriate, in providing these projections.
- Certain 2024 MAP values used for these projections were calculated based on the following assumptions:
    - 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 drug 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 RVUs calculated by FAIR Health based on our repository of private claims data.
    - FAIR Health does not gap fill values for new codes effective January 1, 2024, that were not valued by Medicare. FAIR Health requires a minimum threshold of claims for a procedure before we can establish an RVU. FAIR Health will evaluate these codes for the 2025 MSPM to determine if we are able to value these codes at that time.

2024 Projections – Current and Alternate Conversion Factors

Category	Freq.	2024 RVUs	CF=50	CF=51	CF=51.5 (Current)	CF=52	CF=53
Evaluation and Management	110,175	330,750	$ 16,526,855	$ 16,847,357	$ 17,007,734	$ 17,166,884	$ 17,484,384
HCPCS Level II	256,619	156,165	$ 7,814,546	$ 7,806,428	$ 7,814,552	$ 7,822,350	$ 7,838,136
Medicine & Injection	12,073	26,272	$ 1,305,822	$ 1,330,726	$ 1,338,563	$ 1,350,571	$ 1,374,590
Pathology & Laboratory	10,356	8,731	$ 435,593	$ 430,246	$ 434,364	$ 437,997	$ 445,499
Physical Medicine	653,279	606,127	$ 30,286,688	$ 30,856,740	$ 31,141,942	$ 31,426,792	$ 31,996,843
Radiology	45,703	84,225	$ 4,213,111	$ 4,296,667	$ 4,338,520	$ 4,380,198	$ 4,463,732
Special Reports	1,065	1,259	$ 62,911	$ 64,169	$ 64,799	$ 65,427	$ 66,674
Surgery	29,309	238,886	$ 11,931,647	$ 12,161,357	$ 12,276,114	$ 12,390,740	$ 12,620,128
Total	**1,118,579**	**1,452,415**	**$ 72,577,173**	**$ 73,793,689**	**$ 74,416,588**	**$75,040,960**	**$ 76,289,986**

Upon approval of a conversion factor for 2024, FAIR Health will provide an updated Medical Services Provider Manual, which will include all approved changes in policies and a final set of rate tables.

Please let us know if you have any questions.