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Workers' Compensation Commission

ADVISORY NOTICE

2023 Medical Services Provider Manual

Updates

March 14, 2023

At the Business Meeting on March 13, 2023 the SC Workers' Compensation Commission approved changes to the Medical Services Provider Manual (MSPM) for 2023. New text is <u>underlined</u> and deleted text is marked with a ~~strikethrough.~~

The Commission approved the Conversion Factor of $51.50 for the 2023 MSPM and approved the Anesthesia Unit rate of $32.85.

The changes will be effective April 1, 2023.

The 2023 MSPM may be purchased from the link on the Commission's website after April 1, 2023.

Summary of Changes

2023 Medical Services Provider

Manual

March 14, 2023

FAIR Health has reviewed the policies in the fee schedule 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 fee schedule will be made current by including codes established for 2023 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 2023 Medical Services Provider Manual (MSPM). Page numbers refer to the pages in the South Carolina MSPM effective April 1, 2022.

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

1. **Fee Schedule Layout (Page 31)** – Language relating to state-specific codes that were assigned new code numbers in 2021 was deleted, as 2023 is the third fee schedule since this change was adopted:

   ∞ 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.*~~

2. **Maximum Allowable Payment (Page 31)** – Language about codes paid based on individual consideration (IC) was moved for clarity.

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

   Some services have been assigned IC (individual consideration) in the MAP column. Payment is determined by the payer based upon submitted documentation. Other services may be listed with the value of "NC" (not covered) and should not be billed or reimbursed. Additional information

regarding IC and NC can be found in Chapter 1. Overview and Guidelines in the subsection titled "Services Without Maximum Allowable Payment (MAP) Amounts."

3. **Section 1. Evaluation and Management (E/M) Services (Page 35)** – the AMA introduced changes to the E/M guidelines in 2023, extending a 2021 revision in coding for office visits to hospital and observation services, consultations, nursing facility and home and residence services. Time or medical decision making (MDM) may now be used to select the appropriate code for use with these services. The E/M section of the 2023 MSPM has been updated accordingly. In addition, a link has been included to provide easy access to an AMA publication on the updated E/M guidelines.

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 2023 CPT book or https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf.

Evaluation and Management Time
~~Beginning in 2021, t~~ Time alone may be used to select the appropriate code level of office or other outpatient evaluation and management services (CPT 99202-99205 and 99212-99215), inpatient and observation care, (CPT 99221-99223, 99231-99236 and 99238-99239), nursing facility services (99307-99310 and 99315-99316) and home and residence services (99341-99345). Consultation codes (CPT 99242-99245 and 99252-99255) are not reimbursable under the MSPM.

~~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.~~

Certain categories of time-based E/M codes that do not have levels of services based on MDM (e.g., Critical Care Services) in the E/M section use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional and the patient and/or family/caregiver. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

For coding purposes, time for these services is the total time on the date of the encounter. It includes both the face-to-face time with the patient and/or family/ caregiver and non-face-to-face time personally spent by the physician and/or other qualified health care professional(s) on the day of the encounter (includes time in activities that require the physician or other qualified health care professional and does not include time in activities normally performed by clinical staff). It includes time regardless of the location of the physician or other qualified health care professional (e.g., whether on or off the inpatient unit or in or out of the outpatient office). It does not include any time spent in the performance of other separately reported service(s).

A shared or split visit is defined as a visit in which a physician and other qualified health care provider(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care provider(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (i.e., when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The appropriate time should be documented in the medical record when it is used as the basis for code selection.

Physician/other qualified health care provider time includes the following activities, when performed:

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/ caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

4. **Section 6. Medicine and Injections (Page 386) –** to match text that was updated in the 2022 MSPM Pharmacy section, a sentence about a secondary source of AWP was added.

INJECTABLE PHARMACEUTICALS

Payment for injection codes includes the supplies usually required to perform the procedure, but not the medications. Injections are classified as subcutaneous, intramuscular, or intravenous. Subcutaneous (SC) injections and intramuscular (IM) injections are billed using CPT code 96372; intravenous (IV) injections are billed using CPT code 96374. Each of these CPT codes has been assigned a basic MAP amount, as listed in the *Medical Services Provider Manual.*

When an injection is given during an E/M service, the cost of providing the injection is included in the payment for the E/M service and must not be billed or paid separately. The cost of the injectable pharmaceutical may be billed using the appropriate HCPCS code listed in this section. If a HCPCS code for the injectable pharmaceutical does not exist, use CPT code 99070 and price

the drug at its average wholesale price (AWP) as contained in the current edition of Medi-Span published by Wolters Kluwer Health. Where the AWP of a medication is not published by Medi-Span, the IBM Micromedex RED BOOK may be used as a secondary source.

5. **Section 9. HCPCS Level II (Page 456) –** the explanation for HCPCS modifiers was re-organized for clarity.

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

NU New equipment

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

UE Used durable medical equipment

The following additional modifiers also may be used with HCPCS codes:

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

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

AW Item furnished in conjunction with a surgical dressing

KC Replacement of special power wheelchair interface

KL DMEPOS item delivered via mail

~~**NU New equipment**~~

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

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

~~**UE Used durable medical equipment**~~