Dear Senators TIPPETS, Patrick, Schmidt, and
Representatives HARTGEN, Anderson, King:

The Legislative Services Office, Research and Legislation, has received the enclosed rules of the Industrial Commission:

IDAPA 17.02.04 - Rules Pertaining To The Industrial Commission under the Workers' Compensation Law – Benefits - Proposed Rule (Docket No. 17-0204-1401);

IDAPA 17.02.06 - Rules Pertaining To Employer Reports - Proposed Rule (Docket No. 17-0206-1401);

IDAPA 17.02.08 - Rules Pertaining To Miscellaneous Provisions - Proposed Rule (Docket No. 17-0208-1401);

IDAPA 17.02.09 - Rules Pertaining To Medical Fees - Proposed Rule (Docket No. 17-0209-1401);

IDAPA 17.05.01 - Rules Pertaining To The Crime Victims Compensation Act - Proposed Rule (Docket No. 17-0501-1401).

Pursuant to Section 67-454, Idaho Code, a meeting on the enclosed rules may be called by the cochairmen or by two (2) or more members of the subcommittee giving oral or written notice to Research and Legislation no later than fourteen (14) days after receipt of the rules' analysis from Legislative Services. The final date to call a meeting on the enclosed rules is no later than 10/20/2014. If a meeting is called, the subcommittee must hold the meeting within forty-two (42) days of receipt of the rules' analysis from Legislative Services. The final date to hold a meeting on the enclosed rules is 11/18/2014.

The germane joint subcommittee may request a statement of economic impact with respect to a proposed rule by notifying Research and Legislation. There is no time limit on requesting this statement, and it may be requested whether or not a meeting on the proposed rule is called or after a meeting has been held.

To notify Research and Legislation, call 334-4834, or send a written request to the address on the memorandum attached below.

Legislative Services Office
Idaho State Legislature

Serving Idaho's Citizen Legislature

Eric Milstead
Director

MEMORANDUM

TO: Rules Review Subcommittee of the Senate Commerce & Human Resources Committee and the House Commerce & Human Resources Committee

FROM: Legislative Research Analyst - Elizabeth Bowen

DATE: September 30, 2014

SUBJECT: Industrial Commission

IDAPA 17.02.04 - Rules Pertaining To The Industrial Commission under the Workers' Compensation Law -- Benefits - Proposed Rule (Docket No. 17-0204-1401)

IDAPA 17.02.06 - Rules Pertaining To Employer Reports - Proposed Rule (Docket No. 17-0206-1401)

IDAPA 17.02.08 - Rules Pertaining To Miscellaneous Provisions - Proposed Rule (Docket No. 17-0208-1401)

IDAPA 17.02.09 - Rules Pertaining To Medical Fees - Proposed Rule (Docket No. 17-0209-1401)

IDAPA 17.05.01 - Rules Pertaining To The Crime Victims Compensation Act - Proposed Rule (Docket No. 17-0501-1401)

(1) IDAPA 17.02.04 - Rules Pertaining To The Industrial Commission under the Workers' Compensation Law -- Benefits - Proposed Rule (Docket No. 17-0204-1401)

The Industrial Commission submits notice of proposed rulemaking at IDAPA 17.02.04. The proposed rule would modify a rule that allows reimbursement of health care travel expenses for injured workers who attend necessary medical appointments. Specifically, the proposed rule directs the injured worker to the Commission or the Commission's website to obtain a travel reimbursement form. There is no negative fiscal impact on the state general fund. Negotiated rulemaking was not conducted; however, in drafting the rule, the Commission considered input from a subcommittee of its Advisory Committee. The rule is consistent with the Commission's authority under Sections 72-508 and 72-432, Idaho Code.

(2) IDAPA 17.02.06 - Rules Pertaining To Employer Reports - Proposed Rule (Docket No. 17-0206-1401)

The Industrial Commission submits notice of proposed rulemaking at IDAPA 17.02.06. The proposed rule eliminates language that extends the deadline for insurance adjusters to file a summary of payments where indemnity payments have not been timely made. Additionally, the rule increases the time period for an employer to file a summary of payments in cases of default for reason of insolvency or bankruptcy. There is no negative fiscal impact on the state general fund. Negotiated rulemaking was not conducted; however, in drafting the rule, the Commission did consider input from a subcommittee of its Advisory Committee. The rule is consistent with the Commission's authority under Section 72-508, Idaho Code.

(3) IDAPA 17.02.08 - Rules Pertaining To Miscellaneous Provisions - Proposed Rule (Docket No. 17-0208-1401)

The Industrial Commission submits notice of proposed rulemaking at IDAPA 17.02.08. The proposed rule provides the Commission's mailing address and directs interested parties to the Commission or the Commission's website to obtain a form for notice of claim status. There is no negative fiscal impact on the state general fund. Negotiated rulemaking was not conducted; however, in drafting the rule, the Commission considered input from a subcommittee of its Advisory Committee. The rule is consistent with the Commission's authority under Section 72-508, Idaho Code.

(4) IDAPA 17.02.09 - Rules Pertaining To Medical Fees - Proposed Rule (Docket No. 17-0209-1401)

The Industrial Commission submits notice of proposed rulemaking at IDAPA 17.02.09. The proposed rule updates the medical fee schedule in order to reflect market conditions. Additionally, the rule changes the allowable period for payment of fees due to a medical provider. There is no negative fiscal impact on the state general fund. Negotiated rulemaking was not conducted; however, in drafting the rule, the Commission considered input from a subcommittee of its Advisory Committee. The rule is consistent with the Commission's authority under Section 72-508, Idaho Code.

(5) IDAPA 17.05.01 - Rules Pertaining To The Crime Victims Compensation Act - Proposed Rule (Docket No. 17-0501-1401)

The Industrial Commission submits notice of proposed rulemaking at IDAPA 17.05.01. The proposed rule updates the crime victims medical fee schedule and clarifies calculations of allowable payments. The rule also provides a method for calculating reimbursement for travel expenses relating to necessary medical care and services. Finally, the rule clarifies time limitations for providers to file claims with the crime victims program. There is no negative fiscal impact on the state general fund. Negotiated rulemaking was not conducted because the changes are necessary in order for the rule to be consistent with the Current Procedural Terminology Codes, and because the current medical fee schedule is not correctly reimbursing providers for some services. The rule is consistent with the Commission's authority under Sections 72-1004 and 72-1026, Idaho Code.

cc: Industrial Commission
Mindy Montgomery

IDAPA 17 - IDAHO INDUSTRIAL COMMISSION

17.02.04 - ADMINISTRATIVE RULES OF THE INDUSTRIAL COMMISSION UNDER THE WORKERS' COMPENSATION LAW -- BENEFITS

DOCKET NO. 17-0204-1401

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 72-508, 72-408, 72-103, 72-102, 72-207, 72-419, 72-602 and 72-432, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 2014.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The rule allows for the reimbursement of health care travel expenses of an injured worker who attends necessary medical appointments as a result of an industrial injury or occupational disease, pursuant to Section 72-432(1), Idaho Code; and the rule removes the form for the reimbursement of health care travel expenses from the actual rule and directs the injured worker to the Commission address or website to obtain the form.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: There is no fiscal impact.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year resulting from this rulemaking: There is no negative fiscal impact.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because a subcommittee of the Commission's Advisory Committee, which included representatives of insurance carriers and medical providers, has been providing input to the Industrial Commission on the issue.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: No documents have been incorporated by reference into this rule.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Matt Vook, Benefits Analyst Employer Education and Evaluation Coordinator, (208) 334-6003.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 22, 2014.

DATED this 29th Day of August, 2014.

Mindy Montgomery, Director
Industrial Commission
700 S. Clearwater Lane
PO Box 83720
Boise, Idaho 83720-0041
Phone: (208) 334-6000
Fax: (208) 334-5145

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 17-0204-1401
(Only those Sections being amended are shown.)

321. RULE GOVERNING REIMBURSEMENT FOR TRAVEL EXPENSES.

01. Calculating Distance. As used in Section 72-432(1), Idaho Code, the phrase "... such reasonable medical, surgical or other attendance or treatment, ..." shall include the cost of transportation to and from a physician (as defined in Section 72-102(21), Idaho Code, and hospital appointments, where such transportation is reasonably related to or necessitated by the diagnosis, treatment, or care of claimant's industrial injury or occupational disease; provided, however, that claimant shall not be reimbursed for the first fifteen (15) miles of any round trip, nor for traveling any round-trip distance of fifteen (15) miles or less. Such distance shall be calculated by the shortest practical route of travel. (8-22-91)

02. Mileage Rate. If claimant has access to, and is able to operate, a vehicle for transportation envisioned in Subsection 321.01, employer shall reimburse claimant at the mileage rate then allowed by the State Board of Examiners for State employees. Such rate shall be published annually by the Industrial Commission, together with the average state wage for the upcoming period. All such miles shall be reimbursed, with fractions of a mile greater than one-half (1/2) mile rounded to the next higher mile and fractions of a mile below one-half (1/2) mile disregarded. (8-22-91)

03. Commercial Transportation. If claimant has no vehicle, or has access to a vehicle and is reasonably unable to utilize the vehicle for transportation envisioned in Subsection 321.01 above, claimant's employer shall reimburse claimant the actual cost of commercial transportation as evidenced by actual receipts. Notwithstanding the above provision, no claimant shall be eligible for reimbursement of the actual cost of commercial transportation where such claimant is unable to operate a motor vehicle due to the revocation or suspension of driving privileges because claimant was under the influence of alcohol and/or drugs. (8-22-91)

04. Request for Reimbursement. It shall be claimant's responsibility to submit a travel reimbursement request to the employer. Such request shall be made on a form substantially the same as Industrial Commission Form IC 432(1), ~~*which is substantially shown in draft format below*~~ available from the Commission and posted on the Commission's website at www.iic.idaho.gov. The claimant must attach to the form a copy of a bill or receipt showing that the visit occurred. The employer shall furnish the claimant with copies of this form.
~~*(8-22-91)*~~( )

~~***IC Form 432(1):***~~

~~***REIMBURSEMENT FOR HEALTH CARE TRAVEL EXPENSES***~~
~~***PURSUANT TO SECTION 72-432(1), IDAHO CODE***~~

~~*Name of Injured Worker* _____~~

~~*Claim #* _____ *SSN:* _____~~

~~*Address* _____~~

_____
_____

~~*Phone #* _____~~

~~*1. Use this form when claiming reimbursement for travel expenses incurred while pursuing reasonable or necessitated diagnosis, treatment, or care of an industrial injury or occupational disease.*~~

~~*2. Only mileage in excess of fifteen (15) miles for any given round trip is reimbursable. However, you should*~~

~~*report the total mileage for each round trip. You are expected to take the shortest practical route of travel.*~~

~~*3. Reimbursement shall be made at the mileage rate allowed by the State Board of Examiners for state employees. The current rate for this mileage is available through your insurance company or by contacting the Idaho Industrial Commission.*~~

~~*4. While prompt submittal of your claim for travel reimbursement is important, you should not submit requests for reimbursement more frequently than once every thirty (30) days.*~~

~~*5. YOU MUST ATTACH TO THIS FORM A COPY OF A BILL OR RECEIPT SHOWING THAT EACH VISIT OCCURRED*~~

~~*A sample copy of IC Form 432(1) is available from the Industrial Commission,*~~
~~*Compensation Consultants,*~~
~~*700 S. Clearwater Lane,*~~
~~*P. O. Box 83720, Boise, Idaho 83720-0041, telephone (208) 334-6000.*~~

~~*(8-22-91)*~~

05. Frequency of Requests. Claimant shall not request transportation reimbursement more frequently than once every thirty (30) days. However, notwithstanding this provision, should a claimant request transportation reimbursement more frequently than every thirty (30) days, employer need not issue more than one reimbursement check in any thirty-day (30) period. (8-22-91)

IDAPA 17 - IDAHO INDUSTRIAL COMMISSION

17.02.06 - EMPLOYERS' REPORTS

DOCKET NO. 17-0206-1401

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 72-508, 72-432, 72-602, and 72-707, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 2014.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The rule eliminates the language that extends the deadline for filing of a summary of payments for adjusters who do not timely make indemnity payments; and changes the time period from sixty (60) days to one-hundred twenty (120) days to file a summary of payments in case of default by an employer for reason of insolvency or bankruptcy.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: There is no fiscal impact.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year resulting from this rulemaking: There is no negative fiscal impact.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because a subcommittee of the Commission's Advisory Committee, which included representatives of insurance carriers and self-insured employers, has been providing input to the Industrial Commission on the issue.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: No documents have been incorporated by reference into this rule.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Matt Vook, Benefits Analyst Employer Education and Evaluation Coordinator, (208) 334-6003.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 22, 2014.

DATED this 29th Day of August, 2014.

Mindy Montgomery, Director
Industrial Commission
700 S. Clearwater Lane
PO Box 83720
Boise, Idaho 83720-0041
Phone: (208) 334-6000
Fax: (208) 334-5145

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 17-0206-1401
(Only those Sections being amended are shown.)

021. SUMMARIES OF PAYMENT.

01. Authority and Definitions. Pursuant to Sections 72-432, 72-508, 72-602 and 72-707, Idaho Code, the Industrial Commission of the State of Idaho promulgates this rule governing the procedure for submission of summaries of payment to the Industrial Commission. This procedure applies to all workers' compensation claims. The following definitions shall be applicable to this Rule. (2-20-95)

a. "Commission," means the Idaho Industrial Commission. (2-20-95)

b. "Medical Only Claim," means the injured worker will neither suffer a disability lasting more than five calendar days as a result of a job-related injury or occupational disease nor be admitted to a hospital as an in-patient. (2-20-95)

c. "Time loss claim," means the injured worker will suffer, or has suffered, a disability that lasts more than five calendar days as a result of a job-related injury or occupational disease, or the injured worker requires, or required, in-patient treatment as a result of such injury or disease. (2-20-95)

d. "Impairment rated claim," means those claims in which a provider establishes an impairment rating for the injured worker. (2-20-95)

e. "Termination of disability," means the date upon which the obligation of the Employer/Surety/Adjuster becomes certain as to duration and amount whether by settlement, decision or periodic payments in the ordinary course of claims processing. If resolved by lump sum settlement (LSS), the termination of disability shall occur on the date the LSS is approved and an order approving is filed by the Industrial Commission. If resolved by decision, the termination of disability shall occur on the date the decision resolving all issues becomes final. ~~*In the context of periodic payments in the ordinary course of business, the termination of disability shall occur on the date on which final payment is made to the claimant.*~~ ~~*(2-20-95)*~~( )

f. "Death claim," means the injured worker died as a result of a work-related injury or occupational disease. (2-20-95)

g. "Employer" is defined in Idaho Code, Section 72-102(11) and includes agents of employers such as attorneys, sureties and adjusters. (2-20-95)

h. "Closure," means that the file will be retired following an audit by the Commission. (2-20-95)

02. Summaries Requirement. A summary of payment shall be filed, in duplicate, by the Employer/Surety/Adjuster within one hundred twenty (120) days of termination of disability for all time-loss claims upon which an Employer/Surety/Adjuster has made payments, except for those claims which are resolved by lump sum settlement. In the case of medical and related benefits only cases, no summaries of payment need to be filed. In the context of death claims and permanent total disability claims, interim summaries of payments shall be filed annually within the first quarter of each calendar year. Interim summaries shall be submitted setting forth substantially the same information required by Final Summaries of Payment, including the balance of payments made to the beginning of the current calendar year, payments during the calendar year, and a total of payments made. This total balance shall be carried forward as the amount of payments made to the beginning of the current year. The Final Summary shall be so designated. Supporting documentation shall be attached to any summary of payment filed with the Commission. (3-30-07)

03. Form. The summary of payment forms are available, pre-printed, from the Industrial Commission, which has designated the form as IC Form 6. The summary of payment shall be submitted on eight and one-half by eleven inch (8 1/2" X 11") paper in a format substantially similar to the following: (2-20-95)

a. For death claims:

SUMMARY OF PAYMENTS
FATAL CASE

Surety No. _____ I.C. No. _____
Injured Person: Employer:
Social Security Number: Address:
Address:
Character of Injury:
Date of Accident: Actual Weekly Wages:

DEPENDENTS

Name of Dependent	Relationship	Date of Birth (if under 18)

AWARDS OF PAYMENTS
COMPENSATION

Payments % AWSW	Amount	Weeks	Total	Remarks
Total Compensation Payments:				

BURIAL AND OTHER EXPENSES

Payment for funeral expenses $ Payment to hospital(s) $
Payment to doctor(s) $ Payment for misc. $
Total Medical Expenses (do not include funeral expenses) $
COMMENTS:

Claims Examiner Date

INDUSTRIAL COMMISSION APPROVAL

APPROVED: _____, 20____
BY: _____

b. For time-loss claims:

SUMMARY OF PAYMENTS
TIME-LOSS CASE

Surety No. _____ I.C. No. _____
Injured Person:
Social Security Number: Employer:
Address: Address:
Character of Injury:

Date of Accident: Actual Weekly Wages:
Date Able to Resume Work: Compensation
Rate:
Actual Time Lost: Weeks Days
Date of First Payment:

AWARDS OF PAYMENTS

Payments of Compensation		Amount		Type (TT or PP)
Begin	Weeks	Days	Return to Work	
Payment of Medical Benefits		Amount		
Doctor(s)				
Hospital(s)				
Physical Therapy				
Mileage				
Miscellaneous				
Comments:				

Claims Examiner Date

INDUSTRIAL COMMISSION APPROVAL

APPROVED: , 20

BY:

(2-20-95)

04. Approval. Within ninety (90) days of receipt of Summary of Payment as set forth above, the Industrial Commission shall notify the Employer/Surety/Adjuster that such summary has been approved or shall notify of its inability to reconcile the summary to its records and request additional information. If the Employer/Surety/Adjuster does not receive either an approval or request for additional information within the ninety (90) day period, the Employer/Surety/Adjuster may proceed with closure. In the event the Commission requests additional information, whether in writing or telephonic, the Employer/Surety/Adjuster shall submit the requested information within fifteen (15) working days. If the Employer/Surety/Adjuster is unable to furnish the requested information, the Employer/Surety/Adjuster shall notify the Commission, in writing, of its inability to respond and the reasons therefor within the fifteen (15) working days. The Commission may schedule a show cause hearing to determine whether or not the Employer/Surety/Adjuster should be allowed to continue its status under the workers' compensation laws, including whether the Employer should be allowed to continue self-insured status. (3-30-07)

05. Changes in Status. In case of any default by the Employer or in the event the Employer shall fail to pay any final award or awards, by reason of insolvency or because a receiver has been appointed, the Employer shall submit a summary of payments for every time-loss and death claim within ~~*sixty (60)*~~ one hundred twenty (120) days of the default, insolvency, or appointment of a receiver. This summary will be designated as an interim summary and does not relieve the Employer, successor or receiver from continued reporting requirements. The receiver or successor shall continue to report to the Commission, including the submission of summaries of payments and schedules of outstanding awards. ~~*(2-20-95)*~~( )

IDAPA 17 - IDAHO INDUSTRIAL COMMISSION

17.02.08 - MISCELLANEOUS PROVISIONS

DOCKET NO. 17-0208-1401

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 72-508, 72-404, 72-707, 72-735, and 72-803, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 2014.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The rule provides the Industrial Commission's mailing address; and removes the form notice to claimants of a status change, pursuant to Section 72-806, Idaho Code, from the actual rule and directs the constituent to the Commission address or website to obtain the form.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: There is no fiscal impact.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year resulting from this rulemaking: There is no negative fiscal impact.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because a subcommittee of the Commission's Advisory Committee, which included representatives of insurance carriers and self-insured employers, has been providing input to the Industrial Commission on the issue.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: No documents have been incorporated by reference into this rule.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Matt Vook, Benefits Analyst Employer Education and Evaluation Coordinator, (208) 334-6003.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 22, 2014.

DATED this 29th Day of August, 2014.

Mindy Montgomery, Director
Industrial Commission
700 S. Clearwater Lane
PO Box 83720
Boise, Idaho 83720-0041
Phone: (208) 334-6000
Fax: (208) 334-5145

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 17-0208-1401
(Only those Sections being amended are shown.)

033. RULE GOVERNING APPROVAL OF ATTORNEY FEES IN WORKERS' COMPENSATION CASES.

01. Authority and Definitions. Pursuant to Sections 72-404, 72-508, 72-707, 72-735 and 72-803, Idaho Code, the Commission promulgates this rule to govern the approval of attorney fees. (4-7-11)

a. "Available funds" means a sum of money to which a charging lien may attach. It shall not include any compensation paid or not disputed to be owed prior to claimant's agreement to retain the attorney. (4-7-11)

b. "Approval by Commission" means the Commission has approved the attorney fees in conjunction with an award of compensation or a lump sum settlement or otherwise in accordance with this rule upon a proper showing by the attorney seeking to have the fees approved. (4-7-11)

c. "Charging lien" means a lien, against a claimant's right to any compensation under the Workers' Compensation laws, which may be asserted by an attorney who is able to demonstrate that: (4-7-11)

i. There are compensation benefits available for distribution on equitable principles; (4-7-11)

ii. The services of the attorney operated primarily or substantially to secure the fund out of which the attorney seeks to be paid; (4-7-11)

iii. It was agreed that counsel anticipated payment from compensation funds rather than from the client; (4-7-11)

iv. The claim is limited to costs, fees, or other disbursements incurred in the case through which the fund was raised; and (4-7-11)

v. There are equitable considerations that necessitate the recognition and application of the charging lien. (4-7-11)

d. "Fee agreement" means a written document evidencing an agreement between a claimant and counsel, in conformity with Rule 1.5, Idaho Rules of Professional Conduct (IRPC). (4-7-11)

e. "Reasonable" means that an attorney's fees are consistent with the fee agreement and are to be satisfied from available funds, subject to the element of reasonableness contained in IRPC 1.5. (4-7-11)

i. In a case in which no hearing on the merits has been held, twenty-five percent (25%) of available funds shall be presumed reasonable; or (4-7-11)

ii. In a case in which a hearing has been held and briefs submitted (or waived) under Judicial Rules of Practice and Procedure (JRP), Rules X and XI, thirty percent (30%) of available funds shall be presumed reasonable; or (4-7-11)

iii. In any case in which compensation is paid for total permanent disability, fifteen percent (15%) of such disability compensation after ten (10) years from date such total permanent disability payments commenced. (4-7-11)

02. Statement of Charging Lien. (4-7-11)

a. All requests for approval of fees shall be deemed requests for approval of a charging lien. (4-7-11)

b. An attorney representing a claimant in a Workers' Compensation matter shall in any proposed lump sum settlement, or upon request of the Commission, file with the Commission, and serve the claimant with a copy of the fee agreement, and an affidavit or memorandum containing: (4-7-11)

i. The date upon which the attorney became involved in the matter; (4-7-11)

ii. Any issues which were undisputed at the time the attorney became involved; (4-7-11)

iii. The total dollar value of all compensation paid or admitted as owed by employer immediately prior to the attorney's involvement; (4-7-11)

iv. Disputed issues that arose subsequent to the date the attorney was hired; (4-7-11)

v. Counsel's itemization of compensation that constitutes available funds; (4-7-11)

vi. Counsel's itemization of costs and calculation of fees; and (4-7-11)

vii. Counsel's itemization of medical bills for which claim was made in the underlying action, but which remain unpaid by employer/surety at the time of lump sum settlement, along with counsel's explanation of the treatment to be given such bills/claims following approval of the lump sum settlement. (4-7-11)

viii. The statement of the attorney identifying with reasonable detail his or her fulfillment of each element of the charging lien. (4-7-11)

c. Upon receipt and a determination of compliance with this Rule by the Commission by reference to its staff, the Commission may issue an Order Approving Fees without a hearing. (4-7-11)

03. Procedure if Fees Are Determined Not to Be Reasonable. (4-7-11)

a. Upon receipt of the affidavit or memorandum, the Commission will designate staff members to determine reasonableness of the fee. The Commission staff will notify counsel in writing of the staff's informal determination, which shall state the reasons for the determination that the requested fee is not reasonable. Omission of any information required by Subsection 033.02 may constitute grounds for an informal determination that the fee requested is not reasonable. (4-7-11)

b. If counsel disagrees with the Commission staff's informal determination, counsel may file, within fourteen (14) days of the date of the determination, a Request for Hearing for the purpose of presenting evidence and argument on the matter. Upon receipt of the Request for Hearing, the Commission shall schedule a hearing on the matter. A Request for Hearing shall be treated as a motion under Rule III(e), JRP. (4-7-11)

c. The Commission shall order an employer to release any available funds in excess of those subject to the requested charging lien and may order payment of fees subject to the charging lien which have been determined to be reasonable. (4-7-11)

d. The proponent of a fee which is greater than the percentage of recovery stated in Subsections 033.01.e.i., 033.01.e.ii., or 033.01.e.iii. shall have the burden of establishing by clear and convincing evidence entitlement to the greater fee. The attorney shall always bear the burden of proving by a preponderance of the evidence his or her assertion of a charging lien and reasonableness of his or her fee. (4-7-11)

04. Disclosure. Upon retention, the attorney shall provide to claimant a copy of a disclosure statement. No fee may be taken from a claimant by an attorney on a contingency fee basis unless the claimant acknowledges receipt of the disclosure by signing it. Upon request by the Commission, an attorney shall provide a copy of the signed disclosure statement to the Commission. The terms of the disclosure may be contained in the fee agreement, so long as it contains the text of the numbered paragraphs one (1) and two (2) of the disclosure. A copy of the agreement must be given to the client. The disclosure statement shall be in a format substantially similar to the following:

State of Idaho
Industrial Commission

Client's name printed or typed_____

Attorney's name and address_____
printed or typed

DISCLOSURE STATEMENT

1. In workers' compensation matters, attorney's fees normally do not exceed twenty-five percent (25%) of the benefits your attorney obtains for you in a case in which no hearing on the merits has been completed. In a case in which a hearing on the merits has been completed, attorney's fees normally do not exceed thirty percent (30%) of the benefits your attorney obtains for you.

2. Depending upon the circumstances of your case, you and your attorney may agree to a higher or lower percentage which would be subject to Commission approval. Further, if you and your attorney have a dispute regarding attorney fees, either of you may petition the Industrial Commission, PO Box 83720, Boise, ID 83720-0041, to resolve the dispute.

I certify that I have read and understand this disclosure statement.

Client's Signature Date _____

Attorney's Signature Date_____

~~(4-7-11)~~(____)

034. -- 060. (RESERVED)

061. RULE GOVERNING NOTICE TO CLAIMANTS OF STATUS CHANGE PURSUANT TO SECTION 72-806, IDAHO CODE.

01. Notice of Change of Status. As required and defined by Idaho Code, Section 72-806, a worker shall receive written notice within fifteen (15) days of any change of status or condition. (4-7-11)

02. By Whom Given. Any notice to a worker required by Idaho Code, Section 72-806 shall be given by: the surety if the employer has secured Workers' Compensation Insurance; or the employer if the employer is self-insured; or the employer if the employer carries no Workers' Compensation Insurance. (4-7-11)

03. Form of Notice. Any notice to a worker required by Idaho Code, Section 72-806 shall be mailed within ten (10) days by regular United States Mail to the last known address of the worker, as shown in the records of the party required to give notice as set forth above. The Notice shall be given ~~on~~ in a format substantially similar to IC Form 8, ~~*as prescribed by the Commission for this purpose, as substantially set forth below:*~~ available from the Commission and posted on the Commission's website at www.iic.idaho.gov.

~~**IC Form 8:**~~	
~~**NOTICE OF CLAIM STATUS**~~	
~~*Injured Worker*~~	~~*SSN*~~
~~*Date of Injury*~~	
~~*Employer*~~	
~~*Insurance Company*~~	

~~IC Form 8:~~		
~~NOTICE OF CLAIM STATUS~~		
~~Address~~	~~State~~	~~Zip~~
~~This is to notify you of the denial or change of status of your workers' compensation claim as indicated in the statement checked below.~~		
~~Your claim is denied.~~		
~~Reason~~		
~~Your benefit payments will be~~	~~Reduced~~	~~Increased~~
~~Effective date~~		
~~Reason~~		
~~Your benefit payments will be stopped.~~	~~Effective date~~	
~~Reason~~		
~~Your claim is being investigated.~~		
~~A decision should be made by~~		
~~Other~~		~~Effective date~~
~~Explanation~~		
~~See attached medical reports~~		
~~Signature of insurance company adjuster/examiner~~		~~Date~~
~~Name (typed or printed)~~		
~~A sample copy of IC Form 8 is available from the;~~ ~~Industrial Commission~~ ~~700 S. Clearwater Lane~~ ~~P. O. Box 83720,~~ ~~Boise, Idaho 83720-0041~~ ~~Telephone (208) 334-6000.~~		

~~(4-7-11)~~( )

04. Medical Reports. As required by Idaho Code, Section 72-806, if the change is based on a medical report, the party giving notice shall attach a copy of the report to the notice. (4-7-11)

05. Copies of Notice. The party giving notice pursuant to Idaho Code, Section 72-806 shall send a copy of any such notice to the Industrial Commission, the employer, and the worker's attorney, if the worker is represented, at the same time notice is sent to the worker. (4-7-11)

IDAPA 17 - IDAHO INDUSTRIAL COMMISSION

17.02.09 - MEDICAL FEES

DOCKET NO. 17-0209-1401

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 72-508, 72-720, 72-721, 72-722, 72-723, and 72-803, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 2014.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

This rule implements an update to the facility fee schedule to reflect market conditions. A change to the CPT code range affecting psychiatric diagnostic evaluations is made to align with coding changes implemented by the American Medical Association. A change to the reimbursement for certain hospital outpatient diagnostic lab services is made to align with a change made by Centers for Medicare & Medicaid Services (CMS). The allowable period for prompt payment by a payer is changed to commence upon acceptance of liability if made after receipt of the provider's bill.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: There is no fiscal impact.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year resulting from this rulemaking: There is no negative fiscal impact.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because a subcommittee of the Commission's Advisory Committee, which included representatives of insurance carriers and medical providers, has been providing input to the Industrial Commission on the issue.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: No documents have been incorporated by reference into this rule.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact Patti Vaughn, Medical Fee Schedule Analyst (208) 334-6084.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 22, 2014.

DATED this 29th Day of August, 2014.

Mindy Montgomery, Director
Industrial Commission
700 S. Clearwater Lane
PO Box 83720
Boise, Idaho 83720-0041
Phone: (208) 334-6000
Fax: (208) 334-5145

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 17-0209-1401
(Only those Sections being amended are shown.)

031. ACCEPTABLE CHARGES FOR MEDICAL SERVICES PROVIDED BY PHYSICIANS UNDER THE IDAHO WORKERS' COMPENSATION LAW.
Pursuant to Section 72-508 and Section 72-803, Idaho Code, the Industrial Commission (hereinafter "the Commission") hereby adopts the following rule for determining acceptable charges for medical services provided by physicians under the Idaho Workers' Compensation Law. (4-7-11)

01. Acceptable Charge. Payors shall pay providers the acceptable charge for medical services provided by physicians. (4-7-11)

02. Adoption of Standard for Physicians. The Commission hereby adopts the Resource-Based Relative Value Scale (RBRVS), published by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services, as amended, as the standard to be used for determining the acceptable charge for medical services provided under the Idaho Workers' Compensation Law by physicians. (4-7-11)

03. Conversion Factors. The following conversion factors shall be applied to the total facility or non-facility Relative Value Unit (RVU) as determined by place of service found in the latest RBRVS, as amended, that was published before December 31 of the previous calendar year for a medical service identified by a code assigned to that service in the latest edition of the Physicians' Current Procedural Terminology (CPT), published by the American Medical Association, as amended:

MEDICAL FEE SCHEDULE			
SERVICE CATEGORY	**CODE RANGE(S)**	**DESCRIPTION**	**CONVERSION FACTOR**
Anesthesia	00000 - 09999	Anesthesia	$60.33
Surgery - Group One	22000 - 22999 23000 - 24999 25000 - 27299 27300 - 27999 29800 - 29999 61000 - 61999 62000 - 62259 63000 - 63999	Spine Shoulder, Upper Arm, & Elbow Forearm, Wrist, Hand, Pelvis & Hip Leg, Knee, & Ankle Endoscopy & Arthroscopy Skull, Meninges & Brain Repair, Neuroendoscopy & Shunts Spine & Spinal Cord	$135.00
Surgery - Group Two	28000 - 28999 64550 - 64999	Foot & Toes Nerves & Nervous System	$124.00
Surgery - Group Three	10000 - 19999 20000 - 21999 29000 - 29799 30000 - 39999 40000 - 49999 50000 - 59999 60000 - 60999 62260 - 62999 64000 - 64549 65000 - 69999	Integumentary System Musculoskeletal System Casts & Strapping Respiratory & Cardiovascular Digestive System Urinary System Endocrine System Spine & Spinal Cord Nerves & Nervous System Eye & Ear	$88.54

MEDICAL FEE SCHEDULE			
SERVICE CATEGORY	**CODE RANGE(S)**	**DESCRIPTION**	**CONVERSION FACTOR**
Radiology	70000 - 79999	Radiology	$88.54
Pathology & Laboratory	80000 - 89999	Pathology & Laboratory	To Be Determined
Medicine - Group One	90000 - 907~~9~~49 94000 - 94999 97000 - 97799 97800 - 98999	Immunization, Injections, & Infusions Pulmonary / Pulse Oximetry Physical Medicine & Rehabilitation Acupuncture, Osteopathy, & Chiropractic	$49.00
Medicine - Group Two	90~~80~~750 - 92999 93000 - 93999 95000 - 96020 96040 - 96999 99000 - 99607	Psychiatry & Medicine Cardiography, Catheterization, Vascular Studies Allergy / Neuromuscular Procedures Assessments & Special Procedures E / M & Miscellaneous Services	$70.00

~~(3-20-14)~~( )

04. Anesthesiology. The Conversion Factor for the Anesthesiology CPT Codes shall be multiplied by the Anesthesia Base Units assigned to that CPT Code by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services as of December 31 of the previous calendar year, plus the allowable time units reported for the procedure. Time units are computed by dividing reported time by fifteen (15) minutes. Time units will not be used for CPT Code 01996. (4-7-11)

05. Adjustment of Conversion Factors. The conversion factors set out in this rule shall be adjusted each fiscal year (FY) by the Commission to reflect changes in inflation or market conditions in accordance with Section 72-803, Idaho Code. (4-7-11)

06. Services Without CPT Code, RVU or Conversion Factor. The acceptable charge for medical services that do not have a current CPT code, a currently assigned RVU, or a conversion factor will be the reasonable charge for that service, based upon the usual and customary charge and other relevant evidence, as determined by the Commission. Where a service with a CPT Code, RVU, and conversion factor is, nonetheless, claimed to be exceptional or unusual, the Commission may, notwithstanding the conversion factor for that service set out in Subsection 031.03, above, determine the acceptable charge for that service, based on all relevant evidence in accordance with the procedures set out in Section 035, below. (3-20-14)

07. Coding. The Commission will generally follow the coding guidelines published by the Centers for Medicare and Medicaid Services and by the American Medical Association, including the use of modifiers. The procedure with the largest RVU will be the primary procedure and will be listed first on the claim form. Modifiers will be reimbursed as follows: (4-7-11)

a. Modifier 50: Additional fifty percent (50%) for bilateral procedure. (4-7-11)

b. Modifier 51: Fifty percent (50%) of secondary procedure. This modifier will be applied to each medical or surgical procedure rendered during the same session as the primary procedure. (4-7-11)

c. Modifier 80: Twenty-five percent (25%) of coded procedure. (4-7-11)

d. Modifier 81: Fifteen percent (15%) of coded procedure. This modifier applies to MD and non-MD assistants. (4-7-11)

08. Medicine Dispensed By Physicians. Reimbursement to physicians for any medicine shall not exceed the acceptable charge calculated for that medicine as if provided by a pharmacy under Section 033 of this rule without a dispensing or compounding fee. Reimbursement to physicians for repackaged medicine shall be the Average Wholesale Price (AWP) for the medicine prior to repackaging, identified by the National Drug Code (NDC) reported by the original manufacturer. Reimbursement may be withheld until the original manufacturer's National Drug Code (NDC) is provided by the physician. (7-1-13)

032. ACCEPTABLE CHARGES FOR MEDICAL SERVICES PROVIDED BY HOSPITALS AND AMBULATORY SURGERY CENTERS UNDER THE IDAHO WORKERS' COMPENSATION LAW.
Pursuant to Section 72-508 and Section 72-803, Idaho Code, the Commission hereby adopts the following rule for determining acceptable charges for medical services provided by hospitals and ambulatory surgery centers under the Idaho Workers' Compensation Law. (1-1-12)

01. Acceptable Charge. Payors shall pay providers the acceptable charge for medical services provided by hospitals and ambulatory surgery centers. (1-1-12)

02. Adoption of Standards for Hospitals and ASCs. The following standards shall be used to determine the acceptable charge for hospitals and ambulatory surgery centers. (1-1-12)

a. Critical Access and Rehabilitation Hospitals. The standard for determining the acceptable charge for inpatient and outpatient services provided by a critical access or rehabilitation hospital is ninety percent (90%) of the reasonable charge. Implantable hardware charges shall be reimbursed at the rate of the actual cost plus fifty percent (50%). (1-1-12)

b. Hospital Inpatient Services. The standard for determining the acceptable charge for inpatient services provided by hospitals, other than critical access and rehabilitation hospitals, is calculated by multiplying the base rate by the current MS-DRG weight for that service. The base rate for inpatient services is ten thousand two hundred dollars ($10,~~0~~200). Inpatient services that do not have a relative weight shall be paid at eighty-five percent (85%) of the reasonable charge; however, implantable hardware charges billed for services without an MS-DRG weight shall be reimbursed at the rate of actual cost plus fifty percent (50%). ~~(1-1-12)~~( )

c. Hospital Outpatient and Ambulatory Surgical Center (ASC) Services. The standard for determining the acceptable charge for outpatient services provided by hospitals (other than critical access and rehabilitation hospitals) and for services provided by ambulatory surgical centers is calculated by multiplying the base rate by the Medicare Hospital Outpatient Prospective Payment System (OPPS) APC weight in effect on the first day of January of the current calendar year. The base rate for hospital outpatient services is one hundred ~~and thirty-eight~~ forty dollars and seventy-five cents ($~~138~~140.75). The base rate for ASC services is ninety-one dollars and fifty cents ($9~~0~~1.50). ~~(1-1-12)~~( )

i. Medical services for which there is no APC weight listed shall be reimbursed at seventy-five percent (75%) of the reasonable charge. (7-1-12)

ii. Status code N items ~~(other than implantable hardware)~~ or items with no CPT or Healthcare Common Procedure Coding System (HCPCS) code shall receive no payment except as provided in Subsection 032.02.c.ii.(1). or 032.02.c.ii.(2). of this rule. ~~(1-1-12)~~( )

(1) Implantable Hardware may be eligible for separate payment under Subsection 032.02.e.iii. of this rule. ( )

(2) Outpatient laboratory tests provided with no other hospital outpatient service on the same date, or outpatient laboratory tests provided on the same date of service as other hospital outpatient services that are clinically unrelated may be paid separately if billed with modifier L1. Payment shall be made in the same manner that services with no APC weight are paid under Subsection 032.02.c.i. of this rule. ( )

iii. Two (2) or more medical procedures with a status code T on the same claim shall be reimbursed with the highest weighted code paid at one hundred percent (100%) of the APC calculated amount and all other status code T items paid at fifty percent (50%). (1-1-12)

iv. Status code Q items with an assigned APC weight will not be discounted. (1-1-12)

d. Hospitals Outside of Idaho. Reimbursement for services provided by hospitals outside the state of Idaho may be based upon the agreement of the parties. If there is no agreement, services shall be paid in accordance with the workers' compensation fee schedule in effect in the state in which services are rendered. If there is no hospital fee schedule in effect in such state, or if the fee schedule in that state does not allow reimbursement for the services rendered, reimbursement shall be paid in accordance with these rules. (1-1-12)

e. Additional Hospital Payments. When the charge for a medical service provided by a hospital (other than a critical access or rehabilitation hospital) meets the following standards, additional payment shall be made for that service, as indicated. (1-1-12)

i. Inpatient Threshold Exceeded. When the charge for a hospital inpatient MS-DRG coded service exceeds the sum of thirty thousand dollars ($30,000) plus the payment calculated under the provisions of Subparagraph 032.02.b. of this rule, then the total payment for that service shall be the sum of the MS-DRG payment and the amount charged above that threshold multiplied by seventy-five percent (75%). Implantable charges shall be excluded from the calculation for an additional inpatient payment under this Subparagraph. (1-1-12)

ii. Inpatient Implantable Hardware. Hospitals may seek additional reimbursement beyond the MSDRG payment for invoiced implantable hardware where the aggregate invoice cost is greater than ten thousand dollars ($10,000). Additional reimbursement shall be the invoice cost plus an amount which is equal to ten percent (10%) of the invoice cost, but which does not exceed three thousand dollars ($3,000). Handling and freight charges shall be included in invoice cost. (1-1-12)

iii. Outpatient Implantable Hardware. Hospitals and ASCs may seek additional reimbursement beyond the APC payment for invoiced implantable hardware where the aggregate invoice cost is greater than five hundred dollars ($500). Additional reimbursement shall be the invoice cost plus an amount which is equal to ten percent (10%) of the invoice cost, but which does not exceed one thousand dollars ($1,000). Handling and freight charges shall be included in invoice cost. (1-1-12)

03. Disputes. The Commission shall determine the acceptable charge for hospital and ASC services that are disputed based on all relevant evidence in accordance with the procedures set out in Section 035 of this rule. (1-1-12)

04. Adjustment of Hospital and ASC Base Rates. The Commission may periodically adjust the base rates set out in Subparagraphs 032.02.b. and 032.02.c. of this rule to reflect changes in inflation or market conditions. (1-1-12)

(BREAK IN CONTINUITY OF SECTIONS)

035. BILLING AND PAYMENT REQUIREMENTS FOR MEDICAL SERVICES AND PROCEDURES PRELIMINARY TO DISPUTE RESOLUTION.

01. Authority. Pursuant to Section 72-508 and Section 72-803, Idaho Code, the Industrial Commission hereby promulgates this rule governing billing and payment requirements for medical services provided under the Workers' Compensation Law and the procedures for resolving disputes between payors and providers over those bills or payments. (4-7-11)

02. Time Periods. None of the periods herein shall begin to run before the Notice of Injury/Claim for Benefits has been filed with the Employer as required by law. (4-7-11)

03. Provider to Furnish Information. A Provider, when submitting a bill to a Payor, shall inform the Payor of the nature and extent of medical services furnished and for which the bill is submitted. This information shall include, but is not limited to, the patient's name, the employer's name, the date the medical service was

provided, the diagnosis, if any, and the amount of the charge or charges. Failure to submit a bill complying with this Subsection 035.03 to the Payor within one hundred twenty (120) days of the date of service will result in the ineligibility of the Provider to utilize the dispute resolution procedures of the Commission set out in Subsection 035.10 for that service. (7-1-13)

a. A Provider's bill shall, whenever possible, describe the Medical Service provided, using the American Medical Association's appropriate Current Procedural Terminology (CPT) coding, including modifiers, the appropriate Healthcare Common Procedure Coding System (HCPCS) code, the diagnostic and procedure code set version required by the Centers for Medicare and Medicaid Services (CMS) and the original National Drug Code (NDC) for the year in which the service was performed. (7-1-13)

b. The bill shall also contain the name, address and telephone number of the individual the Payor may contact in the event the Payor seeks additional information regarding the Provider's bill. (4-7-11)

c. If requested by the Payor, the bill shall be accompanied by a written report as defined by IDAPA 17.02.04, "Administrative Rules of the Industrial Commission Under the Workers' Compensation Law -- Benefits." Subsection 322.01.f. Where a bill is not accompanied by such Report, the periods expressed in Subsections 035.04 and 035.06, below, shall not begin to run until the Payor receives the Report. (7-1-13)

04. Prompt Payment. Unless the Payor denies liability for the claim or, pursuant to Subsection 035.06, below, sends a Preliminary Objection, a Request for Clarification, or both, as to any charge, the Payor shall pay the charge within thirty (30) calendar days of receipt of the bill or upon acceptance of liability, if made after bill is received from Provider. ~~(7-1-13)~~( )

05. Partial Payment. If the Payor acknowledges liability for the claim and, pursuant to Subsection 035.06, below, sends a Preliminary Objection, a Request for Clarification, or both, as to only part of a Provider's bill, the Payor must pay the charge or charges, or portion thereof, as to which no Preliminary Objection or Request for Clarification has been made, within thirty (30) calendar days of receipt of the bill. (7-1-13)

06. Preliminary Objections and Requests for Clarification. (4-7-11)

a. Whenever a Payor objects to all or any part of a Provider's bill on the ground that such bill contains a charge or charges that do not comport with the applicable administrative rule, the Payor shall send a written Preliminary Objection to the Provider within thirty (30) calendar days of the Payor's receipt of the bill explaining the basis for each of the Payor's objections. (4-7-11)

b. Where the Payor requires additional information, the Payor shall send a written Request for Clarification to the Provider within thirty (30) calendar days of the Payor's receipt of the bill, and shall specifically describe the information sought. (4-7-11)

c. Each Preliminary Objection and Request for Clarification shall contain the name, address and phone number of the individual located within the state of Idaho that the Provider may contact regarding the Preliminary Objection or Request for Clarification. (4-7-11)

d. Where a Payor does not send a Preliminary Objection to a charge set forth in a bill or a Request for Clarification within thirty (30) calendar days of receipt of the bill, or provide an in-state contact in accord with Subsection 035.06.c., it shall be precluded from objecting to such charge as failing to comport with the applicable administrative rule. (7-1-13)

07. Provider Reply to Preliminary Objection or Request for Clarification. (4-7-11)

a. Where a Payor has timely sent a Preliminary Objection, Request for Clarification, or both, the Provider shall send to the Payor a written Reply, if any it has, within thirty (30) calendar days of the Provider's receipt of each Preliminary Objection or Request for Clarification. (4-7-11)

b. If a Provider fails to timely reply to a Preliminary Objection, the Provider shall be deemed to have acquiesced in the Payor's objection. (4-7-11)

c. If a Provider fails to timely reply to a Request for Clarification, the period in which the Payor shall pay or issue a Final Objection shall not begin to run until such clarification is received. (4-7-11)

08. Payor Shall Pay or Issue Final Objection. The Payor shall pay the Provider's bill in whole or in part or shall send to the Provider a written Final Objection, if any it has, to all or part of the bill within thirty (30) calendar days of the Payor's receipt of the Reply. (4-7-11)

09. Failure of Payor to Finally Object. Where the Payor does not timely send a Final Objection to any charge or portion thereof to which it continues to have an objection, it shall be precluded from further objecting to such charge as unacceptable. (4-7-11)

10. Dispute Resolution Process. If, after completing the applicable steps set forth above, a Payor and Provider are unable to agree on the appropriate charge for any Medical Service, a Provider which has complied with the applicable requirements of this rule may move the Commission to resolve the dispute as provided in the Judicial Rule Re: Disputes Between Providers and Payors, as referenced in Sections 031, 032, 033, and 034 of this rule. If Provider's motion disputing CPT or MS-DRG coded items prevails, Payor shall pay the amount found by the Commission to be owed, plus an additional thirty percent (30%) of that amount to compensate Provider for costs and expenses associated with using the dispute resolution process. For motions filed by a Provider disputing items without CPT or MS-DRG codes, the additional thirty percent (30%) shall be due only if the Payor does not pay the amount found due within thirty (30) days of the administrative order. (7-1-13)

IDAPA 17 - IDAHO INDUSTRIAL COMMISSION

17.05.01 - RULES UNDER THE CRIME VICTIMS COMPENSATION ACT

DOCKET NO. 17-0501-1401

NOTICE OF RULEMAKING - PROPOSED RULE

AUTHORITY: In compliance with Section 67-5221(1), Idaho Code, notice is hereby given that this agency has initiated proposed rulemaking procedures. The action is authorized pursuant to Sections 72-1004 and 72-1026, Idaho Code.

PUBLIC HEARING SCHEDULE: Public hearing(s) concerning this rulemaking will be scheduled if requested in writing by twenty-five (25) persons, a political subdivision, or an agency, not later than October 15, 2014.

The hearing site(s) will be accessible to persons with disabilities. Requests for accommodation must be made not later than five (5) days prior to the hearing, to the agency address below.

DESCRIPTIVE SUMMARY: The following is a nontechnical explanation of the substance and purpose of the proposed rulemaking:

The rule is necessary to implement updates under the CVC Medical Fee Schedule and clarify the calculations of the allowable payment of CPT Codes established by the American Medical Association; and provide direction and a consistent method for calculating mileage reimbursement for the necessary treatment and services for eligible victims of the program.

The rule is also necessary to clarify the limitations on how long providers have to file their claims with the program for payment consideration. It is difficult and time-consuming to gather the appropriate supporting documentation for claims that are several years old.

FEE SUMMARY: The following is a specific description of the fee or charge imposed or increased: There is no fiscal impact.

FISCAL IMPACT: The following is a specific description, if applicable, of any negative fiscal impact on the state general fund greater than ten thousand dollars ($10,000) during the fiscal year resulting from this rulemaking: There is no negative fiscal impact.

NEGOTIATED RULEMAKING: Pursuant to Section 67-5220(2), Idaho Code, negotiated rulemaking was not conducted because the amendments are necessary to implement the changes in the Current Procedural Terminology Codes, published by the American Medical Association. The Crime Victims Compensation Medical Fee Schedule is not correctly reimbursing providers for some services delivered to eligible victims of crime; and the rule amendment would allow the program to appropriately reimburse providers for eligible services.

INCORPORATION BY REFERENCE: Pursuant to Section 67-5229(2)(a), Idaho Code, the following is a brief synopsis of why the materials cited are being incorporated by reference into this rule: No documents have been incorporated by reference into this rule.

ASSISTANCE ON TECHNICAL QUESTIONS, SUBMISSION OF WRITTEN COMMENTS: For assistance on technical questions concerning the proposed rule, contact George Gutierrez, Crime Victims Bureau Chief, (208) 334-6070.

Anyone may submit written comments regarding this proposed rulemaking. All written comments must be directed to the undersigned and must be delivered on or before October 22, 2014.

DATED this 29th Day of August, 2014.

Mindy Montgomery, Director
Industrial Commission
700 S. Clearwater Lane
PO Box 83720
Boise, Idaho 83720-0041
Phone: (208) 334-6000
Fax: (208) 334-5145

THE FOLLOWING IS THE PROPOSED TEXT OF DOCKET NO. 17-0501-1401
(Only those Sections being amended are shown.)

011. APPLICATIONS FOR COMPENSATION.

01. Claim for Benefits. To claim benefits under the Crime Victims Compensation Act, the claimant shall file an Application for Compensation with the Commission. Applications for Compensation shall be made using the form approved by the Commission. An Application for Compensation shall be deemed filed when it is received at the Commission's office in Boise. (4-7-11)

02. Providing Information. Before paying benefits to any claimant, the Commission shall gather sufficient information to establish that the claimant is eligible for benefits. The Commission may require the claimant to assist the Commission in obtaining that information. (11-17-86)

03. Employment Verification. To verify information concerning a victim's employment, the Commission may require the victim's employer or employers to complete an Employment Verification form or the Commission may obtain such information from an employer by telephone. (11-17-86)

04. Order. After sufficient information has been gathered pursuant to Subsection 011.02 of this rule, the Commission may enter an award granting or partially granting benefits or an order denying benefits. The Commission may also enter orders necessary to further the purposes of the Act. (4-7-11)

05. Finality of Order. An award or order issued by the Commission shall be final and conclusive as to all matters considered in the award or order; provided that within twenty (20) days from the date that such an award or order is issued, the claimant may file a request that the Commission reconsider the order or award, or the Commission may reconsider the matter on its own motion, and the award or order of the Commission shall be final upon issuance of the order on reconsideration; and provided further that, within forty five (45) days from the date that any award or order is issued by the Commission, a claimant may file a Request for Hearing before the Commissioners. The Hearing shall be held in accordance with the procedures set out in Section 012 of these rules. Requests for Hearing and requests that the Commission reconsider an order or award shall be deemed filed when received at the Commission's office in Boise. (4-7-11)

06. Recipients of Payments for Medical Services. If, pursuant to any order of the Commission or the Crime Victims Supervisor, it is determined that a claimant is entitled to payment of medical expenses as provided in Section 72-1019(2), Idaho Code, or funeral or burial expenses as provided in Section 72-1019(4), Idaho Code, payment shall be made directly to the medical provider or the provider of funeral or burial services unless the claimant has already paid the provider; if the claimant has already paid the provider, payment shall be made to the claimant. (4-7-11)

07. Allowable Payments for Medical Services. The Commission shall pay providers the allowable payment for medical services under these rules adopted in accordance with Section 72-1026, Idaho Code. (4-7-11)

a. Adoption of Standard. The Commission hereby adopts the Resource-Based Relative Value Scale (RBRVS), published by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and

Human Services, as amended, as the standard to be used for determining the allowable payment under the Crime Victims Compensation Act for medical services provided by providers other than hospitals and ASCs. The standard for determining the allowable payment for hospitals and ASCs shall be: (4-7-11)

i. For large hospitals: Eighty-five percent (85%) of the reasonable inpatient charge. (4-7-11)

ii. For small hospitals: Ninety percent (90%) of the reasonable inpatient charge. (4-7-11)

iii. For ambulatory surgery centers (ASCs) and hospital outpatient charges: Eighty percent (80%) of the reasonable charge. (4-7-11)

iv. Surgically implanted hardware shall be reimbursed at the rate of actual cost plus fifty percent (50%). (4-7-11)

v. Paragraph 011.07.e. of this rule, shall not apply to hospitals or ASCs. The Commission shall determine the allowable payment for hospital and ASC services based on all relevant evidence. (4-7-11)

b. Conversion Factors. The following conversion factors shall be applied to the fully-implemented facility or non-facility Relative Value Unit (RVU) as determined by place of service found in the latest RBRVS, as amended, that was published before December 31 of the previous calendar year for a medical service identified by a code assigned to that service in the latest edition of the Physicians' Current Procedural Terminology (CPT), published by the American Medical Association, as amended:

MEDICAL FEE SCHEDULE			
DESCRIPTION	**CODE RANGE(S)**		**CONVERSION FACTOR**
Anesthesia	00000 - 09999		$60.05
Surgery - Group One	22000 - 22999 23000 - 24999 25000 - 27299 27300 - 27999 29800 - 29999 61000 - 61999 62000 - 62259 63000 - 63999	Spine Shoulder, Upper Arm, & Elbow Forearm, Wrist, Hand, Pelvis & Hip Leg, Knee, & Ankle Endoscopy & Arthroscopy Skull, Meninges & Brain Repair, Neuroendoscopy & Shunts Spine & Spinal Cord	$144.48
Surgery - Group Two	28000 - 28999 64550 - 64999	Foot & Toes Nerves & Nervous System	$129.00
Surgery - Group Three	13000 - 19999 20650 - 21999	Integumentary System Musculoskeletal System	$113.52

MEDICAL FEE SCHEDULE			
DESCRIPTION	**CODE RANGE(S)**		**CONVERSION FACTOR**
Surgery - Group Four	20000 - 20615 30000 - 39999 40000 - 49999 50000 - 59999 60000 - 60999 62260 - 62999 64000 - 64549 65000 - 69999	Musculoskeletal System Respiratory & Cardiovascular Digestive System Urinary System Endocrine System Spine & Spinal Cord Nerves & Nervous System Eye & Ear	$87.72
Surgery - Group Five	10000 - 12999 29000 - 29799	Integumentary System Casts & Strapping	$69.14
Radiology	70000 - 79999	Radiology	$87.72
Pathology & Laboratory	80000 - 89999	Pathology & Laboratory	To Be Determined
Medicine - Group One	90000 - 907~~9~~49 94000 - 94999 97000 - 97799 97800 - 98999	Immunization, Injections, & Infusions Pulmonary / Pulse Oximetry Physical Medicine & Rehabilitation Acupuncture, Osteopathy, & Chiropractic	$46.44
Medicine - Group Two	90~~80~~750 - 92999 96040 - 96999 99000 - 99607	Psychiatry & Medicine Assessments & Special Procedures E / M & Miscellaneous Services	$66.56
Medicine - Group Three	93000 - 93999 95000 - 96020	Cardiography, Catheterization, & Vascular Studies Allergy / Neuromuscular Procedures	$72.24

~~(4-7-11)~~( )

c. The Conversion Factor for the Anesthesiology CPT Codes shall be multiplied by the Anesthesia Base Units assigned to that CPT Code by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services as of December 31 of the previous calendar year, plus the allowable time units reported for the procedure. Time units are computed by dividing reported time by fifteen (15) minutes. Time units will not be used for CPT Code 01996. (4-7-11)

d. Adjustment of Conversion Factors. The conversion factors set out in this rule may be adjusted each fiscal year (FY), starting with FY 2012, as determined by the Commission. (4-7-11)

e. Services Without a CPT Code, RVU or Conversion Factor. The allowable payment for medical services that do not have a current CPT code, a currently assigned RVU, or a conversion factor will be the reasonable charge for that service, based upon the usual and customary charge and other relevant evidence, as determined by the Commission. Where a service with a CPT Code, RVU, and conversion factor is, nonetheless, claimed to be exceptional or unusual, the Commission may, notwithstanding the conversion factor for that service set out in Subsection 011.07.b. of this rule, determine the allowable payment for that service, based on all relevant evidence. (4-7-11)

f. Coding. The Commission will generally follow the coding guidelines published by the Centers for Medicare and Medicaid Services and by the American Medical Association, including the use of modifiers. The procedure with the largest RVU will be the primary procedure and will be listed first on the claim form. Modifiers will be reimbursed as follows: (4-7-11)

i. Modifier 50: Additional fifty percent (50%) for bilateral procedure. (4-7-11)

ii. Modifier 51: Fifty percent (50%) of secondary procedure. This modifier will be applied to each medical or surgical procedure rendered during the same session as the primary procedure. (4-7-11)

iii. Modifier 80: Twenty-five percent (25%) of coded procedure. (4-7-11)

iv. Modifier 81: Fifteen percent (15%) of coded procedure. This modifier applies to MD and non-MD assistants. (4-7-11)

08. Wage Loss Benefits. For the purpose of determining compensation benefits under Sections 72-1019(1) and 72-1019(3), Idaho Code, "wages received at the time of the criminally injurious conduct" shall be the victim's gross weekly wage; which shall be determined as follows: (4-7-11)

a. If the wages were fixed by the year, the weekly wage shall be the yearly wage divided by fifty-two (52). (11-17-86)

b. If the wages were fixed by the month, the weekly wage shall be the monthly wage multiplied by twelve (12) and divided by fifty-two (52). (11-17-86)

c. If the wages were fixed by the week, the amount so fixed shall be the weekly wage. (11-17-86)

d. If the wages were fixed by the hour, and the victim worked or was scheduled to work the same number of hours each week, the weekly wage shall be the hourly rate times the number of hours that the victim worked or was scheduled to work each week, plus one-half (1/2) the hourly wage times the number of hours worked or scheduled each week in excess of forty (40) hours if the victim was paid time-and-a-half for work in excess of forty (40) hours per week. (11-17-86)

e. If the wages were fixed by the hour and the victim did not work the same number of hours each week, or if the victim was paid on a piecework or commission basis, the weekly wage shall be computed by averaging the amounts that the victim was paid during his last four completed pay periods prior to the criminally injurious conduct and converting that amount to a weekly basis using a method consistent with parts 1 through 3 of this rule; provided that, if the victim was employed for less than four (4) pay periods before the criminally injurious conduct, the average shall be computed based upon the time period that he worked. (11-17-86)

f. If none of the above methods are applicable, the weekly wage shall be computed in a manner consistent with the above methods. (11-17-86)

09. Treating Physician. A victim may choose his own treating physician. If, after filing an Application for Compensation, a victim changes physicians without prior approval of the Commission, or if, without prior approval of the Commission, he seeks treatment or examination by a physician to whom he was referred by his treating physician, the Commission may deny payment for such treatment or examination. (11-17-86)

10. Overpayment. If the Commission erroneously makes payments to which a claimant is not entitled,

the Commission may reduce future payments to that claimant by an amount equal to the overpayment or request a refund when overpayments are made to either the claimant or the provider. (4-7-11)

11. Limit on Compensation. Compensation payable under Sections 72-1019(7)(a) and 72-1019(7)(b), Idaho Code, may not exceed twenty thousand dollars ($20,000). Compensation payable to a victim or his dependents under Sections 72-1019(7)(a) and 72-1019(7)(b), Idaho Code, when added to compensation payable under Sections 72-1019(2) and 72-1019(4), Idaho Code, may not exceed twenty-five thousand dollars ($25,000). (4-7-11)

12. Weekly Compensation Benefits If Victim Employable But Not Employed. If a victim was employable, but not employed at the time of the criminally injurious conduct and as a result of that conduct has no reasonable prospect of being regularly employed in the normal labor market, he shall receive benefits pursuant to Section 72-1019(7)(a), Idaho Code, as follows, only until the victim has a reasonable prospect of being regularly employed in the normal labor market, or for a shorter period as determined by the Commission,: (4-7-11)

a. If at the time of the injurious conduct the victim was receiving unemployment benefits and as a result of that conduct the victim becomes ineligible for those benefits, the claimant's weekly benefits under the Crime Victims Compensation Act shall be the lesser of one hundred and fifty dollars ($150) or his weekly benefit amount under the Employment Security Law. (4-7-11)

b. If at the time of the criminally injurious conduct the victim was unemployed, but scheduled to begin employment on a date certain and if he was unable to work for one (1) week as a result of that conduct, weekly benefits under the Crime Victims Compensation Act shall be the lesser of one hundred and fifty dollars ($150) or two-thirds (2/3) of the amount that he would have earned at his scheduled employment, and those benefits shall be payable beginning on the date that his employment was scheduled to begin. (4-7-11)

c. If prior to the criminally injurious conduct the victim was performing necessary household duties which he is disabled from performing as a result of that conduct and it is necessary to employ a person who does not reside in the victim's house to perform those duties, the victim shall receive weekly benefits under the Crime Victims Compensation Act equal to the amount paid to the person so employed, but not exceeding one hundred and fifty dollars ($150) per week. (4-7-11)

d. In other circumstances, the Commission may award an amount it deems appropriate. (11-17-86)

13. Effective Date. Benefits shall be paid only to claimants whose Applications for Compensation are based upon criminally injurious conduct which occurred on or after July 1, 1986. (11-17-86)

14. Reimbursement for Transportation Expenses. If the claimant utilizes a private vehicle, reimbursement shall be at the mileage rate allowed by the state board of examiners for state employees. Reimbursement shall be provided only if services are not available in the local area and shall be limited to one (1) round trip per day. The claimant shall not be reimbursed for the first fifteen (15) miles of any round trip, nor for traveling any round trip of fifteen (15) miles or less. Such distance shall be calculated by the shortest practical route of travel. The mileage reimbursement amount shall be credited to the medical benefit. ( )

15. Payment of Bills. Bills for treatment and sexual assault forensic examinations must be submitted within two (2) years from the date of treatment or the date of eligibility, whichever is later, to be compensable.( )