SOUTH DAKOTA DEPARTMENT OF LABOR AND REGULATION

OFFICE OF THE SECRETARY

HF No. 1D, 2011/12
DECLARATORY RULING
Re: ARSD § 47:03:05:05, ARSD § 47:03:05:10, ARSD § 47:03:05:11, and ARSD § 47:03:05:12

This matter comes before Pamela Roberts, the Secretary of the South Dakota Department of Labor and Regulation as a petition for declaratory ruling pursuant to SDCL § 1-26-15 and ARSD § 47:01:01:04. The Secretary has determined this is matter of widespread impact. A statewide public hearing was held on February 28, 2012 before the Department, Administrative Law Judge Catherine Duenwald presiding. Testifying at the hearing were witnesses Larry Kucker, James Marsh, and Chris VandenBos. The Hearing was also open to public testimony via the Digital Dakota Network at public sites in Aberdeen, Rapid City, and Sioux Falls. Written public comments were also received.

Appearing before the Department are Petitioners, Stanley County School and Associated School Boards of South Dakota Worker's Compensation Trust Fund, by through their attorney of record, Naomi R. Cromwell; Respondent, St. Mary's Healthcare Center, by and through its attorney of record, Talbot J. Wieczorek; Intervenors, City of Pierre, Children's Castle, Pierre School District, Gettysburg School, SDML Worker's Compensation Fund, First Dakota Indemnity and Dakota Truck Underwriters, by and through their attorney of record, Michael S. McKnight; and Intervenors, State of South Dakota – Bureau of Personnel, Workers' Compensation Administrator's Office, by and through their attorney of record, Robert B. Anderson.

The Petition for Declaratory Ruling seeks an interpretation of the South Dakota Administrative Rules addressing Workers' Compensation medical reimbursement. The Parties have stipulated that the questions raised only apply to the services of radiology and physical therapy (this includes occupational and speech therapies).

Issue #1 (regarding ARSD §§ 47:03:05:10, 47:03:05:11, and 47:03:05:12): Whether prior to December 12, 2011, payment for radiology or physical therapy services or procedures provided at a hospital facility were to be paid according to the workers' compensation physician fee schedule set forth in Appendix A, as provided by ARSD §§ 47:03:05:10 and 47:03:05:11, or at 80% of billed usual and customary charges under ARSD § 47:03:05:12?

Issue #2 (regarding ARSD §§ 47:03:05:05 and 47:03:05:12): Whether on or after December 12, 2011, payment for radiology or physical therapy services or procedures provided at a hospital facility are to be paid pursuant to the methodology set forth in ARSD § 47:03:05:05, or at 80% of billed usual and customary charges under ARSD § 47:03:05:12?

Rules

ARSD §47:03:05:01(8) defines "Medical services" or "treatment" as "any procedure, operation, consultation, supply, or product provided for the purposes of curing or relieving an employee of the effects of a compensable injury or disability."

ARSD §47:03:05:05 (prior to December 12, 2011). To be reimbursed, the charge must be for reasonable and necessary services for the cure or relief of the effects of a compensable injury or disability. A health care provider is not entitled to payment from an insurer or employee for fees in excess of the maximum reimbursement allowed under this chapter.

ARSD §47:03:05:05 (effective December 12, 2011).

To be reimbursed, the charge must be for reasonable and necessary services for the cure or relief of the effects of a compensable injury or disability. A health care provider is not entitled to payment from an insurer or employee for fees in excess of the maximum reimbursement allowed under this chapter.

Except as otherwise provided in this chapter, to determine the maximum reimbursement for services, the base unit value for a procedure code is multiplied by the following factors:

Procedure Code	**Factor**
10000-69999	$98.24
70000-79999	$18.60
80000-89999	$14.90
90000-99499	$ 6.40

If a code is properly submitted for one of these services, but is not listed in **Relative Values for Physicians**, or the base unit value is RNE or BR, the reimbursement is 80% of the provider's charge.

ARSD §47:03:05:10 (repealed December 11, 2011). Reimbursement for physician, technical, or professional services is limited to the lesser of the physician's usual and customary charges or the amount specified in Appendix A.

ARSD §47:03:05:11 (repealed December 11, 2011). Maximum reimbursements for professional or technical services rendered by hospitals or ambulatory surgical centers are those stated in §47:03:05:10.

ARSD §47:03:05:12. The maximum reimbursement for medical services not otherwise identified in this chapter is eighty percent of the amount charged. Only those medical facilities identified in Appendix B are subject to the provisions of this section.

Facts

The following undisputed facts are set forth. St. Mary's Healthcare Center (St. Mary's), is a healthcare provider, and did provide services to an employee of the Stanley County School District as well as employees of the other Intervenor Employers named in this matter. The healthcare provided was for work-related injuries. For each of the services, St. Mary's was paid by the respective Employer/Insurer/Provider. St. Mary's recalculated the bills and found that the billing was incorrect and sent a subsequent bill for the services provided to the Employer/ Insurer/Provider. Reimbursement of the second billing was disputed by the Employer/Insurer/ Provider and St. Mary's filed petitions for hearing with the Department on medical benefits. Each of these matters deal with the same law and similar facts, therefore a Declaratory Ruling was suggested. Judicial Notice is taken on the petitions, answers, and pleadings on Department Hearing File No.'s 31-33, and 36-41.

The South Dakota Administrative Rules provide that billing for workers' compensation reimbursement must be done in accordance with applicable reporting and coding standards of the Centers for Medicare and Medicaid Studies (CMS). ARSD §47:03:09:01. The billing is submitted to the workers compensation insurance carrier or employer on either a Form CMS-1450 (or a Form UB-04) (charges from a facility or hospital) or a Form CMS-1500 (charges from a physician or clinic).

Each cost billed by a facility or clinic on either of the CMS Forms is identified by a numerical code. These codes are known as Current Procedural Terminology codes (CPT Codes), and are developed by the American Medical Association (AMA) and Medicare (the HCPCS Level II codes). These codes and others are listed in the Relative Values for Physicians (hereinafter

the RVP), the book referenced at ARSD §47:03:05:05. The RVP is organized into nine sections: Anesthesia, Surgery, Radiology, Pathology, Medicine, Evaluation and Management, Category II, Category III, and HCPCS Level II (non-CPT codes developed and maintained by CMS). See generally Relative Values for Physicians, Relative Values Studies, Inc., 2012 published by Ingenix, Inc.

In a typical RVP listing, the first number listed is the update year (removed after three years), that is followed by the CMS **Code number,** the **Description**, the **Units** (a numerical relative value assigned to the procedure), the Anesthesia Unit Value (**Anes**) if required, and finally a **Global** period (the number of days when any subsequent care should be considered part of the original procedure). As an example, below is a typical code entry in the Medicine Section of the RVP.

Example: **UPD**	**Code**		**Description**	**Units**	**Anes**	**Global**
-	94620	00	Pulmonary Stress Test	20.0		XXX
		26		8.0		
		TC		12.0		

In the above example, the code no longer has a UPD date as it has not been updated for over three years; the Global indicator XXX means that the global concept does not apply; and there are no Anesthesia requirements. The RVP typically assigns a Unit value to each code. This RVP Unit value is what is referred in §47:03:05:05 (amended) as a base unit value. Many codes list "BR" or "RNE" in place of the Unit number. BR stands for By Report and RNE stands for Relativity Not Established. For those codes, the billing party must supply their own cost of the code. In many instances (as in the above example), the RVP breaks down the **Total Units** into a **26** unit and a **TC** unit; specifically in the Radiology, Pathology & Laboratory, and the Medical sections. The **26** unit is the value of the professional component of a service and the **TC** is the technical component.

The RVP description of the **26** reads: "The professional component includes examination of the patient, when indicated; performance and/or supervision of the procedure or lab test; interpretation and /or written report concerning the examination or lab test; and consultation with referring physician." *Id.* at pg. 245, 295, 390.

The **TC** unit as described in the RVP: "The unit value listed on the TC line is used to designate the technical value of providing the service. Modifier TC may be used to designate this component. The technical component includes the personnel, materials, space, equipment,

and other allocated facility overhead normally included in providing the service." **The TC and the 26 units combined equal the Total Units assigned.** *Id.* (emphasis added).

There are other modifiers that may be assigned to a code and not every code is given a Unit number. *Id.* In many instances, modifiers may be added to codes to increase or decrease the Units. There are many codes which are different for in-patient and out-patient treatments; different units are prescribed for each.

Before December 12, 2011, Appendix A to ARSD §47:03:05 was a Physician Fee Schedule. The Fee Schedule gave the reimbursement fee amount of each CPT Code. There was also a unit value listed for each CPT Code. The Fee Schedule base unit value coincided with the Unit Value listed in the RVP. The factor that was multiplied with the base unit to arrive at the Fee Amount, was not listed in the Fee Schedule, but could be determined by dividing the Fee Amount by the Unit Value. If a CPT Code was not listed in Appendix A, or there was not Unit Value assigned to the code in Appendix A, then the reimbursement was 80% of the amount charged by the provider. ARSD §47:03:05:12.

After the new rules went into effect on December 12, 2011, the RVP unit value is multiplied by the specified conversion factor (CF) set out in §47:03:05:05 resulting in the maximum reimbursable amount. For some procedures, there is not a RVP Unit value assigned; there is a BR or an RNE. In those cases, the rules state that the reimbursement is 80% of the provider's charge. This 80% rule is the same as it was prior to December 12, 2011. [1]

The RVP details how a CF should be developed. "The conversion factor (CF) should be determined by taking into consideration current fees (if available), prevailing area rates, and overhead costs, including malpractice insurance, rent, salaries, and the cost of living." RVP at pg. 5.

When comparing clinic versus hospital billing, one of the main differences is the CMS form on which the bill is presented. Billing for reimbursement for a clinic or a specific professional service is billed on a CMS Form 1500. Billing from a hospital or other similar facility is done on a UB-04.

[1] Pursuant to the South Dakota Supreme Court in *Wise v. Brooks Const. Ser.*, 2006 S.D. 80, 721 N.W.2d 461, the reimbursement rate may be up to 100% of the total cost of the procedure if paid by a third party without the benefit of the workers' compensation medical fee schedule. To alleviate confusion, only the 80% reimbursement is listed in this Ruling with the understanding that it may be reimbursed at 100%, in some cases.

South Dakota Rules require that a proper workers' compensation bill for reimbursement be made pursuant to CMS guidelines or rules or "properly submitted." ARSD §47:03:05:05. CMS rule changes occur regularly. The Department and the State of South Dakota have no authority to interpret the CMS rules. The Department does allow providers to correct any billing errors without penalty, i.e. billing from a hospital on a Form 1500 instead of on a UB-04.

Further facts may be developed in the Analysis below.

Analysis

Issue #1 - Whether prior to December 12, 2011, payment for radiology or physical therapy services or procedures provided at a hospital facility were to be paid according to the workers' compensation physician fee schedule set forth in Appendix A, as provided by ARSD §§ 47:03:05:10 and 47:03:05:11, or at 80% of billed usual and customary charges under ARSD § 47:03:05:12?

If the radiology or therapy services were listed in Appendix A, then it is correct to bill out and be reimbursed at the rate set out in Appendix A. The radiology section of the RVP and Appendix A separate the technical component (TC) from the professional (26). The **TC** is the facility costs including overhead. Within Appendix A and the RVP, there is no differentiation between in-patient and out-patient Radiology. In contrast, there are different codes for physical therapies for people in their homes (CMS Codes S9128, S9129, S9131), or in a hospice setting (G0151-G0161), or in a medical facility (97110-97546). RVP pgs. 434-435, 559, 685.

Examples of this separation may be found in the Hearing Files from which the Declaratory Judgment is based. On the initial billing to the Employer/Insurer/Provider, St. Mary's billed the radiology TC code only. St. Mary's did not list the 26 code on the initial bill. Presumably, the reading of the x-ray, and the professional portion of the code was completed at another clinic or facility. Therefore, St. Mary's billed the insurance carrier for only the technical portion of the x-ray.

In another hearing file, the therapy was conducted on an out-patient basis. The code modifiers on the bill reflect that the therapy was conducted out-patient and not in-patient. The logical conclusion is that because there is a modifier for out-patient, then the basic code would be in-patient.

Modifiers, set out in the RVP, either reduce or increase the unit values. St. Mary's can add the appropriate CMS modifier to the radiology or therapy code if appropriate, for in-patient

services and bill accordingly. But if there is no appropriate modifier to add for in-patient services, or reduced for out-patient services, then the codes must be paid at the rate that is listed in Appendix A. If a CMS Code is not listed in Appendix A, then the rate is 80% of the amount charged by the facility.

The rules are not ambiguous but are very clear, the "maximum reimbursements for professional or technical services rendered by hospitals or ambulatory surgical centers are those stated in §47:03:05:10." ARSD §47:03:05:11. And the reimbursements stated in §47:03:05:10 are those in Appendix A. If the reimbursements and the modifiers are not contained in Appendix A, then the reimbursement is at 80%. ARSD §47:03:05:12.

St. Mary's is asking the Department to rule that the CPT Code Unit Values in either Appendix A or the RVP do not apply to any workers' compensation procedure that is billed from a hospital. The Administrative Rules do not give facilities the ability to charge 80% of the usual and customary charge, just because it is a full-care hospital and not an out-patient clinic. The codes are present within the RVP for St. Mary's to modify the unit values and bill accordingly. St. Mary's has asked the Department to interpret the rules to reflect that any procedure listed from a hospital is paid at the 80% cost. That is not the case. The codes listed in Appendix A and the RVP are for both hospitals and professional clinics.

Issue #2 - Whether on or after December 12, 2011, payment for radiology or physical therapy services or procedures provided at a hospital facility are to be paid pursuant to the methodology set forth in ARSD § 47:03:05:05, or at 80% of billed usual and customary charges under ARSD § 47:03:05:12?

The basic concept of South Dakota's workers' compensation reimbursement did not change when the administrative rules changed. Instead of looking to Appendix A to find the dollar amount or the unit value, the medical providers and payors must look to the RVP for the unit value and multiply by the conversion factor listed at ARSD §47:03:05:05. If the unit value is not set out in the RVP, then the facility or provider may be reimbursed at 80% of the billed usual and customary charges.

Just because a hospital is providing a service, does not mean that code for a service listed in the RVP is automatically null and void. The CMS codes in the RVP are applicable to both hospitals and clinics. If there is an appropriate modifier that a hospital would like to add to a bill, then it may be added. If it is not appropriate, then the modifier may not be added.

In Conclusion, it is the Department's interpretation of ARSD §§ 47:03:05:05, 47:03:05:10, 47:03:05:11, and 47:03:05:12, that St. Mary's or other hospitals may not present a bill for reimbursement for workers' compensation, for 80% of usual and customary charges if Appendix A (prior to December 12, 2011) or the Relative Value for Physicians (after December 12, 2011) give a Unit Value for the services provided.

Dated this 30th day of May, 2012.

Pamela Roberts
Secretary
Department of Labor and Regulation