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Workers' Compensation Commission

ADVISORY

April 2, 2026

2026 SC Workers' Compensation Commission
Medical Services Provider Manual Effective April 1, 2026

At the Business Meeting on March 16, 2026, the SC Workers' Compensation Commission approved changes to the Medical Services Provider Manual (MSPM) for 2026.

The codes in the fee schedule were made current by including codes established for 2026. In addition to administrative changes such as updating copyright dates, code ranges, numerical examples, statutory and internal document references, and URL links, the 2026 MSPM also includes the following substantive changes to text:

- Section 1: Evaluation and Management- Changes to the policy regarding the billing for a shared or split physician visit consistent with current medical practice.

- Section 1: Evaluation and Management & Section 3: Surgery- Includes "authorized non-physician practitioner" to allow non-physician practitioners to bill for services rendered consistent with current medical practice.

There is no change in the maximum allowable payment (MAP) conversion factor for 2026. Amounts are based on a conversion factor of $52.00.

There is no change in the anesthesiology maximum allowable payment (AMAP) for 2026. Amounts will be updated based on a conversion factor of $32.85.

The changes are effective today, April 1, 2026.

The 2026 MSPM is available for purchase on the Commission's website: Medical Fee Schedules | Workers' Compensation Commission

Please direct any questions, concerns, or comments to:

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Preliminary Summary of Proposed Changes

2026 Medical Services Provider Manual

January 9, 2026

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

The CPT© and HCPCS codes in the provider manual will be made current by including codes established for 2026 and deleting obsolete codes. Maximum allowable payment (MAP) amounts will be updated based on the conversion factors adopted by the Workers' Compensation Commission. In addition to administrative changes such as updating copyright dates, code ranges, numerical examples and URL links, substantive changes to the text, which are outlined below, are included in the proposed version of the 2026 MSPM. Page numbers refer to the pages in the South Carolina MSPM effective April 1, 2025.

There are very few substantive changes proposed for the 2026 MSPM. The following sections have no proposed changes:

Part 1	Chapter I. Overview and Guidelines: Healthcare Common Procedure Coding System
	Chapter III. Billing Policy
	Chapter IV. Payment Policy
	Chapter V. Completing and Submitting Claims
Part 2	Section 2. Anesthesia
	Section 4. Radiology
	Section 5. Pathology and Laboratory
	Section 7. Physical Medicine
	Section 8. Special Reports and Services
	Section 9. HCPCS Level II
	Section 10. Pharmacy

Where applicable, new text is <u>underlined</u> and deleted text is marked with a ~~strikethrough~~.

Part I

Chapter II. General Policy

Copies of Records and Reports

- Page 7 – Delete "~~(See Appendix A for S.C. Code Section 42-15-95 and Regulation 67-1301.)~~" as reference is no longer needed.

Part II. Fee Schedule

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

- Page 35, Evaluation and Management Time – Proposed language more closely aligns the MSPM with CPT language.
    - **Delete:** "~~When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care provider(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (i.e., when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).~~"
    - **Insert:** <u>If code selection is based on total time on the date of the encounter, the service is reported by the professional who spent the majority of the face-to-face or non-face-to-face time performing the service. For the purpose of reporting E/M services within the context of team-based care, performance of a substantive part of the MDM requires that the physician(s) or other qualified health care professional (s) made or approved the management plan for the number and complexity of problems addressed at the encounter and takes responsibility for that plan with its inherent risk of complications and/or morbidity or mortality of patient management. By doing so, a physician or other qualified health care professional has performed two of the three elements used in the selection of the code level based on MDM. If the amount and/or complexity of data to be reviewed and analyzed is used by the physician or other qualified health care professional to determine the reported code level, assessing an independent historian's narrative and the ordering or review of tests or documents do not have to be personally performed by the physician or other qualified health care professional, because the relevant items would be considered in formulating the management plan. Independent interpretation of tests and discussion of management plan or test interpretation must be personally performed by the physician or other qualified health care professional if these are used to determine the reported code level by the physician or other qualified health care professional.</u>

- Page 37 – added "or authorized non-physician practitioner" to align the MSPM with current medical practice.
    - Physical Therapy Services, "A treating physician <u>or authorized non-physician practitioner</u> who sees an injured worker for the single purpose of monitoring the outcome of physical therapy may be paid for only one E/M service per week."
    - Injectable Pharmaceuticals, "If the injection is part of an office visit where other services are provided and an office visit is billed, the physician <u>or authorized non-physician practitioner</u> will be paid only for the cost of the pharmaceutical but not for the injection fee. The injectable pharmaceutical must be billed using the appropriate HCPCS A, C, J, or Q code as listed in Section 9. HCPCS Level II.

If the single purpose of an office visit is for the injection, the physician or authorized non-physician practitioner may be paid for the cost of the injectable pharmaceutical plus a fee for the injection but cannot be paid for an office visit. (See Injectable Pharmaceuticals in Section 6. Medicine, for complete information on billing for injections.)"

- Travel Reimbursement, "Physicians or authorized non-physician practitioners may be reimbursed for travel associated with depositions or other medical testimony."

- Supplies And Materials (CPT 99070), "Supplies and materials provided by the physician or authorized non-physician practitioner over and above those usually included with the office visit may be paid."

Section 3. Surgery

- Page 71 Musculoskeletal System – added "authorized non-physician practitioner" to align the MSPM with current medical practice.
  - "Restorative treatment or procedure(s) rendered by another physician or authorized non-physician practitioner following the application of the initial cast/splint/strap may be reported with a treatment of fracture and/or dislocation code.

    A physician or authorized non-physician practitioner who applies the initial cast, strap, or splint and provides all fracture, dislocation, or injury care cannot separately report the application of casts and strapping codes. The first cast/splint or strap application is included in the treatment of a fracture and/or dislocation."

Section 6. Medicine and Injections

- Page 356 Psychological Services – Delete "~~(See CPT 2025 page xv for definition of other qualified health care provider.)~~" as the MSPM includes a listing of qualified providers making the reference unnecessary.

Fee Schedule Analysis

January 30, 2026

FAIR Health appreciates the opportunity to assist the South Carolina Workers' Compensation Commission in updating the Medical Services Provider Manual (MSPM). This analysis uses medical call data (2024 dates of service) provided by the National Council on Compensation Insurance, Inc. (NCCI) and South Carolina maximum allowable payment (MAP) amounts to review conversion factors and propose MAP values for the 2026 fee schedule. Actual paid amounts for the 2024 calendar year were included in NCCI data, aggregated at the procedure code/modifier level.

FAIR Health used the NCCI data to:

1. Compare 2024 actual spending to projected amounts based on 2024 fee schedule MAPS.
2. Project spending for 2025.
3. Project spending for 2026 based on multiple conversion factor alternatives.

2024 Paid Data and Frequencies

The following is a summary of the 2024 data received from NCCI:

NCCI Data – 2024 Calendar Year

Service Type	Total Paid	Total Charged	Transactions	Units
Ambulance*	$ 3,302,458	$ 7,217,649	16,579	430,638
Anesthesia**	$ 1,175,630	$ 7,465,025	4,260	468,851
CPT (Less Anesthesia)	$ 57,502,824	$ 134,156,650	677,565	923,438
HCPCS (Less Ambulance)	$ 22,386,944	$ 33,009,945	71,520	643,374
Total	**$ 84,367,856**	**$ 181,849,269**	**769,924**	**2,466,301**

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

Data Used in the Analysis

FAIR Health used the following methodology to analyze the NCCI data and project future payments based on fee schedule MAPs:

- The NCCI paid data from 2024 were used to determine the number of occurrences (frequency) for each service.
    - Codes deleted by CPT or paid based on Individual Consideration are not included.
- Services were reviewed at the procedure code/modifier level to account for differences in paid amounts based on fee schedule MAP amounts and policies. For example:
    - Codes reported with modifiers 26 and TC were projected separately, based on the occurrences in the NCCI data and MAP amounts in the fee schedule.
    - HCPCS Codes reported with modifiers NU (new), UE (used) and RR (rental) were projected separately based on the occurrences in the NCCI data and fee schedule MAP values.
    - Records with other modifiers or with modifiers NU, UE and RR appended to codes where these modifiers are not applicable and/or expected were considered as though the records did not contain modifiers.
    - Services containing modifiers that are paid at adjusted amounts according to South Carolina policies (e.g., assistant surgeon modifiers 80-82 and AS) were projected based on 2024 occurrences and adjusted MAP amounts.

2024 Spending

Actual spending in 2024 based on the NCCI data was compared to projected spending based on 2024 fee schedule MAP values.

- Actual spending in 2024 was 78.3% of the projected amount. This may be due to:
    - Network discounts
    - Negotiated payments
    - Provider charges less than MAP
    - Other

2024 Spending

Category	Frequency	Payments (NCCI)	2024 Fee Schedule Projections
Evaluation and Management	111,094	$ 15,186,570	$ 17,737,212
HCPCS Level II	315,436	$ 5,368,932	$ 7,525,183
Medicine and Injections	12,061	$ 1,326,257	$ 1,423,710
Pathology and Laboratory	9,646	$ 314,876	$ 341,424
Physical Medicine	706,328	$ 24,570,259	$ 34,414,757
Radiology	45,240	$ 4,489,207	$ 4,457,026
Special Reports and Services	666	$ 49,085	$ 45,422
Surgery	27,551	$ 9,965,551	$ 12,294,164
Grand Total	**1,228,022**	**$ 61,270,737**	**$ 78,238,899**

2025 Projections

- Total dollar amounts were projected based on 2024 occurrences and 2025 relative value units (RVUs).
- Using these frequencies and RVUs, FAIR Health projected the estimated spending based on 2025 fee schedule MAP values, including the 9.5% cap on MAP increases and decreases compared to the prior year, where applicable.
- Ambulance data is paid at 100% of Medicare and is not included in this analysis.
- Please see the separate analysis for anesthesia.

2025 Projections

Category	Frequency	Payments (NCCI)	2025 Fee Schedule Projections
Evaluation and Management	111,094	$ 346,186	$ 17,981,605
HCPCS Level II	241,954	$ 154,100	$ 7,743,210
Medicine and Injections	12,061	$ 28,117	$ 1,445,533
Pathology and Laboratory	9,646	$ 6,828	$ 354,326
Physical Medicine	706,328	$ 668,735	$ 34,649,309
Radiology	45,240	$ 85,798	$ 4,460,874
Special Reports and Services	666	$ 883	$ 45,774
Surgery	27,551	$ 241,157	$ 12,454,240
Grand Total	**1,154,540**	**$ 1,531,806**	**$ 79,134,870**

2026 Projections and Alternate Conversion Factors

- The projections for the 2026 fee schedule are based on 2024 frequencies and 2026 RVUs, to which the current conversion factor of 52 is applied. Projections based on other conversion factors: 51, 52, 52.5 and 53 are also provided. The cap of +/- 9.5% of the prior year's MAP value for each service was applied, when appropriate, in providing these projections.

2024 Frequency and 2026 RVUs

Category	Frequency	2026 RVUs
Eval and Mgmt	111,094	359,794
HCPCS Level II	228,052	156,461
Medicine & Injection	12,061	29,471
Path & Lab	9,646	6,649
Physical Medicine	706,312	661,874
Radiology	45,239	86,480
Special Reports	668	907
Surgery	27,549	229,754
Grand Total	**1,140,621**	**1,531,390**

- Certain 2026 MAP values used for these projections were calculated based on the following assumptions:
    - If a service is not valued in the Medicare Physician Fee Schedule, FAIR Health determined whether the service was valued by another Medicare fee schedule (e.g., the Clinical Laboratory, DMEPOS or Average Sales Price drug fee schedule). FAIR Health used Medicare values in the analysis whenever a Medicare value was available.
    - If Medicare did not provide a professional value in *any* fee schedule for a service, FAIR Health gap filled the value using RVUs calculated by FAIR Health based on our repository of private claims data.
    - FAIR Health does not gap fill values for new codes effective January 1, 2026, that were not valued by Medicare. FAIR Health requires a minimum threshold of claims for a procedure before we can establish an RVU. FAIR Health will evaluate these codes for the 2027 MSPM to determine if we are able to value these codes at that time.

2026 Projections – Current and Alternate Conversion Factors

Category	CF = 51	CF = 52 (current)	CF = 52.5	CF = 53	CF = 54
Eval and Mgmt	$ 18,356,735	$ 18,694,773	$ 18,867,090	$ 19,039,617	$ 19,372,274
HCPCS Level II	$ 7,889,096	$ 7,887,309	$ 7,885,527	$ 7,884,430	$ 7,892,135
Medicine & Injection	$ 1,488,702	$ 1,515,685	$ 1,529,073	$ 1,541,887	$ 1,558,680
Path & Lab	$ 350,246	$ 355,862	$ 357,822	$ 352,573	$ 359,014
Physical Medicine	$ 33,684,353	$ 34,301,978	$ 34,610,825	$ 34,919,516	$ 35,537,054
Radiology	$ 4,410,567	$ 4,496,962	$ 4,540,135	$ 4,582,941	$ 4,667,725
Special Reports	$ 46,200	$ 47,018	$ 47,436	$ 47,853	$ 48,688
Surgery	$ 11,701,514	$ 11,857,543	$ 11,952,506	$ 12,050,752	$ 12,239,215
Grand Total	**$ 77,927,413**	**$ 79,157,130**	**$ 79,790,414**	**$ 80,419,569**	**$ 81,674,785**

Upon approval of a conversion factor for 2026, FAIR Health will provide an updated Medical Services Provider Manual, which will include all approved changes in policies and a final set of rate tables.

Please let us know if you have any questions.

Analysis of Anesthesia Conversion Factor

January 9, 2026

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

FAIR Health reviewed the anesthesia conversion factor from several aspects:

- Comparison to Medicare
- Comparison to private health insurance
    - Billed charges
    - Allowed amounts
- Anesthesia Society of America survey results
- Comparison to other states' workers' compensation fee schedules

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

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

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

Medicare

CMS increased the Medicare anesthesia conversion factor slightly in 2026 from 20.3178 to 20.599838 for qualifying alternative payment model participants and 20.49754 for non-qualifying participants. Qualifying participants are those physicians and practitioners that meet certain thresholds for participation. The new two-tiered reimbursement method is part of a quality and cost of care initiative required by statute and implemented by CMS for 2026. The South Carolina MSPM will only include one conversion factor for anesthesia however; both CMS conversion factors are included in this comparison. The South Carolina workers' compensation anesthesia conversion factor of $32.85 is approximately 160% of the national CMS anesthesia conversion factor. The comparison below is based on the Medicare conversion factor published in the 2026 Final Rule.

	National Comparison for Anesthesia		South Carolina Comparison		
	Qualifying APM	Non-Qualifying APM	Anesthesia Qualifying APM	Anesthesia Non-Qualifying APM	Other Professional Services
SC 2025 Conversion Factor	$32.85	$32.85	$32.85	$32.85	$52.00
2026 Medicare Conversion Factor	$20.599835	$20.49754	$20.17 (CMS adjusted for SC)	$20.07 (CMS adjusted for SC)	$33.40 (CMS Qualifying APM)
Ratio	159.5%	160.3%	162.9%	163.7%	155.7%

Private Health Insurance

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

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

The benchmarks below are based on anesthesia services in the FAIR Health database provided in the state of South Carolina. Charge benchmarks (Billed Anesthesia) are based on claims from July 2024 through June 2025 and allowed benchmarks (Allowed Anesthesia) are based on allowed amounts from claims incurred from January through December 2024. These are the latest releases available at the time of developing this report.

Type	Release	Average	5th	10th	15th	20th	25th	30th	35th	40th	45th
Billed Anesthesia	Nov-25	152.23	61.89	76.11	88.10	104.53	116.49	124.75	137.09	149.45	154.72
Allowed Anesthesia	Aug-25	61.96	22.91	28.80	30.85	35.46	40.87	45.53	51.13	55.75	59.77

Type	Release	50th	55th	60th	65th	70th	75th	80th	85th	90th	95th
Billed Anesthesia	Nov-25	160.72	166.21	169.53	172.52	176.01	180.34	187.02	196.22	209.08	238.44
Allowed Anesthesia	Aug-25	62.42	66.75	70.18	73.21	75.35	78.49	83.32	87.00	88.06	106.07

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

In this analysis, the current $32.85 conversion factor falls between the15th and 20th percentiles of allowed values for private insurance. That means that between 80% and 85% of the allowed values in the FAIR Health database are equal to or greater than $32.85. The 50th percentile (conversion factor of $62.42) is the median conversion factor value in private insurance data, and the average allowed conversion factor benchmark is $61.96.

ASA Survey Results for Commercial Fees Paid for Anesthesia Services

The American Society of Anesthesiologists (ASA) surveys anesthesia providers across the country, asking them to report the conversion factors for up to five of their largest commercial managed care contracts. The study no longer provides state level data for South Carolina but does include South Carolina practice data in the major and minor geographical regions as well as at a national level. The full study can be found at ASA Monitor.

The survey normalizes the conversion factor based on 15-minute time units, which is the same as used in the MSPM. The November 2025 study reports a national average commercial conversion factor of $82.43, and a national median conversion factor of $76.00 which was derived from the 2024 ASA Commercial Conversion Factor Survey. The chart below shows the low (25th percentile), median, average, and high (75th percentile) conversion factors nationally, for the southern region and for the southeast region according to the study.

	National	Southern Region	Southeast Region
Low	66.00	65.50	79.82
Median	76.00	78.63	95.00
Average	82.43	82.62	98.82
High	92.00	95.00	113.06

State Workers' Compensation Fee Schedules

FAIR Health reviewed anesthesia conversion factors documented in state workers' compensation fee schedules effective in 2025.

State	Conversion Factor (per 15-minute time unit)
South Carolina	**$32.85**
Alabama	$67.47
Arizona	$61.00
Colorado	$44.00
Florida	$44.23*
Georgia	$65.73*
Kentucky	$78.53
Louisiana	$50.00
Maryland	$25.55

State	Conversion Factor (per 15-minute time unit)
South Carolina	**$32.85**
Mississippi	$75.00
North Carolina	$58.20– first 60 min $2.05 each add'l min
North Dakota	$76.71
Ohio	$40.76
Oklahoma	$56.48
Tennessee	$75.00
Vermont	$34.25
Virginia (6 regions)	$51.48 - $82.59

* Converted to 15-minute time units from 10-minute time units

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

Summary

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

- The current South Carolina MSPM anesthesia conversion factor is $32.85 or 163% of the 2026 Medicare conversion factor for South Carolina and 160% of the national Medicare anesthesia conversion factor. This is a slightly lower percentage (2%-3%) when compared to the 2025 Medicare conversion factor due to slight increases in the Medicare conversion factor for 2026.
- The 160% ratio of the South Carolina MSPM anesthesia conversion factor to the national Medicare conversion factor is slightly greater than the 155% ratio of the conversion factor for other professional services.
- The average allowed conversion factor for South Carolina in private insurance is $61.96 which is nearly double the MSPM conversion factor. The MSPM conversion factor falls between the15th and 20th percentiles of allowed values which is consistent with 2025.
- Based on the 2025 ASA conversion factor survey results, the MSPM conversion factor is low when compared to the national and regional level conversion factors.
- South Carolina’s conversion factor of $32.85 is low when compared to other states’ workers’ compensation programs.