State of South Carolina

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Workers' Compensation Commission

MEMORANUM

TO: COMMISSIONERS

FROM: Gary Cannon
Executive Director

DATE: February 22, 2022

RE: Medical Services Provider Manual (MSPM) Work Session

Attached are the materials for the Commission Work Session on February 22, 2022 beginning at 5:00 p.m. in the First Floor Conference Room.

The purpose of the Work Session is to discuss the proposed changes to the Medical Services Provider Manual Chris O'Donnell, FairHealth Team Leader and her team will participate by Zoom.

Issues for discussion:

1. The Conversion Factor for 2022.
    a. The current CF is $51.5

2. Proposed changes within the MSPM
    a. Copies of Records and Reports – no change
    b. Telemedicine – proposed elimination of the sunset provision for telemedicine enacted because of pandemic.
    c. IME – proposed language clarifies that medical testimony related to IMEs is part of the IME and not subject to the reimbursement cap. Several stakeholders commented during the public hearing objecting to the proposed change.
    d. Over the counter medications – the proposed language established reimbursement caps for non-prescription patch medications.

e. Medical Testimony – proposed language to clarify IME and associated cost and fees are not subject to the reimbursement cap.
f. Prescription strength topical compounds – proposed language not from Ad Hoc Committee but submitted by members of the committee who work with prescription strength topical compounds.
Original proposal included a reimbursement cap for prescription-strength topical medications as well as topical compounded medication. Stakeholders' comments objected to the inclusion of topical strength medications in this new section. Optum submitted amended language to delete topical medications from the section. See Optum letter dated January 19, 2022 from Kevin C. Tribout. In "Summary of Changes, February 17, 2022" from FairHealth, the Topical Strength and Compound Medications section is new. It is proposed to place a Maximum Allowable Payment (MAP) on both topical medications and compounded medications in order to control the cost.
g. In the same Prescription Strength Topical Compounds section included language which required physicians to prescribe over-the-counter medications in lieu of prescription or custom compound. The medical community stakeholder opposed this language.

3. The Commission's 2019 Agreement with FairHealth, provides they may charge "reasonable fees for the Fee Schedules." The fees will be determined by mutual agreement of the parties. FairHealth would like to begin offering stakeholders the ability to order the Fee Schedule on March 1, 2022. See attached letter from Donna Smith.

4. Elimination of the statutory requirement of a 10% cap on increases and decreases of relative values in the calculation of the Conversion Factor.

Enclosed items:
Tab 1 - Agenda
Tab 2 – Explanation of Conversion Factor Analysis, FairHealth Preliminary Summary of Changes Updated 2-17-22, FairHealth Commissioners Report Fixed Typo and Jan 24, 2022 Business Meeting MSPM Agenda documents
Tab 3 – Summary of Stakeholder Feedback
Tab 4 - Fair Health's request to increase the price of the Fee Schedule

A G E N D A

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

WORKSESSION

1333 Main Street, 5th Floor
Columbia, South Carolina 29201
February 22, 2022- 5:00 p.m.

Meeting to be held in the First Floor Conference Room

This meeting agenda was posted prior to the meeting and proper advance notice was made to all concerned parties in compliance with requirements in the Freedom of Information Act.

1.	CALL TO ORDER	CHAIRMAN BECK
2.	PURPOSE OF MEETING	CHAIRMAN BECK
3.	REVIEW OF PROPOSED CHANGES TO MSPM	CHRISTINE O'DONNELL
4.	REVIEW OF STAKEHOLDER COMMENTS	CHAIRMAN BECK
5.	DISCUSSION OF PROPOSED CHANGES	CHAIRMAN BECK
6.	REQUEST TO ADJUST PURCHASE PRICE OF FEE SCHEDULE	GARY CANNON
7.	ADJOURNMENT	CHAIRMAN BECK

Conversion Factor Analysis - Explanations

The conversion factor analysis includes two types of calculations:

- **2021 fee schedule-neutral analysis**

  This calculation backs into a conversion factor by dividing the amount spent in each service area in 2020 (the last year for which we have paid data) by the total number of RVUs reported. Because the starting point is the actual paid data, it includes payments that reflect discounted network amounts and other billed amounts that were lower than the fee schedule MAPs, which are the *maximum* allowable payment. The result produces a set of conversion factors based on 2021 RVUs that maintains similar spending in 2020 for each service area. Several factors contribute to the low conversion factors produced by this view:

  - Discounted network amounts/negotiated rates that are less than the fee schedule MAPs
  - Amounts billed by providers that are less than the fee schedule MAPs
  - The impact of the +9.5% statutory cap, which results in a fee schedule MAP that is less than what would be produced by the formula of RVUs x the conversion factor
  - 2021 increases to office visit RVUs, which could not be fully recognized due to the +9.5% cap; office visits are among the most frequently billed codes by all providers

- **2022 projections**

  Projections for 2022 are calculated by applying fee schedule conversion factors to the CMS 2022 RVUs based on the number of occurrences that each procedure code/modifier combination appears in the NCCI paid data from 2020. These projections do not take into account network discounts and bills lower than the fee schedule MAPs, because we cannot project the volume of these occurrences. 2022 projections include the +/- 9.5% cap on changes in MAP values for all codes.

It is expected that the caps, network discounts and negotiated arrangements will continue in 2022 so that actual paid amounts will be less than projections based on the full fee schedule MAPs. Therefore, when reviewing conversion factors, these factors should be taken into consideration.

2021 Fee Schedule Neutral analysis

Category	Frequency	Total 2021 RVUs	NCCI Payment	Budget Neutral Conversion Factor
Evaluation and Management	114,626	327,685	$ 12,437,429.00	37.96
HCPCS Level II	162,325	123,298	$ 4,307,648.80	34.94
Medicine & Injection	12,805	28,984	$ 1,217,166.70	41.99
Pathology & Laboratory	9,894	8,557	$ 398,839.44	46.61
Physical Medicine	708,933	644,807	$ 23,348,208.00	36.21
Radiology	46,443	87,115	$ 4,437,912.60	50.94
Special Reports	990	1,030	$ 46,792.34	45.43
Surgery	30,145	237,507	$ 10,658,747.00	44.88
Total	1,086,161	1,458,983	$ 56,852,743.88	38.97

2022 Projections

Category	Total $ 2022 CF=50	CF50	Total $ 2022 CF=51	CF51	Total $ 2022 CF=51.5	CF51.5	Total $ 2022 CF=52	CF52	Total $ 2022 CF=53	CF53	Total $ 2022 with CF=54	CF54
Evaluation and Management	15,915,961	48.4	$16,013,541	48.7	$16,062,458	48.8	$16,110,940	49.0	$16,205,399	49.3	$16,298,371	49.6
HCPCS Level II	6,560,280	51.1	$6,577,317	51.2	$6,585,956	51.3	$6,594,470	51.3	$6,611,576	51.5	$6,628,664	51.6
Medicine & Injection	1,435,516	49.5	$1,462,904	50.5	$1,476,624	51.0	$1,490,267	51.4	$1,516,079	52.3	$1,537,217	53.0
Pathology & Laboratory	432,950	48.5	$439,976	49.3	$443,709	49.7	$446,455	50.0	$453,525	50.8	$461,735	51.8
Physical Medicine	31,993,344	49.9	$32,559,059	50.8	$32,843,980	51.3	$33,121,819	51.7	$33,682,157	52.6	$34,241,530	53.5
Radiology	4,303,437	50.1	$4,388,464	51.1	$4,431,078	51.6	$4,473,459	52.1	$4,558,154	53.0	$4,624,423	53.8
Special Reports	50,526	50.0	$51,535	51.0	$52,041	51.5	$52,545	52.0	$53,555	53.0	$54,560	54.0
Surgery	12,004,061	50.0	$12,233,692	51.0	$12,347,927	51.5	$12,460,880	52.0	$12,684,564	52.9	$12,899,761	53.8
Total	**$72,696,075**	**49.7**	**$73,726,488**	**50.4**	**$74,243,773**	**50.8**	**$74,750,835**	**51.1**	**$75,765,009**	**51.8**	**$76,746,261**	**52.5**

Preliminary Summary of Changes

2022 Medical Services Provider Manual

December 17, 2021

Updated February 17, 2022 to reflect stakeholder feedback
Changes proposed based on stakeholder feedback are highlighted

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

The codes in the fee schedule will be made current by including codes established for 2022 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 and URL links, substantive changes to the text, which are outlined below, are included in the proposed version of the 2022 Medical Services Provider Manual (MSPM). Page numbers refer to the pages in the South Carolina MSPM effective April 1, 2021.

The Commission's Ad Hoc Advisory Committee presented seven recommendations at the Commission's Business Meeting in October 2021. Two recommendations are included in this summary with recommendations. The other five recommendations are not included herein because they are not directly related to the fee schedule and will require further study and a statutory or regulatory change. They will be addressed at a later date.

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

1. **Chapter 2. General Policy**

   Copies of Records and Reports (page 9) – The Ad Hoc Committee proposed adopting a change which requires any party to furnish medical records and other records and reports free of charge. However, the Commission received additional feedback that this proposal places a burden on providers who receive multiple requests to provide the same documentation to different parties. Providing copies free of change may exacerbate this problem, which already presents a significant administrative cost driver to medical practices.

   The Commission's staff recommends delaying adoption of this recommendation because of the comments from stakeholders concerned about the potential financial impact on the medical service providers.

   There are no proposed changes to the policy for copies of reports and records on page 9.

2. **Part II: Fee Schedule**

   Telemedicine (Page 32) – If the Commission decides to make the telemedicine policy permanent after the end of the COVID-19 pandemic emergency and continues to allow applicable services to be provided via telehealth, language about the expiration date of the policy will be deleted. The Telemedicine section will be updated as follows:

Telemedicine

Telemedicine is the use of electronic information and telecommunication technologies to provide care when the provider and patient are in different locations. Technologies used to provide telemedicine include telephone, video, the internet, mobile app and remote patient monitoring. Services provided by telemedicine are identified by the use of location code 02 (telemedicine) and Modifier 95, Synchronous Telemedicine Service, on the bill.

Certain services that are eligible for reimbursement under the South Carolina Medical Services Provider Manual when provided by telehealth during the COVID-19 pandemic emergency are identified with ~~a~~n star (★) in the rate tables. Telemedicine may not be used for emergent conditions. The maximum payment for telemedicine services is 100% of the billed charge, not to exceed the non-facility maximum allowable payment (MAP) listed in the rate tables. Service level adjustment factors are applicable based on the licensure of the healthcare professional providing the telemedicine service.

Additional services may be provided via telemedicine with pre-authorization by the payer.

The location for the telemedicine service is defined as the location of the patient/injured worker. Providers must be licensed to practice in South Carolina and telemedicine services may be provided by physicians, physician assistants, psychologists, nurse practitioners, physical therapists, occupational therapists, speech therapists and social workers. Telemedicine activities provided by physical therapy assistants and occupational therapy assistants must be supervised and directed by a physical therapist or occupational therapist, as appropriate, whose license is in good standing in South Carolina.

~~The South Carolina Workers' Compensation Commission will determine the expiration date of this policy, which will be aligned with the suspension of the COVID-19 Pandemic Emergency.~~

~~If the pandemic emergency is lifted prior to March 31, 2022, telemedicine services may be provided with pre-authorization through March 31, 2022.~~

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

Footnote on Heading "Levels of E/M Services[1]" (Page 35) – The footnote reference was included in the 2021 MSPM, however, the language in the footnote was omitted. We will restore the footnote language by adding the following footnote at the bottom of the page:

[1] Adapted from CPT 2022, pp 6-12

Independent Medical Evaluation IME (page 37) – See # 5, proposed update for Medical Testimony below. If this change is adopted, the IME language below will be updated to clarify that medical testimony related to IMEs is part of the IME and therefore not subject to the reimbursement cap that applies to other medical testimony.

INDEPENDENT MEDICAL EVALUATION (IME)

An Independent Medical Evaluation is an objective medical or chiropractic evaluation of the injured employee's medical condition and work status which is requested by the insurance carrier, self-insured employer, an attorney, or a Workers' Compensation Commissioner. An IME includes the review of available records and test reports, examination of the patient, and a written report regarding the medical condition and work status of the injured worker.

The employer or carrier may schedule an IME with a medical provider of its choice to assist in determining the status of an injured employee's condition. Acceptable reasons for conducting an IME include, but are not limited to:

1. Instances when the authorized treating physician has not provided current medical reports;
2. Determining whether a change in medical provider is necessary;
3. Determining whether treatment is necessary or the employee appears not to be making appropriate progress in recuperation;
4. Determining whether over-utilization by a medical provider has occurred.

The medical provider performing the IME may not be the medical provider selected to provide the treatment or follow-up care, unless the carrier or self-insurer and the employee agree to this, or unless an emergency exists.

Before performing an IME, a physician must have a written request from the Commission, the employer/insurance carrier, the injured worker or his/her attorney, or other appropriate third party. To report an IME, use CPT code 99456. Payment for this service (including medical testimony related to IMEs) varies and is based on individual consideration (IC) or negotiation between the carrier and provider.

4. **Section 6. Medicine and Injections**

Independent Medical Evaluations (page 455) – Same as above in #3, the Evaluation and Management section. See # 5, proposed updated for Medical Testimony below. If this change is adopted, the IME language below will be updated to clarify that medical testimony related to IMEs is part of the IME and therefore not subject to the reimbursement cap that applies to other medical testimony.

INDEPENDENT MEDICAL EVALUATION (IME)

An Independent Medical Evaluation is an objective medical or chiropractic evaluation of the injured employee's medical condition and work status which is requested by the insurance carrier, self-insured employer, an attorney, or a Workers' Compensation Commissioner. An IME includes the review of available records and test reports, examination of the patient, and a written report regarding the medical condition and work status of the injured worker.

The employer or carrier may schedule an IME with a medical provider of its choice to assist in determining the status of an injured employee's condition. Acceptable reasons for conducting an IME include, but are not limited to:

1. Instances when the authorized treating physician has not provided current medical reports;
2. Determining whether a change in medical provider is necessary;
3. Determining whether treatment is necessary or the employee appears not to be making appropriate progress in recuperation;
4. Determining whether over-utilization by a medical provider has occurred.

The medical provider performing the IME may not be the medical provider selected to provide the treatment or follow-up care, unless the carrier or self-insurer and the employee agree to this, or unless an emergency exists.

Before performing an IME, a physician must have a written request from the Commission, the employer/insurance carrier, the injured worker or his/her attorney, or other appropriate third party. To report an IME, use CPT code 99456. Payment for this service (including medical testimony related to IMEs) varies and is based on individual consideration (IC) or negotiation between the carrier and provider.

Over the Counter Preparations (page 456) – The changes proposed below are not part of the formal recommendation of the Ad Hoc Committee. However, members of the committee who work with prescription drug bills requested that reimbursement for non-prescription strength patches be included. This proposed change builds on language that was considered and deferred from last year.

OVER-THE-COUNTER PREPARATIONS

Physician dispensed ~~O~~over-the-counter preparations ~~dispensed by the provider~~ must be preauthorized prior to dispensing. With the exception of non-prescription strength patches, CPT code 99070 must be used to bill for over-the-counter (proprietary) preparations. The name of the preparation, dosage, and package size must be listed either on the claim form or in the attached office report. The charge must not exceed actual cost plus an additional 20 percent. Payment will not be made for nutrient preparations and other dietary supplements.

Non-prescription strength patches shall be reimbursed at the lesser of actual cost plus 20% or $70.00 for a 30-day supply, pro-rated based on the number of days dispensed.

5. **Section 8. Special Reports and Services**

Medical Testimony (page 526) – The language added to the policy below is in response to a recommendation from the Ad Hoc Advisory Committee. The intent is to clarify that medical testimony provided with respect to an independent medical examination (IME) is not subject to the maximum payment cap.

MEDICAL TESTIMONY

Medical testimony by personal appearance of a physician, whether before a Commissioner or in a court of law, is reported using South Carolina specific codes SC001 and SC002. Payment is based on the time spent "in court" only. Time for preparation or travel is not considered when determining payment. Use South Carolina specific code SC001 to report the initial hour, and South Carolina specific code SC002 to report each additional quarter hour of medical testimony by personal appearance by a physician. For all other providers, use South Carolina specific code SC003.

Medical testimony by deposition of a physician is reported using South Carolina specific service codes SC004 and SC005. Use South Carolina specific code SC004 to report the initial hour and code SC005 to report each additional quarter hour of medical testimony by deposition of a physician. Time is measured based on the actual time spent in deposition. Time spent reviewing records is not considered when determining payment. For all other providers, use South Carolina specific code SC006.

Independent Medical Examinations (IME) and costs and fees associated with an IME are not subject to the MAP.

6. **Section 10. Pharmacy**

Prescription Strength Topical Compounds (page 740) – The Ad Hoc Committee did not include a recommendation on prescription strength topical compounds. However, members of the Ad Hoc Committee who work with prescription drugs proposed the following language. Last year, a similar update was considered, but not adopted due to feedback about the difficulty of administering claims with state-specific codes. The language proposed below addresses topical compounds without the need for new codes and would be added at the end of the Pharmacy section of the MSPM.

PRESCRIPTION ~~STRENGTH~~ TOPICAL AND TOPICAL COMPOUND~~S~~ MEDICATIONS

Compound drugs must be preauthorized for each dispensing. In order to qualify as a compound under this section, the medication must require a prescription; the ingredients must be combined, mixed, or altered by a licensed pharmacist or a pharmacy technician being overseen by a licensed pharmacist, a licensed physician, or, in the case of an outsourcing facility, a person under the supervision of a licensed pharmacist; and it must create a medication tailored to the needs of an individual patient. All ingredient materials must be listed by quantity used per prescription. Continued use (refills) may require documentation of effectiveness including functional improvement. Fees include materials, shipping and handling, and time. Automatic refilling is not allowed.

1. Payment for prescription topical medications shall be $240.00 for a 30-day supply, pro-rated based on the number of days supply dispensed, not to exceed 90 days.

~~1.~~2. Payment for prescription-~~strength topical medications and~~ topical compound~~ed~~ medication~~s~~, shall be the lesser of:

   a. The sum of the average wholesale price by gram weight for each ingredient based on the original manufacturer's NDC Number for the ingredient; or

   b. $240.00 for a 30-day supply, pro-rated based on the number of days supply dispensed, not to exceed 90 days;

   Plus a single dispensing fee of $5.00.

~~2.~~3. Any component ingredient in a compound medication for which there is no NDC or that is not FDA approved for topical use, shall not be reimbursed.

~~3.~~4. Physicians ~~shall~~ are urged to prescribe therapeutically equivalent medications or over-the-counter medications when available in lieu of a prescription-strength topical or custom compound.

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Fee Schedule Analysis

December 17, 2021

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 (2020 dates of service) provided by the National Council on Compensation Insurance, Inc. (NCCI) and South Carolina maximum allowable payment (MAP) amounts to develop conversion factors and propose MAP values for the 2022 fee schedule.

FAIR Health received paid amounts from NCCI for the 2020 calendar year, aggregated at the procedure code/modifier level. FAIR Health used the data from 2020 to:

1. Develop a "fee schedule-neutral" conversion factor designed to reflect a similar level of spending based on 2021 MAP amounts; and
2. Project paid amounts for 2022 based on multiple conversion factor alternatives.

2020 Paid Data and Frequencies

The following is a summary of the 2020 data received from NCCI:

NCCI Data - 2020 Calendar Year

Service Type	Total Paid	Total Charged	Transactions	Units
CPT (Less Anesthesia)	$54,751,003.88	$118,533,235.35	663,721	941,149
Anethesia*	$1,294,918.12	$8,097,318.69	5,137	568,777
HCPCS (Less Ambulance)	$19,677,712.73	$27,961,206.65	76,127	681,986
Ambulance**	$2,340,216.45	$3,934,994.61	13,076	260,781
Total	$78,063,851.18	$158,526,755.30	758,061	2,452,693

* Assumes most units are minutes

** Assumes most units are miles

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 2020 were used to determine the number of occurrences (frequency) for each service.

- Services were reviewed at the procedure code/modifier level to account for differences in paid amounts based on fee schedule MAP amounts and policies. For example:
    - The occurrences for codes reported with modifier 26 and TC were projected separately, based on the MAP amounts in the fee schedule.
    - HCPCS Codes reported with modifiers NU (new), UE (used) and RR (rental) were projected separately based on the occurrences in the NCCI data and fee schedule MAP values.
    - 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 (assistant surgeon modifiers 80-82 and AS) were projected based on 2020 occurrences and adjusted MAP amounts.

Fee Schedule-Neutral Conversion Factor - 2021 Projections

- Total dollar amounts were projected based on 2020 occurrences and 2021 relative value units (RVUs).
- Using these frequencies and RVUs and incorporating the +/- 9.5% cap on MAP increases and decreases compared to the prior year where applicable, FAIR Health calculated a conversion factor designed to maintain spending at the 2020 level for each service area.
- The total fee schedule budget neutral conversion factor is 38.97.
- Ambulance data is paid at 100% of Medicare and is not included in this analysis.
- Please see the separate analysis for anesthesia.

2021 Projections

Category	Frequency	Total 2021 RVUs	NCCI Payment	Budget Neutral Conversion Factor
Evaluation and Management	114,626	327,685	$ 12,437,429.00	37.96
HCPCS Level II	162,325	123,298	$ 4,307,648.80	34.94
Medicine & Injection	12,805	28,984	$ 1,217,166.70	41.99
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Total	1,086,161	1,458,983	$ 56,852,743.88	38.97

The relatively low conversion factor in this analysis may be influenced by several factors including:

- The impact of the 9.5% statutory cap on increases to the fee schedule. This effect may be compounded when increases to the conversion factor cannot be recognized over the course of several years and may result in the MAP never reaching the calculated formula amount.
- The impact of COVID-19 and telemedicine on office visits, surgical and imaging procedures.
- 2021 increases to the RVUs for office visits, which are among the most frequently billed codes. The full RVU increase could not be recognized due to the 9.5% cap on increases to the MAP.

- Negotiated rates that are below fee schedule MAPs; especially high frequency codes in the HCPCS and Physical Medicine sections.

Comparison of Alternate Conversion Factors – 2022 Projections

- The projections of paid amounts for the 2022 fee schedule are based on 2020 frequencies and 2022 RVUs, to which conversion factors of 50, 51, 51.5 (the current South Carolina conversion factor), 52 53 and 54 were applied. The cap of +/- 9.5% of the prior year's MAP value for each service was applied, when appropriate, in providing these projections.
- Certain 2022 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 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, 2022 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 2023 MSPM to determine if we are able to value these codes at that time.

2022 Projections

Category	Total $ 2022 CF=50	CF50	Total $ 2022 CF=51	CF51	Total $ 2022 CF=51.5	CF51.5	Total $ 2022 CF=52	CF52	Total $ 2022 CF=53	CF53	Total $ 2022 with CF=54	CF54
Evaluation and Management	15,915,961	48.4	$16,013,541	48.7	$16,062,458	48.8	$16,110,940	49.0	$16,205,399	49.3	$16,298,371	49.6
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Total	**$72,696,075**	**49.7**	**$73,726,488**	**50.4**	**$74,243,773**	**50.8**	**$74,750,835**	**51.1**	**$75,765,009**	**51.8**	**$76,746,261**	**52.5**

Upon approval of a conversion factor for 2022, 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.

Chris O'Donnell
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Workers' Compensation Commission

MEMORANUM

TO: **Commissioners**

FROM: **Gary Cannon**

DATE: **January 24, 2021**

RE: **Medical Services Provider Manual (MSPM)**

At the Business Meeting on January 24 Christine O'Donnell, project leader from FairHealth will review the analysis and recommendations for changes to the MSPM presented at the Business Meeting in December 2021.

A public comment period for the proposed changes to the MSPM is scheduled for the Business Meeting to the opportunity for you to review the comments submitted and hear from any other stakeholders who wish to comment. The following is a list of organizations and individuals who submitted comments on the proposed changes: :

SC Orthopeadic Association
Palmetto Pain Management
Hubert Wood, Esq.
Physicians Research Institute
Optum
SC Medical Association

The comments are attached.

Also attached are the analysis and recommendations prepared by FairHealth and presented at the December 21 Business Meeting. and posted on the Commission's website requesting stakeholder comment.

January 18, 2022

Gary Cannon
Executive Director
SC Workers' Compensation Commission
via email: aproveaux@wcc.sc.gov

Dear Director Cannon:

The South Carolina Orthopaedic Association, representing orthopaedic surgeons throughout South Carolina who are both employed by health systems and working in private practice, is pleased to offer comments related to the proposed Medical Services Provider Manual (MSPM) update.

SCOA was honored to participate in the Ad Hoc MSPM Advisory Committee last year. We were encouraged by the Committee's recommendations – particularly that SC's Maximum Allowable Payment (MAP) to authorized providers be increased to mirror the percentage paid by neighboring states and be more closely aligned to the multi-state median values as depicted by the "WCRI Medical Price Index for Workers' Compensation, 13th Edition, May 2021." The current disparity is well-documented in the Committee's recommendations.

Unfortunately, we do not believe this recommendation can be achieved by a "fee schedule-neutral" conversion factor designed to reflect a similar level of spending based on 2021 MAP amounts as Fair Health has been instructed to calculate.

The cost incurred by physicians to treat injured workers has not been "neutral" for many years; therefore, expecting them to continue providing medical services for neutral payment is unrealistic. Audience commentary during the Commissioners' Roundtable at the 2021 SCWCEA Educational Conference made it clear that adjusters are already struggling to find musculoskeletal physicians to accept new appointments in a timely manner. The administrative burden of workers' compensation coupled with increasingly low payment for those services are directly correlated to this disruption.

Particularly concerning is Fair Health's observation that the 9.5% statutory cap on fee schedule increases artificially compresses the conversion factor in several ways:

- "The impact of the 9.5% statutory cap on increases to the fee schedule. This effect may be compounded when increases to the conversion factor cannot be recognized over the course of several years and may result in the MAP never reaching the calculated formula amount."

- "2021 increases to the RVUs for office visits, which are among the most frequently billed codes. The full RVU increase could not be recognized due to the 9.5% cap on increases to the MAP."

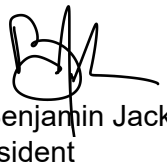
Since the SC MAP relies on Medicare's RBRVS calculations as its foundation, it's disturbing that the full RVU increases endorsed by Medicare are not being realized. We understand the Commission is limited by Statute to a single conversion factor and the 9.5% cap, but we are compelled to reiterate that current and proposed MAP amounts are inadequate and are eroding access to musculoskeletal care for injured workers.

SCOA agrees that additional collaboration among stakeholders is required before updates are made to the Copies of Records and Reports provisions in the MSPM.

SCOA supports the proposed updates for Medical Testimony for depositions linked to IMEs.

We look forward to future collaboration with Stakeholders and the Commission to pursue the Ad Hoc MSPM Committee's recommendations not addressed in the 2022 update.

Respectfully,



J. Benjamin Jackson, III, MD, MBA
President
South Carolina Orthopaedic Assocation

PALMETTO PAIN MANAGEMENT
PAIN MANAGEMENT & SPINAL DIAGNOSTICS
EZRA B. RIBER, M.D.
Board Certified in Anesthesiology,
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January 18, 2022

T. Scott Beck, Chairman
South Carolina Workers' Compensation Commission
Post Office Box 1715
1333 Main Street
Columbia, South Carolina 29202-1715

RE: Proposed Changes to the 2022 Medical Services Provider Manual

Dear Chairman and Members of the Commission,

I have been treating injured workers in South Carolina for more than 30 years. My training includes board certification in anesthesiology, pain medicine, and addiction medicine. I have previously worked with the medical board on protocols for physician prescribing and fully support the various policies South Carolina has implemented over the years to address medication misuse (implementation of pain management guidelines, limiting initial opioid prescriptions in certain instances, requiring all dispensers report dispensing activity of Schedule II-IV controlled substances to the SCRIPTS program, etc.) Over the years, I have had the opportunity to participate in various advisory committees established by this Commission and appreciate the Commission's continued willingness to engage with stakeholders for input.

Most recently, I was involved in the Ad Hoc Advisory Committee for the 2022 Medical Services Provider Manual. In addition to those recommendations made by the Ad Hoc Advisory Committee to the upcoming Manual, Fair Health has proposed further changes, including a new section to the Manual called "Prescription Strength Topical Compounds".

At first review, this appears to only address prescription topical compounds. However, the proposed language goes much further. This section also seeks to address other prescription medications and includes a requirement that "physicians shall prescribe therapeutically equivalent over-the-counter medications when available in lieu of a prescription or custom compound." To expand this section to address other prescription medications, which serve as supplemental and / or alternative treatment to opioids for addressing pain, and to include a mandate on how or what a physician should prescribe is not appropriate and should be removed from the proposed Manual changes under consideration.

As a standard practice, if an injured worker would be best served with over-the-counter medications, I already recommend those medications. However, if in my professional judgment I believe a prescription medication is medically necessary for the injured worker, it is that medication I prescribe. An injured worker's physician is in the best position to determine what is most appropriate for any particular patient and pain issue. Our training and expertise guide us through the complexity and nuance that distinguishes treatment alternatives from one another. With the appropriate autonomy, we are able to leverage our experience to ensure that each patient receives the safest and most effective care. Patient care-related decision making, including whether a prescription medication is warranted, should remain between the physician and the patient.

Over the years, my focus has been on diagnosing and safely treating injured workers to bring them to maximum medical improvement (MMI) as quickly as possible. We physicians and our injured worker patients already face many hurdles when it comes to treatment. Please do not saddle us with additional directives that can delay and jeopardize patient care.

Thank you for your consideration.

Ezra B. Riber, M.D.

Pain Society of the Carolinas, Past President (2017-2019), Founding and Current Board Member

South Carolina Society of Interventional Pain Physicians, President and CEO

South Carolina Society of Anesthesiologists, Executive Committee (Pain)

cc: Gary M. Cannon, Executive Director

Proveaux, Amy

From: Hubert Wood <hubie@woodgroupllc.com>
Sent: Tuesday, December 21, 2021 5:07 PM
To: Proveaux, Amy
Cc: Kate Fiehrer Walton
Subject: [External] Revisions to MSPM- Comment on Proposal to Exclude IME Providers from Limitation on Fees for Medical Testimony

Follow Up Flag: Follow up
Flag Status: Flagged

Amy: Please relay to the Commission my strong opposition to the proposed revision excluding IME providers from the fee schedule limitation on medical testimony via deposition or hearing appearance. Such would allow IME providers to charge exorbitant deposition or hearing appearance fees that will make it prohibitive for the parties to cross-examine or otherwise question statements/opinions contained an IME report effectively insulating an IME provider from cross-examination by the opposing party. Such would be particularly detrimental in situations where the opposing side has obtained an IME in connection with which cross-examination is essential to the fair and proper adjudication of the claim. I plan to attend the business meeting on 1/24/22 and request permission to address this subject with the Commission. Thank you for your attention to the matter,

Hubie

Sent from my iPad

PHYSICIANS RESEARCH INSTITUTE
1211 Cathedral Street
Baltimore, Maryland 21201
Tel: 443.449.2287 Fax: 443.449.2290

MEMORANDUM

To: Honorable T. Scott Beck, Chair
Honorable Susan S. Barden, Vice Chair
Honorable R. Michael Campbell, II
Honorable Avery B. Wilkerson, Jr
Honorable Melody L. James
Honorable Aisha Taylor
Honorable Gene McCaskill
From: Joseph A. Schwartz, III
Date: January 19, 2022
RE: Objection to Certain Provisions of Proposed 2022 Medical Services Provider Manual

The Physicians Research Institute (PRI) is presently comprised of 38 State Medical Societies including the South Carolina Medical Association. Since its creation in 2016, its main concentration has been on workers compensation laws and regulations in the various states. To that end, PRI was an active participant in the Ad Hoc Advisory Committee convened by this Commission in the summer and fall of 2021 to make proposed improvements for Commission consideration of the 2022 Medical Services Provider Manual (proposed 2022 Manual).

PRI was particularly concerned about the low reimbursements paid to South Carolina doctors treating workers' compensation patients. According to the 2021 Report of the Workers' Compensation Research Institute (WCRI) reporting on 2020 data, South Carolina placed 35th lowest out of 36 states sampled. Where a median state paid $100 (Alabama for example) and Georgia paid $108, South Carolina paid $75. The Ad Hoc Committee unanimously supported efforts to increase the $75 to $100. While this support was aspirational, it is against this background that PRI is particularly alarmed by the proposed reductions in reimbursements paid to treating doctors.

The Ad Hoc Committee had several meetings and all of its agreed proposals were discussed at each and every meeting with the exception of a late raised proposal from Pharmacy Benefit Managers (PBMs) which was brought up at the final meeting. The final meeting was designed not to discuss new proposals but to agree on the various proposals discussed throughout. When objections were raised, the PBMs withdrew the proposal, apparently in the correct belief that it would be promoted by FAIR Health. These PBM proposals now appear in Sections 6 and 10 of the proposed 2022 Manual.

Section 10. Prescription Strength Topical Compounds

The most troublesome provisions occur in Section 10. This was the same language proposed by PBMs to the Ad Hoc Committee which was met with strenuous objection and was then withdrawn. Even though the Ad Hoc Committee did not endorse this proposal, FAIR Health has elected to include it in the current proposal.

As currently Titled by FAIR Health, the Section purports to deal only with "Prescription Strength Topical Compounds" but that is clearly misleading. Even though that Title occurs throughout, a reading of the actual text indicates this section addresses all topical medicines not just "topical compounds." This language goes beyond that proposed for the 2021 Manual which sought to address "topical compounds," not all topical medications. It also includes a mandate that physicians prescribe "therapeutically equivalent over the counter medications" in certain situations.

Opioid usage has declined dramatically over the years in South Carolina as physicians work with patients to find alternative avenues to treat pain. Attempts to limit physicians' ability to treat patients with appropriate medication should not be permitted. The physician community has embraced the use of non-narcotic treatment for pain management. This proposal seeks to deter use of these alternative medications and imposes an unreasonable mandate on physicians. This not only creates additional burdens on physicians but also jeopardizes appropriate treatment. Requiring usage of "therapeutically equivalent over the counter medications" (whatever that means) not only undermines physician medical judgment but is likely to delay treatment and increase disputes in instances where the physician and the payor's adjuster disagree. Will the Commission then be called upon to settle their dispute? Limiting a physician's ability to properly treat a patient should never be sanctioned.

PRI suggests two changes to Section 10:

- Paragraph 1: In order to effectuate the Title of this Section and FAIR Health's representation that the language addresses topical compounds (FAIR Health Preliminary Summary of Changes, December 17, 2021, page 4), it is necessary to strike "topical medications and" as follows:

> 1. Payment for prescription-strength [~~*topical medications and*~~] topical compounded medication, shall be the lesser of:

With that amendment, the proposal will be the same that was before you in 2021 without the state specific codes which scuttled it at that time.

- Paragraph 3: This paragraph would impose the **first ever** legally required treatment mandate on South Carolina physicians. It removes physician discretion in the treatment of patients and will likely result in substandard care. It needs to be removed.

> [~~*3. Physicians shall prescribe therapeutically equivalent over-the-counter medications when available in lieu of a prescription or custom compound*~~.]

Section 6. Over-The-Counter Preparations

The change to Section 6 exempts "non-prescription strength patches" from the current fee structure and proposes a new reimbursement of the "actual cost plus 20% or $70 for 30 day supply.…" This change was also part of the PBM proposal to the Ad Hoc Committee which was withdrawn. According to FAIR Health (Fee Schedule Analysis, December 17, 2021, page 4), a similar update was considered in 2021. PRI has been unable to find a document to confirm that assertion but, if true, it is a change that this Commission rejected last year. The basis for the formula is certainly not apparent but it does not take much imagination to understand that the PBMs will pay less than they are now paying.

Conclusion

The Ad Hoc Committee received information that workers compensation premiums in South Carolina have been reduced 30% since 2017. This Commission should be rightfully proud of this accomplishment.

PRI appreciates the Commission's attempt to adopt rules to promote efficiency within the system but those rules cannot be at the expense of the injured worker. PRI believes that the proposed changes to Section 6 and Section 10 run counter to the need to raise physician reimbursement rates to an appropriate level so South Carolina is not such an outlier.

JAS:jsm

cc: Gary M. Cannon, Executive Director, South Carolina Workers' Compensation Commission
Richele Taylor, Chief Executive Officer, South Carolina State Medical Association

January 19, 2022

Amy Proveaux
South Carolina Workers' Compensation Commission
1333 Main Street, 5th Floor
P.O. Box 1715
Columbia, SC 29202

Via email: aproveaux@wcc.sc.gov

Re: Comments on proposed changes to the South Carolina Medical Services Provider Manual

Optum Workers' Compensation and Auto No-fault (Optum) appreciates the opportunity to comment on proposed changes to the South Carolina Medical Services Provider Manual. We support the Workers' Compensation Commission's (WCC) efforts to update and keep current the fee schedule and the open dialogue between the WCC and stakeholders during this process.

We continue to support WCC efforts to reign in unique, over-the-counter and topical medications as well as current system practices which allow over-utilization of these drugs. Processes driving this type of medication utilization are completely contrasted by stakeholders who drive cost effective and efficient care. With public policy engagement in numerous states Optum observes similar concerns raised by many workers' compensation agencies. In concert with our previous comments filed in 2021, we renew our backing and offer our assistance during this rule-making process. Thus we respectfully offer these comments and questions for clarification.

Over-The-Counter Preparations
Optum supports this change. However, we assume the term "provider" is intended to cover medical providers who dispense/provide these medications from their office. We suggest this might need clarification. Finally, has the WCC considered any billing requirements which would require the dispensing provider to make available a copy of the cost invoice to justify a reimbursement rate?

Section 10. Pharmacy
Optum supports this change. However, we believe the structure of the reimbursement rates may cause some confusion when pricing prescription-strength topical medications compared to topical compounded medication. Optum respectfully suggests the following structure changes to the existing language and addition of new language as indicated by underline.

1. Payment for prescription-strength topical medications shall be, plus a single dispensing fee of $5.00:
    a. $240.00 for a 30-day supply, pro-rated based on the number of days supply dispensed, not to exceed 90 days
2. Payment for topical compounded medications shall be, plus a single dispensing fee of $5.00:
    a. The sum of the average wholesale price by gram weight for each ingredient based on the original manufacturer's NDC number for each ingredient
3. Any component in a compounded medication for which there is no NDC or that is not FDA approved for topical use shall not be reimbursed
4. Physician are urged to prescribe therapeutically equivalent medications or over-the-counter medications when

available in lieu of a prescription-strength topical or custom compound.

As a workers' compensation PBM and an impacted stakeholder, we remain committed to develop positive policy outcomes with the Commission. We offer our continued assistance including the insight of our Clinical and Data teams. We greatly appreciate the Commission allowing us to provide insight and we look forward to our lasting strong relationship as we move forward. Should you need anything from me or our various Optum teams, please feel free to reach out to me at any time.

Sincerely,

Kevin C. Tribout
Vice President, Public Policy & Regulatory Affairs
Optum Workers' Comp and Auto No-fault
kevin.tribout@optum.com

SCMA
SOUTH CAROLINA MEDICAL ASSOCIATION

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1-800-327-1021
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www.scmedical.org

Richele K. Taylor
General Counsel & Senior Vice President

January 19, 2022

To: Honorable T. Scott Beck, Chair
Honorable Susan S. Barden, Vice Chair
Honorable R. Michael Campbell, II
Honorable Avery B. Wilkerson, Jr
Honorable Melody L. James
Honorable Aisha Taylor
Honorable Gene McCaskill

RE: *Objections to Proposed Fee Schedule*

The South Carolina Medical Association (SCMA) is reaching out on the proposed improvements for the 2022 Medical Services Provider Manual. We are supportive of the Physicians Research Institute (PRI) and its participation in the Commission's Ad Hoc Advisory Committee convened to help make needed improvements. As we understand, the Ad Hoc Advisory Committee allowed participants to offer proposed changes to the Manual in advance of publishing a 2022 version. PRI take on arduous tasks such as these to ensure that physicians are fairly represented. They provide their time and expertise in these matters on behalf of all physicians, to which we are grateful.

When we learned that the Pharmacy Benefit Managers (PBMs) brought a proposal at the last meeting, after all submissions were made, we were disappointed. Although the PBMs withdrew the proposal, we have learned these proposals appeared in the proposed 2022 Manual.

The SCMA supports PRI's objections to the proposed fee schedule and last minute modifications brought by the PBMs. Specifically, the SCMA echoes PRI's statements on Section 10 in objecting to a mandate that physicians prescribe "therapeutically equivalent over the counter medications" first. While we all agree that costs of care must be considered in treatment, third parties should never mandate a physician's clinical judgement.

The SCMA supports PRI's objections as filed in its January 19, 2022, letter regarding Sections 6 and 10. We appreciate your consideration of these concerns.

Sincerely,

Richele K. Taylor

cc: Gary M. Cannon, Executive Director, South Carolina WCC
Joseph A. Schwartz, III, President, Physicians Research Institute

State of South Carolina

1333 Main Street, 5th Floor
P.O. Box 1715
Columbia, S.C. 29202-1715

TEL: (803) 737-5700
www.wcc.sc.gov

Workers' Compensation Commission

MEMORANUM

TO: **Commissioners**

FROM: **Gary Cannon**

DATE: **December 20, 2021**

RE: **Medical Services Provider Manual (MSPM)**

Attached you will find three documents provided by FairHealth. The "Fee Schedule Analysis" is the analysis of the medical data and proposed Conversion Factors. The "Preliminary Summary of Changes, 2022 Medical Services Provider Manual" includes the recommendations for the policy changes in the MSPM. The "Analysis of Anesthesia Conversion Factor – Preliminary Draft" is comparative analysis of the Commission's Anesthesia rate to other states using data from the American Society of Anesthesiologists' (ASA) survey.

The following is a proposed schedule for the Commissioners review of receipt and review of stakeholder comment and adoption:

December 20, 2021 – Commission Business Meeting receipt of 2022 MSPM proposed changes

December 21, 2021 – Issue Advisory Notice for stakeholder comment period.

January 19, 2022 – Deadline for submission of stakeholder comment.

January 24, 2022 – Commission Business Meeting - Public Hearing for 2022 MSPM

February 14, 2022 – Commission Business Meeting

March 21, 2022 – Commission Business Meeting – Adoption of 2022 MSPM

April 1, 2022 – Effective date of 2022 MSPM

Fee Schedule Analysis

December 17, 2021

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 (2020 dates of service) provided by the National Council on Compensation Insurance, Inc. (NCCI) and South Carolina maximum allowable payment (MAP) amounts to develop conversion factors and propose MAP values for the 2022 fee schedule.

FAIR Health received paid amounts from NCCI for the 2020 calendar year, aggregated at the procedure code/modifier level. FAIR Health used the data from 2020 to:

1. Develop a "fee schedule-neutral" conversion factor designed to reflect a similar level of spending based on 2021 MAP amounts; and
2. Project paid amounts for 2022 based on multiple conversion factor alternatives.

2020 Paid Data and Frequencies

The following is a summary of the 2020 data received from NCCI:

NCCI Data - 2020 Calendar Year

Service Type	Total Paid	Total Charged	Transactions	Units
CPT (Less Anesthesia)	$54,751,003.88	$118,533,235.35	663,721	941,149
Anethesia*	$1,294,918.12	$8,097,318.69	5,137	568,777
HCPCS (Less Ambulance)	$19,677,712.73	$27,961,206.65	76,127	681,986
Ambulance**	$2,340,216.45	$3,934,994.61	13,076	260,781
Total	$78,063,851.18	$158,526,755.30	758,061	2,452,693

* Assumes most units are minutes

** Assumes most units are miles

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 2020 were used to determine the number of occurrences (frequency) for each service.

- Services were reviewed at the procedure code/modifier level to account for differences in paid amounts based on fee schedule MAP amounts and policies. For example:
    - The occurrences for codes reported with modifier 26 and TC were projected separately, based on the MAP amounts in the fee schedule.
    - HCPCS Codes reported with modifiers NU (new), UE (used) and RR (rental) were projected separately based on the occurrences in the NCCI data and fee schedule MAP values.
    - 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 (assistant surgeon modifiers 80-82 and AS) were projected based on 2020 occurrences and adjusted MAP amounts.

Fee Schedule-Neutral Conversion Factor - 2021 Projections

- Total dollar amounts were projected based on 2020 occurrences and 2021 relative value units (RVUs).
- Using these frequencies and RVUs and incorporating the +/- 9.5% cap on MAP increases and decreases compared to the prior year where applicable, FAIR Health calculated a conversion factor designed to maintain spending at the 2020 level for each service area.
- The total fee schedule budget neutral conversion factor is 38.97.
- Ambulance data is paid at 100% of Medicare and is not included in this analysis.
- Please see the separate analysis for anesthesia.

2021 Projections

Category	Frequency	Total 2021 RVUs	NCCI Payment	Budget Neutral Conversion Factor
Evaluation and Management	114,626	327,685	$ 12,437,429.00	37.96
HCPCS Level II	162,325	123,298	$ 4,307,648.80	34.94
Medicine & Injection	12,805	28,984	$ 1,217,166.70	41.99
Pathology & Laboratory	9,894	8,557	$ 398,839.44	46.61
Physical Medicine	708,933	644,807	$ 23,348,208.00	36.21
Radiology	46,443	87,115	$ 4,437,912.60	50.94
Special Reports	990	1,030	$ 46,792.34	45.43
Surgery	30,145	237,507	$ 10,658,747.00	44.88
Total	1,086,161	1,458,983	$ 56,852,743.88	38.97

The relatively low conversion factor in this analysis may be influenced by several factors including:

- The impact of the 9.5% statutory cap on increases to the fee schedule. This effect may be compounded when increases to the conversion factor cannot be recognized over the course of several years and may result in the MAP never reaching the calculated formula amount.
- The impact of COVID-19 and telemedicine on office visits, surgical and imaging procedures.
- 2021 increases to the RVUs for office visits, which are among the most frequently billed codes. The full RVU increase could not be recognized due to the 9.5% cap on increases to the MAP.

- Negotiated rates that are below fee schedule MAPs; especially high frequency codes in the HCPCS and Physical Medicine sections.

Comparison of Alternate Conversion Factors – 2022 Projections

- The projections of paid amounts for the 2022 fee schedule are based on 2020 frequencies and 2022 RVUs, to which conversion factors of 50, 51, 51.5 (the current South Carolina conversion factor), 52 53 and 54 were applied. The cap of +/- 9.5% of the prior year's MAP value for each service was applied, when appropriate, in providing these projections.
- Certain 2022 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 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, 2022 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 2023 MSPM to determine if we are able to value these codes at that time.

2022 Projections

Category	Total $ 2022 CF=50	CF50	Total $ 2022 CF=51	CF51	Total $ 2022 CF=51.5	CF51.5	Total $ 2022 CF=52	CF52	Total $ 2022 CF=53	CF53	Total $ 2022 with CF=54	CF54
Evaluation and Management	15,915,961	48.4	$16,013,541	48.7	$16,062,458	48.8	$16,110,940	49.0	$16,205,399	49.3	$16,298,371	49.6
HCPCS Level II	6,560,280	51.1	$6,577,317	51.2	$6,585,956	51.3	$6,594,470	51.3	$6,611,576	51.5	$6,628,664	51.6
Medicine & Injection	1,435,516	49.5	$1,462,904	50.5	$1,476,624	51.0	$1,490,267	51.4	$1,516,079	52.3	$1,537,217	53.0
Pathology & Laboratory	432,950	48.5	$439,976	49.3	$443,709	49.7	$446,455	50.0	$453,525	50.8	$461,735	51.8
Physical Medicine	31,993,344	49.9	$32,559,059	50.8	$32,843,980	51.3	$33,121,819	51.7	$33,682,157	52.6	$34,241,530	53.5
Radiology	4,303,437	50.1	$4,388,464	51.1	$4,431,078	51.6	$4,473,459	52.1	$4,558,154	53.0	$4,624,423	53.8
Special Reports	50,526	50.0	$51,535	51.0	$52,041	51.5	$52,545	52.0	$53,555	53.0	$54,560	54.0
Surgery	12,004,061	50.0	$12,233,692	51.0	$12,347,927	51.5	$12,460,880	52.0	$12,684,564	52.9	$12,899,761	53.8
Total	**$72,696,075**	**49.7**	**$73,726,488**	**50.4**	**$74,243,773**	**50.8**	**$74,750,835**	**51.1**	**$75,765,009**	**51.8**	**$76,746,261**	**52.5**

Upon approval of a conversion factor for 2022, 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.

Chris O'Donnell
Executive Director, Business Operations
codonnell@fairhealth.org
212-257-2367 (office)
212-710-0646 (mobile)

Preliminary Summary of Changes

2022 Medical Services Provider Manual

December 17, 2021

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

The codes in the fee schedule will be made current by including codes established for 2022 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 and URL links, substantive changes to the text, which are outlined below, are included in the proposed version of the 2022 Medical Services Provider Manual (MSPM). Page numbers refer to the pages in the South Carolina MSPM effective April 1, 2021.

The Commission's Ad Hoc Advisory Committee presented seven recommendations at the Commission's Business Meeting in October 2021. Two recommendations are included in this summary with recommendations. The other five recommendations are not included herein because they are not directly related to the fee schedule and will require further study and a statutory or regulatory change. They will be addressed at a later date.

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

1. **Chapter 2. General Policy**

   Copies of Records and Reports (page 9) – The Ad Hoc Committee proposed adopting a change which requires any party to furnish medical records and other records and reports free of charge. However, the Commission received additional feedback that this proposal places a burden on providers who receive multiple requests to provide the same documentation to different parties. Providing copies free of change may exacerbate this problem, which already presents a significant administrative cost driver to medical practices.

   The Commission's staff recommends delaying adoption of this recommendation because of the comments from stakeholders concerned about the potential financial impact on the medical service providers.

   There are no proposed changes to the policy for copies of reports and records on page 9.

2. **Part II: Fee Schedule**

   Telemedicine (Page 32) – If the Commission decides to make the telemedicine policy permanent after the end of the COVID-19 pandemic emergency and continues to allow applicable services to be provided via telehealth, language about the expiration date of the policy will be deleted. The Telemedicine section will be updated as follows:

Telemedicine

Telemedicine is the use of electronic information and telecommunication technologies to provide care when the provider and patient are in different locations. Technologies used to provide telemedicine include telephone, video, the internet, mobile app and remote patient monitoring. Services provided by telemedicine are identified by the use of location code 02 (telemedicine) and Modifier 95, Synchronous Telemedicine Service, on the bill.

Certain services that are eligible for reimbursement under the South Carolina Medical Services Provider Manual when provided by telehealth during the COVID-19 pandemic emergency are identified with ~~a~~an star (★) in the rate tables. Telemedicine may not be used for emergent conditions. The maximum payment for telemedicine services is 100% of the billed charge, not to exceed the non-facility maximum allowable payment (MAP) listed in the rate tables. Service level adjustment factors are applicable based on the licensure of the healthcare professional providing the telemedicine service.

Additional services may be provided via telemedicine with pre-authorization by the payer.

The location for the telemedicine service is defined as the location of the patient/injured worker. Providers must be licensed to practice in South Carolina and telemedicine services may be provided by physicians, physician assistants, psychologists, nurse practitioners, physical therapists, occupational therapists, speech therapists and social workers. Telemedicine activities provided by physical therapy assistants and occupational therapy assistants must be supervised and directed by a physical therapist or occupational therapist, as appropriate, whose license is in good standing in South Carolina.

~~The South Carolina Workers' Compensation Commission will determine the expiration date of this policy, which will be aligned with the suspension of the COVID-19 Pandemic Emergency.~~

~~If the pandemic emergency is lifted prior to March 31, 2022, telemedicine services may be provided with pre-authorization through March 31, 2022.~~

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

Footnote on Heading "Levels of E/M Services[1]" (Page 35) – The footnote reference was included in the 2021 MSPM, however, the language in the footnote was omitted. We will restore the footnote language by adding the following footnote at the bottom of the page:

[1] Adapted from CPT 2022, pp 6-12

Independent Medical Evaluation IME (page 37) – See # 5, proposed update for Medical Testimony below. If this change is adopted, the IME language below will be updated to clarify that medical testimony related to IMEs is part of the IME and therefore not subject to the reimbursement cap that applies to other medical testimony.

INDEPENDENT MEDICAL EVALUATION (IME)

An Independent Medical Evaluation is an objective medical or chiropractic evaluation of the injured employee's medical condition and work status which is requested by the insurance carrier, self-insured employer, an attorney, or a Workers' Compensation Commissioner. An IME includes the review of available records and test reports, examination of the patient, and a written report regarding the medical condition and work status of the injured worker.

The employer or carrier may schedule an IME with a medical provider of its choice to assist in determining the status of an injured employee's condition. Acceptable reasons for conducting an IME include, but are not limited to:

1. Instances when the authorized treating physician has not provided current medical reports;
2. Determining whether a change in medical provider is necessary;
3. Determining whether treatment is necessary or the employee appears not to be making appropriate progress in recuperation;
4. Determining whether over-utilization by a medical provider has occurred.

The medical provider performing the IME may not be the medical provider selected to provide the treatment or follow-up care, unless the carrier or self-insurer and the employee agree to this, or unless an emergency exists.

Before performing an IME, a physician must have a written request from the Commission, the employer/insurance carrier, the injured worker or his/her attorney, or other appropriate third party. To report an IME, use CPT code 99456. Payment for this service (including medical testimony related to IMEs) varies and is based on individual consideration (IC) or negotiation between the carrier and provider.

4. **Section 6. Medicine and Injections**

Independent Medical Evaluations (page 455) – Same as above in #3, the Evaluation and Management section. See # 5, proposed updated for Medical Testimony below. If this change is adopted, the IME language below will be updated to clarify that medical testimony related to IMEs is part of the IME and therefore not subject to the reimbursement cap that applies to other medical testimony.

INDEPENDENT MEDICAL EVALUATION (IME)

An Independent Medical Evaluation is an objective medical or chiropractic evaluation of the injured employee's medical condition and work status which is requested by the insurance carrier, self-insured employer, an attorney, or a Workers' Compensation Commissioner. An IME includes the review of available records and test reports, examination of the patient, and a written report regarding the medical condition and work status of the injured worker.

The employer or carrier may schedule an IME with a medical provider of its choice to assist in determining the status of an injured employee's condition. Acceptable reasons for conducting an IME include, but are not limited to:

1. Instances when the authorized treating physician has not provided current medical reports;
2. Determining whether a change in medical provider is necessary;
3. Determining whether treatment is necessary or the employee appears not to be making appropriate progress in recuperation;
4. Determining whether over-utilization by a medical provider has occurred.

The medical provider performing the IME may not be the medical provider selected to provide the treatment or follow-up care, unless the carrier or self-insurer and the employee agree to this, or unless an emergency exists.

Before performing an IME, a physician must have a written request from the Commission, the employer/insurance carrier, the injured worker or his/her attorney, or other appropriate third party. To report an IME, use CPT code 99456. Payment for this service (including medical testimony related to IMEs) varies and is based on individual consideration (IC) or negotiation between the carrier and provider.

Over the Counter Preparations (page 456) – The changes proposed below are not part of the formal recommendation of the Ad Hoc Committee. However, members of the committee who work with prescription drug bills requested that reimbursement for non-prescription strength patches be included. This proposed change builds on language that was considered and deferred from last year.

OVER-THE-COUNTER PREPARATIONS
Over-the-counter preparations dispensed by the provider must be preauthorized prior to dispensing. With the exception of non-prescription strength patches, CPT code 99070 must be used to bill for over-the-counter (proprietary) preparations. The name of the preparation, dosage, and package size must be listed either on the claim form or in the attached office report. The charge must not exceed actual cost plus an additional 20 percent. Payment will not be made for nutrient preparations and other dietary supplements.

Non-prescription strength patches shall be reimbursed at the lesser of actual cost plus 20% or $70.00 for a 30-day supply, pro-rated based on the number of days dispensed.

5. **Section 8. Special Reports and Services**

Medical Testimony (page 526) – The language added to the policy below is in response to a recommendation from the Ad Hoc Advisory Committee. The intent is to clarify that medical testimony provided with respect to an independent medical examination (IME) is not subject to the maximum payment cap.

MEDICAL TESTIMONY
Medical testimony by personal appearance of a physician, whether before a Commissioner or in a court of law, is reported using South Carolina specific codes SC001 and SC002. Payment is based on the time spent "in court" only. Time for preparation or travel is not considered when determining payment. Use South Carolina specific code SC001 to report the initial hour, and South Carolina specific code SC002 to report each additional quarter hour of medical testimony by personal appearance by a physician. For all other providers, use South Carolina specific code SC003.

Medical testimony by deposition of a physician is reported using South Carolina specific service codes SC004 and SC005. Use South Carolina specific code SC004 to report the initial hour and code SC005 to report each additional quarter hour of medical testimony by deposition of a physician. Time is measured based on the actual time spent in deposition. Time spent reviewing records is not considered when determining payment. For all other providers, use South Carolina specific code SC006.

Independent Medical Examinations (IME) and costs and fees associated with an IME are not subject to the MAP.

6. **Section 10. Pharmacy**

Prescription Strength Topical Compounds (page 740) – The Ad Hoc Committee did not include a recommendation on prescription strength topical compounds. However, members of the Ad Hoc Committee who work with prescription drugs proposed the following language. Last year, a similar update was considered, but not adopted due to feedback about the difficulty of administering claims with state-specific codes. The language proposed below addresses topical compounds without the need for new codes and would be added at the end of the Pharmacy section of the MSPM.

PRESCRIPTION STRENTH TOPICAL COMPOUNDS
Compound drugs must be preauthorized for each dispensing. In order to qualify as a compound under this section, the medication must require a prescription; the ingredients must be combined,

mixed, or altered by a licensed pharmacist or a pharmacy technician being overseen by a licensed pharmacist, a licensed physician, or, in the case of an outsourcing facility, a person under the supervision of a licensed pharmacist; and it must create a medication tailored to the needs of an individual patient. All ingredient materials must be listed by quantity used per prescription. Continued use (refills) may require documentation of effectiveness including functional improvement. Fees include materials, shipping and handling, and time. Automatic refilling is not allowed.

1. Payment for prescription-strength topical medications and topical compounded medication, shall be the lesser of:
   a. The sum of the average wholesale price by gram weight for each ingredient based on the original manufacturer's NDC Number for the ingredient; or
   b. $240.00 for a 30-day supply, pro-rated based on the number of days supply dispensed, not to exceed 90 days;

   Plus a single dispensing fee of $5.00.
2. Any component ingredient in a compound medication for which there is no NDC or that is not FDA approved for topical use, shall not be reimbursed.
3. Physicians shall prescribe therapeutically equivalent over-the-counter medications when available in lieu of a prescription or custom compound.

FAIR Health
Know Your Source

Analysis of Anesthesia Conversion Factor – Preliminary Draft

December 17, 2021

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
    - Contracted amounts
- ASA survey results from 2021
- Comparison to other states' workers' compensation fee schedules

The current anesthesia conversion factor in the South Carolina Medical Services Provider Manual (MSPM) is $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 $30 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)	$ 90.00	$ 90.00
Time Value Amount	$ 120.00	$ 240.00
Total AMAP	$ 210.00	$ 330.00

Medicare

CMS reduced the Medicare anesthesia conversion factor in 2022 to maintain budget neutrality for professional fees. This reduction helps to offset increased costs for office visits that were introduced in 2021. As a result, the South Carolina anesthesia conversion factor of $30 compares more favorably to the CMS conversion factor than it did last year. The comparison below is based on the Medicare conversion factor published in the 2022 Final Rule.

On December 10, 2021, the Protecting Medicare and American Farmers from Sequester Cuts Act was signed into law. This law restores some of the cuts to the conversion factor that were included in the Final Rule. It is expected that the updated conversion factor will be approximately .8% less than the 2021 conversion factor, however, CMS has not yet published the final rate. FAIR Health will provide an updated report to reflect the final conversion factor in this Medicare comparison.

	Anesthesia – National Comparison	Anesthesia – South Carolina Comparison	Other Professional Services
South Carolina Conversion Factor	$30.00	$30.00	$51.50
2021 Medicare Conversion Factor	$20.9343 (National)	$20.21 (Adjusted by CMS for South Carolina)	$33.5983
Ratio	143.31%	148.44%	153.28%

Private Health Insurance

FAIR Health collects data for anesthesia services from private payors (more than 40 payors contribute data for services performed in South Carolina) and uses this data to develop benchmarks, including benchmarks for anesthesia conversion factors. Insurers and administrators that participate in the FAIR Health Data Contribution Program are required to submit all of their data; they cannot selectively choose which data to contribute to FAIR Health. We are providing benchmarks for anesthesia conversion factors in two different ways:

- Charge benchmarks based on the non-discounted charges billed by providers before any network discounts are applied; and
- Allowed benchmarks based on imputed allowed amounts, which 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 are based on claims from July 2020 through June 2021 and allowed benchmarks are based on imputed allowed amounts from claims incurred from January through December 2020. These are the latest releases available at the time of developing this report.

			Percentiles													
Type	Release	Average	5th	10th	15th	20th	25th	30th	35th	40th	45th	50th	60th	70th	80th	90th
Billed Anesthesia	Nov 2021	131.40	50.03	63.20	72.79	80.52	88.96	98.98	107.72	113.57	119.37	124.83	142.17	164.58	175.54	194.37
Allowed Anesthesia	Aug 2021	61.80	23.98	29.94	34.94	39.21	43.05	47.70	51.37	54.11	56.63	58.94	65.30	76.50	84.43	92.47

The benchmarks for allowed anesthesia may be compared to the South Carolina conversion factor, as the allowed line represents the amounts allowed by payors under their network contracts. This aligns to what is paid to anesthesiologists and certified registered nurse anesthetists (CRNAs) for patients covered by workers' compensation.

In this analysis, a $30 conversion factor approximately aligns to the 10th percentile for private insurance. That means that 90% of the imputed allowed values in the FAIR Health database are equal to or greater than $30. The 50th percentile (conversion factor of $56.63) is the median conversion factor value in the private insurance data and the average allowed conversion factor benchmark is $61.80.

ASA Survey Results for Commercial Fees Paid for Anesthesia Services

The American Society of Anesthesiologists (ASA) publishes an annual study on conversion factors. FAIR Health downloaded the 2021 study from the ASA website at https://pubs.asahq.org/monitor/article/84/10/1/110713/ASA-Survey-Results-Commercial-Fees-Paid-for.

A copy of the ASA Monitor newsletter containing the 2021 survey is appended to this report.

According to the publication, the ASA anonymously surveys anesthesiology practices across the country, asking them to report the conversion factors for up to five of their largest commercial managed care contracts. This study publishes the results of that survey, which are normalized based on 15-minute time units. That is the same time unit used by South Carolina in the MSPM.

South Carolina practices are included in the Southeast Region in the ASA survey.

Conversion Factor	National		Southeast Region		South Carolina	
	2020	2021	2020	2021	2020	2021
Low	31.50	25.65	32.00	36.00	33.00	50.00
Median	73.00	78.00	78.68	92.00	72.00	73.30
Average	82.14	85.23	87.33	98.64	82.02	88.43
High	323.22	292.00	184.50	292.00	162.00	162.00

State Workers' Compensation Fee Schedules

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

State	Conversion Factor (per 15-minute time unit)
South Carolina	**$30.00**
Alabama	$57.63
Colorado	$44.18
Florida	$29.49
Georgia	$61.23
Kentucky	$78.53
Louisiana	$50.00
Maryland	$22.81
Mississippi	$50.00
North Carolina	$58.20 – first 60 min $30.75 – after 60 min
Oklahoma	$48.50
North Dakota	$66.87
Tennessee	$75.00
Virginia (6 regions)	$48.00 - $77.00

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

Summary

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

- The current South Carolina anesthesia conversion factor is $30 or 148.44% of the 2021 Medicare conversion factor for South Carolina and 143.31% % of the national Medicare conversion factor.
- The ratio of the South Carolina workers' compensation anesthesia to Medicare is slightly less than the 153.28% ratio of the conversion factor for other professional services ($51.50) in comparison to Medicare ($33.5983). However, the MAP amounts in the MSPM may also be limited by the +/- 9.5 percent cap on increases or decreases each year, and the formula-based conversion factors would not be applicable to those services.
- The $30 conversion factor is low in comparison to contracted amounts paid through private health insurance as reflected in FAIR Health benchmarks and ASA survey results.

    - The mean and median conversion factor benchmarks developed by FAIR Health, which are based on data contributions for services performed in South Carolina, are lower than the ASA survey results, which are based on up to five of the largest commercial contracts reported by anesthesiology practices responding to the ASA survey.
- South Carolina's $30 conversion factor falls within the range of conversion factors used by other states' workers' compensation programs; however, it is on the lower end of the range.

A copy of the ASA publication *ASA Survey Results for Commercial Fees Paid for Anesthesia Services – 2022* appears on the following pages.

American Society of Anesthesiologists®

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asamonitor.org

ASA Monitor®

THE LEADING SOURCE FOR PERIOPERATIVE HEALTH CARE NEWS

ASA Survey Results:

Commercial Fees Paid for Anesthesia Services – 2021

Stanley W. Stead, MD, MBA, FASA
Sharon K. Merrick, MS, CCS-P

ASA is pleased to present the annual commercial conversion factor survey for 2021. Each summer we survey anesthesiology practices across the country. We ask them to report up to five of their largest managed care (commercial) contract conversion factors (CF) and the percentage each contract represents of their commercial population, along with some demographic information. Our objectives for the survey are to report to our members the average contractual amounts for the top five contracts and to present a view of regional trends in commercial contracting.

Summary

Based on the 2021 ASA commercial conversion factor survey results, the national average commercial conversion factor was $85.23, ranging between $79.04 and $90.23 for the five contracts. The national median

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Caring for the Injured and Acutely Ill

Arman Dagal, MD, FRCA, MHA
Marc P. Steurer, MD, MHA, DESA
Michael J. Murray, MD, PhD, MCCM

Death and disability caused by injuries remain a significant public health issue. For both children and adults younger than age 45, traumatic injuries continue to be the leading cause of death in the United States. Injury-associated deaths furthermore lead to substantial economic consequences. Given the major impact that trauma and acute care can subsequently have, in the late 2000s a number of dedicated and enthusiastic anesthesiologists felt that a dedicated platform was needed to facilitate much -needed support and growth for this emerging subspecialty. This reflected the early casual inception of the Trauma Anesthesiology Society (TAS). The initial annual meetings were small and full of energy. Steady growth in subsequent years mirrored the need and desire of a

Continued on page 9

SPECIAL SECTION

Anesthesia in Low- and Middle-Income Countries 28–38

Guest Editors: Muhammad B. Rafique, MD, FASA; Lalitha Sundararaman, MD; and Elizabeth T. Drum, MD, FASA

Get Vaccinated and *Still* Get COVID-19

Richard Simoneaux
Steven L. Shafer, MD
Editor-in-Chief

Recent news reports describe high-profile "breakthrough" cases of COVID-19 in *fully vaccinated* individuals. In one prominent case, a fully vaccinated Australian socialite was infected and became a superspreader (asamonitor.pub/3k1YEUt). Over a busy weekend in Los Angeles, he transmitted COVID-19 to approximately 60 people.

Hospital breakout in Finland

In May 2021, a patient with COVID-19-associated pneumonia was admitted to the central hospital of the Tavastia Proper health district in Finland (*Euro Surveill* 2021;26:2100636). RT-PCR demonstrated the Delta variant. The patient was discharged four days later. Six days after discharge, two patients in the same ward developed symptoms of infection. Both tested positive for the Delta variant. The infection spread to three additional wards, infecting three patients and 21 health care workers. Some patients were transferred to other hospitals prior to identifying their exposure, transmitting the Delta variant to four other hospitals before the outbreak was identified.

By the time the outbreak was controlled, 58 patients were infected with the Delta variant. Contact tracing identified several patients infected by health care workers despite high vaccination rates and universal use of PPE. Eighteen patients died. Of the deceased patients, six were unvaccinated, 11 had received one dose, and one was fully vaccinated. All had underlying medical conditions.

There were 45 cases among health care workers. None had serious illness.

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PERIODICALS

Payment & Practice Management:
ASA Survey Results

Continued from page 1

increased to $78.00, ranging between $74.00 and $81.50 for the five contracts (Figure 1, Table 1). In the 2020 survey, the mean conversion factor ranged between $76.09 and $85.75, and the median ranged between $69.00 and $77.25. In contrast, the current national Medicare conversion factor for anesthesia services is $21.5600, or about 25.30% of the 2021 overall mean commercial conversion factor.

Figure 1 shows the frequency in percent and distribution of contract values. In order to show all the values in limited space, we are using a broken axis for all plots. The ranges plotted are $0-$200, with a break indicated by wavy lines and then $280-$300. The estimated normal distribution is the solid blue line. We have added a box-and-whiskers plot of the same data immediately below the histogram. The left and right whiskers delineate the minimum and maximum values. The box represents the interquartile range, the left edge of the box is the 25th percentile, the vertical line in the box is the median, and the right edge of the box is the 75th percentile. The solid diamond in the box is the mean.

Table 1 provides the overall survey results by reported managed care contract. As with previous surveys, we requested that participants submit data on five commercial contracts. Most practices submitted three or more contracts. The survey reflects valid responses from 219 practices in 47 states and D.C. The 2020 survey results included data from 238 practices in 43 states.

Table 1: National Managed Care Anesthesia Conversion Factors ($/unit), 2021

Conversion Factors	Contract 1	Contract 2	Contract 3	Contract 4	Contract 5	ALL
Mean	$79.04	$82.80	$87.67	$89.23	$90.23	$85.23
Low	$36.00	$25.65	$40.00	$35.00	$40.00	$25.65
25th Percentile	$63.76	$65.00	$64.50	$68.50	$66.00	$65.00
Median	$74.00	$75.43	$81.00	$82.00	$81.50	$78.00
75th Percentile	$85.37	$97.00	$104.42	$111.83	$114.97	$100.00
High	$186.90	$188.00	$184.50	$184.50	$292.00	$292.00
Number of Responses	219	210	192	167	145	933
Percentage of Managed Care Business	20.4%	10.0%	6.47%	4.70%	4.13%	10.0%

Methodology

The survey was disseminated in June and July 2021. To comply with the principles established by the Department of Justice (DOJ) and the Federal Trade Commission (FTC) in their 1996 Statements of Antitrust Enforcement Policy in Health Care, the survey requested from participants data that were at least three months old. In addition, the following three conditions must have been met:

1. There are at least five providers reporting data upon which each disseminated statistic is based, and
2. No individual provider's data represents more than 25% on a weighted basis of that statistic, and
3. Any information disseminated is sufficiently aggregated such that it would not allow recipients to identify the prices charged or compensation paid by any particular provider.

To comply with the statements, we are only able to provide aggregated data. Since some states did not respond, and other states had insufficient response rates, we are unable to provide specific data for all states. We term "Eligible States" those that submitted sufficient data to be compliant with DOJ and FTC principles and provide state-specific data for only those states. We have 18 Eligible States this year.

This is the eleventh year that we offered the survey electronically through the website www.surveymonkey.com. ASA urged participation through various electronic mail offerings, including ASA committee list serves, *ASAP* (all-member weekly e-mail digest), Vital Signs, the Monday Morning Outreach, communications to state component societies and our Anesthesia Administator and Executive (AAE) members, and via the ASA website.

The responses to the survey represented 233 unique practices. However, due to respondents providing incomplete data, we excluded 14 responses from the overall analysis. Our results are based on the data from 219 practices.

Results

Table 2 presents respondent information for 199 practices (20 practices did not provide us with complete practice demographics) in the analytic sample per Major Geographic Region as identified by the Medical Group Management Association (MGMA) (asamonitor.pub/30PLj9B). These regions are as follows:

- Eastern: CT, DE, DC, ME, MD, MA, NH, NJ, NY, NC, PA, RI, VT, VA, WV
- Midwestern: IL, IN, IA, MI, MN, NE, ND, OH, SD, WI
- Southern: AL, AR, FL, GA, KS, KY, LA, MS, MO, OK, SC, TN, TX
- Western: AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY

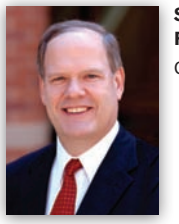
These 199 practices employ or contract with 7,213.6 full-time equivalent (FTE) physician anesthesiologists, 5,211.5 FTE nurse anesthetists, and 1,333.2 FTE anesthesiologist assistants (AAs). The practices also work with an additional 1,758.7 FTE nurse anesthetists and 264 FTE AAs for whom the practice does not directly pay compensation (i.e., facility hires or contracts the nurse anesthetist or AA).

The 219 practices reported a total of 933 managed care contracts. This is fewer than the 1,015 contracts reported last year.

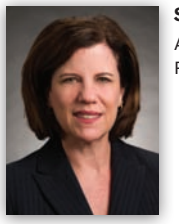
Table 3 provides the same respondent information by Minor Geographic Region as identified by the MGMA.

- CAAKHI: CA, AK, HI
- Eastern Midwest: IL, IN, KY, MI, OH
- Lower Midwest: AR, KS, LA, MO, OK, TX
- Mid Atlantic: DC, DE, MD, VA, WV
- North Atlantic: NJ, NY, PA
- Northeast: CT, MA, ME, NH, RI, VT
- Northwest: ID, OR, WA
- Rocky Mountain: AZ, CO, MT, NM, NV, UT, WY
- Southeast: AL, FL, GA, MS, NC, SC, TN
- Upper Midwest: IA, MN, ND, NE, SD, WI.

Nine hundred two (902) of the contracts are based upon a 15-minute unit, 20 upon a 12-minute unit, and 11 are based upon a 10-minute unit. None were based upon an 8-minute unit. We normalized all contract conversion factors



Stanley W. Stead, MD, MBA, FASA
CEO, Stead Health Group, Inc.



Sharon K. Merrick, MS, CCS-P
ASA Director of Payment and Practice Management.

Figure 1

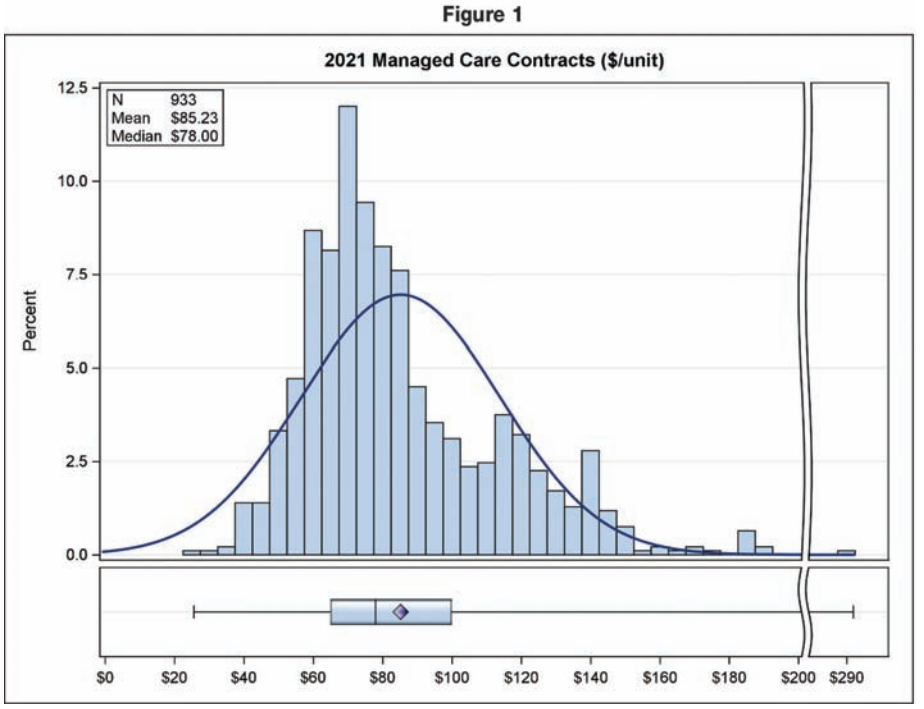


Table 2: Respondent Information by Major Geographic Region, 2021

Region	Practices	Cases	Mean Units/ FTE MD	Mean Units/ Case	FTE MD	FTE Nurse Anesthetist	FTE AA
Eastern	44	1,649,125	23,458	11.14	1,935.4	1,340.0 (1060.4)	529 (258)
Midwest	39	1,569,491	16,034	13.80	1,295.0	1,269.9 (268.3)	178.5 (1)
Southern	70	2,220,494	18,406	12.18	1,653.2	2,127.0 (362)	530.7 (4)
Western	46	1,404,286	7,951	12.87	2,330.0	474.6 (68)	95 (1)
ALL	**199**	**6,843,396**	**16,246**	**12.39**	**7,213.6**	**5,211.5 (1,758.7)**	**1333.2 (264)**

(Number in brackets indicate the number of non-employed FTEs).
Note: 199 of the 219 practices reported case, unit, or FTE data.

Table 3: Respondent Information by Minor Geographic Region, 2021

Region	Practices	Cases	Mean Units/ FTE MD	Mean Units/ Case	FTE MD	FTE Nurse Anesthetist	FTE AA
CAAKHI	12	492,010	9,026	14.78	876.0	121 (68)	1 (1)
Eastern Midwest	22	795,544	17,498	11.83	605.2	523 (178)	80 (0)
Lower Midwest	29	750,176	18,358	11.18	722.9	897.2 (56)	147 (0)
Mid Atlantic	11	363,279	14,813	10.78	273.0	280 (145)	26 (0)
North Atlantic	19	663,994	10,940	11.54	1,199.9	717.5 (167.8)	451 (258)
Northeast	8	148,406	12,306	10.63	237.3	92.5 (57.6)	31 (0)
Northwest	15	463,348	9,136	10.43	722.7	203.8 (0)	0 (0)
Rocky Mountain	19	448,928	6,242	13.73	731.3	149.8 (0)	94 (0)
Southeast	47	1,943,764	29,010	12.68	1,155.5	1479.8 (996)	404.7 (4)
Upper Midwest	17	773,947	14,438	16.53	689.8	746.9 (90.3)	98.5 (1)
ALL	**199**	**6,843,396**	**16,246**	**12.39**	**7,213.6**	**5211.5 (1758.7)**	**1333.2 (264)**

(Number in brackets indicate the number of non-employed FTEs).
Note: 199 of the 219 practices reported case, unit, or FTE data.

Table 4: Conversion Factor Adjustment Based on Time Units, 2021

Time Units	Time Units	Sum of Base and Time Units	CF Value Ratio based for 15-minute units
CMS PSPS 2019[1]			
Mean Base Units	5.2865		
Minutes/Case	64.0949		
10-minute time units	6.409	11.696	1.223
12-minute time units	5.341	10.628	1.112
15-minute time units	4.273	9.559	1.000

1. Mean Minutes per Case and Base Unit taken from is based on data from the 2019 CMS Physician/Supplier Procedure Summary (PSPS) Master File ("Master File"). https://www.cms.gov/NonIdentifiableDataFiles/06_PhysicianSupplierProcedureSummaryMasterFile.asp

Table 5: Respondents Having Flat Fee Components, 2021

	Flat Fee (Any)	Labor & Delivery	Cataracts	Endoscopy	Pain	Other
Eastern	23	20	0	8	0	4
Midwest	22	15	1	12	0	5
Southern	39	35	3	7	0	7
Western	19	12	3	2	1	10
Total	**103**	**82**	**7**	**29**	**1**	**26**

Others include cosmetic and plastic surgery, bundled surgical procedures, total joint replacement, spine surgery, general surgery, organ transplant, radiation oncology, invasive monitoring, and open heart surgery.

Figure 2

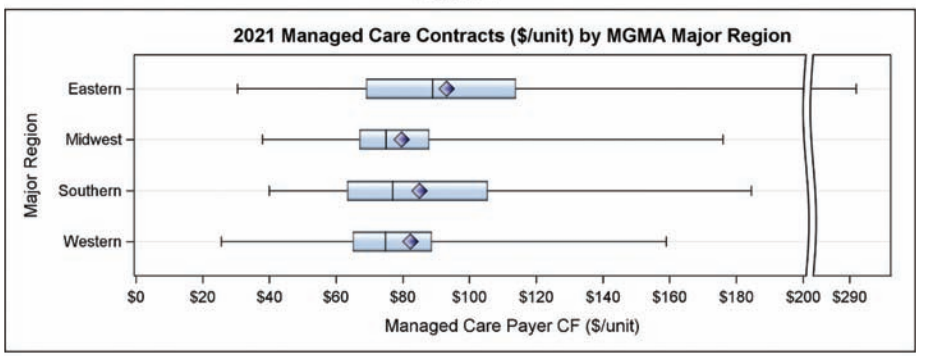


Table 6: Major Region Managed Care Anesthesia Conversion Factors ($/unit), 2021

	Contract 1	Contract 2	Contract 3	Contract 4	Contract 5	ALL
Eastern	n = 49	n = 48	n = 46	n = 38	n = 35	n = 216
Mean	$83.66	$90.45	$97.07	$96.62	$101.29	$93.16
Low	$36.00	$30.48	$50.36	$35.00	$40.00	$30.48
25th Percentile	$68.00	$68.00	$77.00	$76.00	$60.00	$69.00
Median	$76.50	$88.00	$94.51	$92.43	$89.00	$89.00
75th Percentile	$96.30	$103.50	$122.00	$117.00	$130.50	$113.99
High	$186.90	$188.00	$184.00	$170.00	$292.00	$292.00
Midwest	n = 44	n = 42	n = 39	n = 34	n = 28	n = 187
Mean	$77.59	$80.23	$78.06	$80.96	$82.71	$79.66
Low	$46.60	$38.00	$48.00	$38.00	$42.00	$38.00
25th Percentile	$63.76	$68.86	$65.00	$67.63	$70.63	$67.00
Median	$72.00	$74.50	$75.00	$74.50	$81.48	$75.00
75th Percentile	$79.00	$91.00	$86.00	$87.00	$96.36	$88.00
High	$176.00	$145.00	$131.75	$128.33	$124.00	$176.00
Southern	n = 77	n = 74	n = 66	n = 57	n = 49	n = 323
Mean	$77.97	$82.31	$88.29	$92.17	$87.43	$85.01
Low	$50.00	$40.00	$40.00	$40.00	$40.00	$40.00
25th Percentile	$63.00	$65.00	$62.00	$67.00	$62.00	$63.34
Median	$75.00	$75.00	$78.25	$85.00	$85.00	$77.00
75th Percentile	$86.03	$97.00	$116.10	$121.00	$116.99	$105.53
High	$162.00	$139.50	$184.50	$184.50	$139.50	$184.50
Western	n = 49	n = 46	n = 41	n = 38	n = 33	n = 207
Mean	$77.42	$77.98	$85.28	$84.82	$89.03	$82.31
Low	$45.81	$25.65	$50.03	$50.00	$52.00	$25.65
25th Percentile	$65.00	$61.50	$64.00	$70.00	$71.00	$65.00
Median	$71.15	$73.08	$79.00	$76.97	$79.75	$74.85
75th Percentile	$78.34	$85.00	$96.74	$89.40	$89.00	$88.75
High	$159.00	$150.00	$150.00	$150.00	$150.00	$159.00

with 10- and 12-minute time units to the typical 15-minute time unit using an adjustment factor of 1.223 for 10-minute units and 1.112 for 12-minute units (Table 4).

The adjustment factors are calculated as ratios based on the mean time and mean base units per case. To make these calculations, we have used the CMS Physician/Supplier Procedure Summary (PSPS) data set, which represents over 21 million anesthesia claims (asamonitor.pub/3jr8COX).

The mean time was 64.0949 minutes, and mean base units per case were 5.2865 base units. Making the same calculations described above, the adjustment factors are similar to last year: 1.2404 for 10-minute units and 1.1202 for 12-minute units. Of note, the mean time has decreased by 8.3 minutes since last year's mean time of 72.405 minutes.

Figure 3

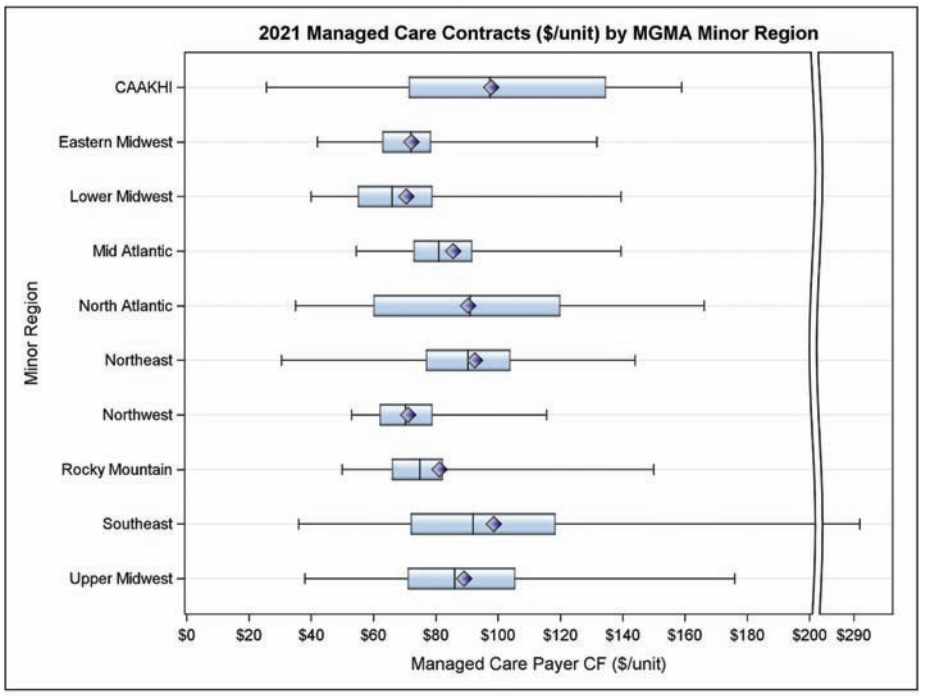


Table 7: Minor Region Managed Care Anesthesia Conversion Factors ($/unit), 2021

MGMA Minor Region	Contracts	Low	25th Percentile	Median	Mean	75th Percentile	High
CAAKHI	58	$25.65	$71.36	$97.37	$97.80	$134.69	$159.00
Eastern Midwest	108	$42.00	$62.88	$72.00	$72.19	$78.50	$131.75
Lower Midwest	137	$40.00	$55.00	$66.00	$70.55	$79.00	$139.50
Mid Atlantic	49	$54.50	$72.90	$81.00	$85.60	$91.75	$139.50
North Atlantic	89	$35.00	$60.00	$91.05	$90.40	$120.00	$166.20
Northeast	47	$30.48	$76.88	$90.37	$92.58	$104.00	$144.00
Northwest	73	$53.00	$62.00	$70.32	$71.14	$79.00	$115.62
Rocky Mountain	76	$50.00	$65.94	$74.93	$81.21	$82.34	$150.00
Southeast	215	$36.00	$72.00	$92.00	$98.64	$118.50	$292.00
Upper Midwest	81	$38.00	$71.00	$86.08	$89.11	$105.58	$176.00

Groups continue to report flat fee contracts for certain procedures. Table 5 shows respondents who identified that they had flat fee contracts. One hundred three of the 183 groups (56.3%) responding to this question negotiated at least one flat fee contract. Eighty-two of the 103 groups that reported having flat fees (44.8%) have flat fee contracts for Labor and Delivery. This is very similar to last year's rate of 44.3%.

Table 6 reports the conversion factor by MGMA Major Region. Contract 1 reflected the highest percentage of the reported commercial business, Contract 2 reflected the second highest percentage, and so on. Thus, when looking at the data, you can see that Contract 1 not only reflects the greatest number of responses (219) but also the highest average percentage of managed care business (20.4%, Table 1). We also reported the total number of responses for each contract in Table 1. Figure 2 shows the contract data for each major region as a box-and-whiskers plot.

We had a sufficient data sample to provide detailed information for all 10 MGMA Minor Regions (Figure 3). Table 7 shows contract data for the minor regions.

This is the seventh year we are presenting state-specific data. Although we had respondents from 47 states and D.C., only 18 states were identified as eligible states (Figure 4, Table 8). Eligible states were those that complied with the DOJ and FTC requirements, listed above. We believe by providing this data, we can encourage more participation in the 2022 CF study and increase the state-level detail of our reporting.

Observations

Based on our review of the analysis, the most interesting findings include:

- The national average conversion factor increased to $85.23, while the median, $78.00, and the range of mean values increased from a range of $76.09-$85.75 in 2020 to a range of $79.04-$90.23 in 2021.
- As was the case in our 2018-2020 surveys, the Eastern Region has the highest mean this year. The Eastern Region mean in 2020 was $97.85, and this year it is $93.16.
- The highest conversion factor reported was $292.00. In 2020, the highest conversion factor reported was $323.22.
- In the 2020 survey, the Medicare conversion factor was 27.03% of the overall commercial mean. In this year's survey, it has fallen to 25.30%.

Conclusions

Our sample size for this year's survey was slightly less than last year but still represents a significant portion of U.S.

Continued on next page

Payment & Practice Management:
ASA Survey Results

Continued from previous page

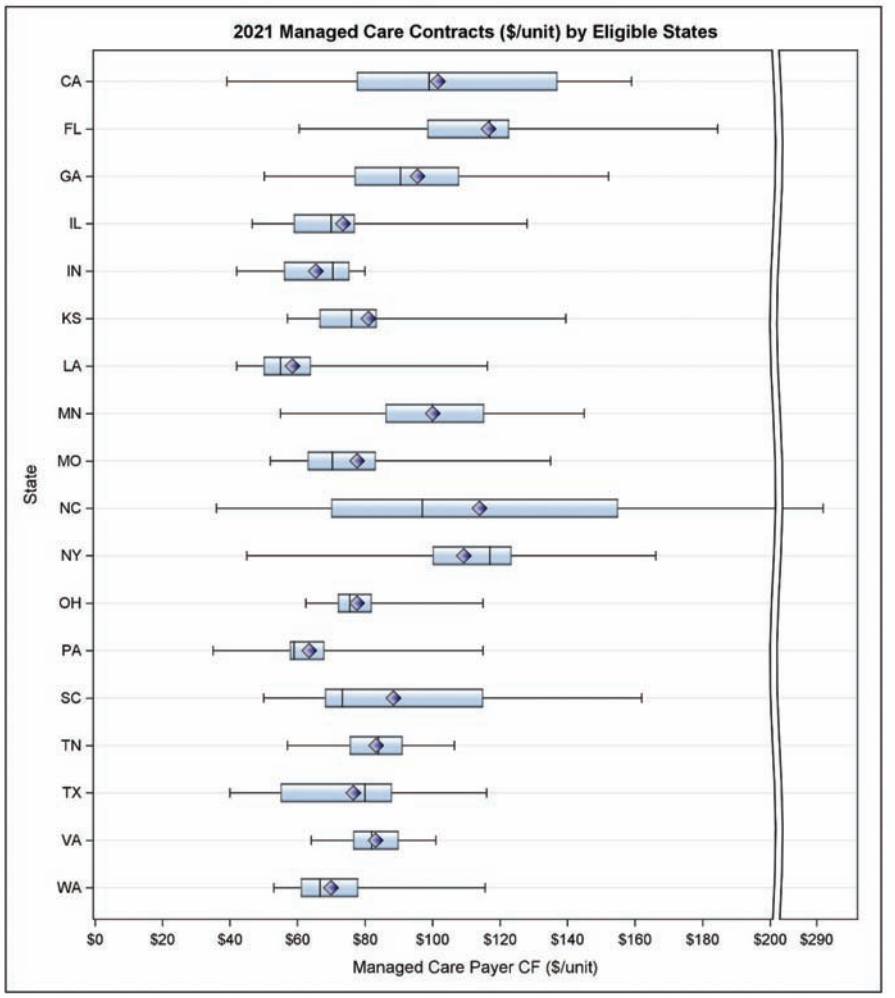
practicing anesthesiologists, nurse anesthetists, and AAs. We were pleased to have respondents report across a broad geographic basis, 47 states and D.C., allowing us to provide detailed regional responses. The number of practices reporting allowed us to report state-specific data from 18 states. Most practices included complete demographic information, and we are hopeful that this trend will continue and all respondents will supply complete information in future surveys.

We will continue to monitor trends in the commercial conversion factor survey results and will launch the survey again in June 2022. It is important that as many practices as possible participate in the 2022 survey to help us obtain an accurate representation of the anesthesia commercial conversion factor. We hope that a significant growth in participants will allow us to publish data for every state. We look forward to your future participation and thank all of the practices that contributed to the 2021 results. ■

Table 8: Eligible States Managed Care Anesthesia Conversion Factors ($/unit), 2021

State	Contracts	Low	25th Percentile	Median	Mean	75th Percentile	High
CA	50	$39.10	$77.59	$99.00	$101.59	$137.03	$159.00
FL	56	$60.50	$98.50	$116.99	$116.59	$122.72	$184.50
GA	41	$50.16	$76.92	$90.53	$95.58	$107.92	$152.20
IL	21	$46.62	$58.92	$70.00	$73.49	$77.00	$128.00
IN	24	$42.00	$56.00	$70.50	$65.45	$75.43	$80.00
KS	28	$57.00	$66.50	$76.00	$81.03	$83.50	$139.50
LA	33	$42.00	$50.00	$55.00	$58.52	$64.00	$116.25
MN	35	$55.00	$86.08	$100.00	$100.07	$115.28	$145.00
MO	24	$52.00	$63.00	$70.35	$77.66	$83.25	$135.00
NC	31	$36.00	$70.00	$97.00	$113.93	$155.00	$292.00
NY	41	$45.00	$100.06	$117.00	$109.27	$123.43	$166.20
OH	46	$62.50	$72.00	$75.50	$77.63	$82.00	$115.00
PA	37	$35.00	$57.75	$59.00	$63.48	$68.00	$115.00
SC	45	$50.00	$68.15	$73.30	$88.43	$115.00	$162.00
TN	20	$57.00	$75.50	$84.00	$83.30	$91.15	$106.50
TX	27	$40.00	$55.00	$80.00	$76.54	$88.00	$116.10
VA	23	$64.10	$76.50	$82.00	$83.13	$90.00	$101.00
WA	53	$53.00	$61.00	$66.70	$69.94	$78.00	$115.62

Figure 4



Summary of Stakeholder Comments
Commission Business Meeting January 24, 2022
Prepared by FairHealth and WCC Staff

Organization	Category	Topic	Feedback	Notes
SC Orthopaedic Association	Medical Services Provider	Fee schedule rates (No Reference)	Single conversion factor and +/- 9.5% cap impediment to physicians participating in WC	Cannot be addressed by the MSPM; requires statutory changes; look forward to working on these issues which cannot be addressed in the MSPM
SC Orthopaedic Association	Medical Services Provider	Copies of records and reports (Ref. Page 1)	Agree that additional study is warranted	
SC Orthopaedic Association	Medical Services Provider	Medical testimony/IMEs (Ref. Page 3)	Supports the proposed updates	
Palmetto Pain Management	Medical Services Provider	Topical compounds (Ref. Page 5)	Opposes language about the use of "therapeutically equivalent over the counter medications when available in lieu of a prescription or custom compound"	If the physician does not believe an OTC medication is therapeutically equivalent" for a particular patient, they can include this explanation with the claim to justify the expense for a prescription medication or custom compound
Hubert Woods, Esq	Attorney	Medical testimony/IMEs (Ref. Page 3)	Opposes language about medical testimony related to IMEs not being subject to the fee schedule MAP; this could cause fees to be so high as to make it cost prohibitive go cross examine the provider offering testimony	Does this require a review of law and previous decisions? Issue is that medical testimony related to IMEs can be considered as not being a medical service, and as such, not governed by the fee schedule

Organization	Category	Topic	Feedback	Notes
Physicians Research Institute (PRI)	Medical Services Provider (represents SC Medical Association, concentrating on WC issues)	Topical compounds (Ref. Page 5)	States that the ad hoc committee rejected this proposal; 1. Proposes to exclude "Payment for prescription-strength ~~topical medications and~~ topical compounded medication, shall be the lesser of:" 2. Wants to strike the section about prescription therapeutically equivalent OTC medications as is it a "legally required treatment mandate"	1. Relates to the SCOA change above; if the commission wants to address prescription topical patches, this should be moved to another section. 2. This was not intended to be a treatment mandate, but to encourage prescribing lower cost medications when a therapeutic equivalent exists. If the physician feels a prescription topical or compound topical is needed, they would provide a justification based on the medical needs of the patient
Physicians Research Institute (PRI)	Medical Services Provider (represents SC Medical Association, concentrating on WC issues)	OTC drugs (Ref. Page 4)	Opposes introduction of language to reimburse non-prescription strength patches at the lesser of cost + 20% or $70 for a 30-day supply. Also notes that this proposal was withdrawn when discussed at the ad hoc committee	The Commission was not required to propose only changes endorsed by the ad hoc committee - other proposals such as telemedicine were not discussed at all by the committee. At the hearing, the committee chair and other members indicated their support of these changes, though some language modifications may be warranted, if the Commission decides to include this change.
Optum	Pharmacy benefit manager	OTC drugs (Ref. Page 4)	Supports the change but 1. requests a language change to clarify that "provider" is intended to cover providers who dispense these materials from their office. 2. asks if the provider should make a copy of the invoice to support reimbursement.	

Organization	Category	Topic	Feedback	Notes
Optum	Pharmacy benefit manager	Topical compounds (Ref. Page 5)	1. Similar to SCOA and Palmetto, Optum would like to separate the language for prescription strength topicals from compounds and provided. They do not want to limit topical compounds to the $240 per 30-day supply, and only apply the cost per component. 2. They propose loosening the language about therapeutic equivalents to: "Physicians ~~shall~~ are urged to prescribe therapeutically equivalent ~~over the counter~~ medications or over-the-counter medications when available in lieu of a prescription-strength topical or custom compound.	
SC Medical Association	Medical services provider	OTC drugs (Ref. Page 4)	Supports PRI's feedback; also objects that drug language was proposed even though it was "withdrawn" from the ad hoc committee recommendations	
SC Medical Association	Medical services provider	Topical compounds (Ref. Page 5)	Objects that physicians should prescribe "therapeutically equivalent over the counter mediations first. "Don't think the fee schedule should mandate a physician's clinical judgement."	As noted above, we could include language for the physician to justify use of equivalents based on medical necessity for a particular patient

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Workers' Compensation Commission

MEMORANUM

TO: **COMMISSIONERS**

FROM: **Gary Cannon**
Executive Director

DATE: **February 22, 2022**

RE: **Increase in License Fee for Fee Schedule**

Attached is a letter from Donna Smith requesting an increase in the license fee FairHealth charges users of the Medical Services Provider Manual (Fee Schedule).

The 2019 Agreement between the Commission and FairHealth, provides they may charge "reasonable fees for the Fee Schedules." The fees will be determined by mutual agreement of the parties. FairHealth would like to begin offering stakeholders the ability to order the Fee Schedule on March 1, 2022. See attached letter from Donna Smith.

Below is a comparison of the current fee, the proposed fee and fees charged by FairHealth in other states.

	SC 2021 fees	Adjusted Proposed 2022 fees	Other states
Hardcopy	$150	$285	$225 - $285 or higher
PDF	$150	$210	$190-$210
Additional User	$60	$60	$60-$65
Electronic	$350	$400	$350-$400 increasing to $400-$425
Additional User	$60	$60	$60-$65

FAIR Health®
Know Your Source

February 16, 2022

Dear Chairman Beck and Commissioners,

As you know, FAIR Health is compensated for its' work on the South Carolina Medical Services Provider Manual solely by the fees users pay when they order the fee schedule. FAIR Health makes the fee schedule easily available to stakeholders on a website where they can order, pay for, and immediately download electric formats of the fee schedule. Hard copy orders are mailed out as orders are received. FAIR Health would like to adjust the user license fees to cover the work provided on an annual basis. FAIR Health assists the Commission by providing research, analysis, monitoring of AMA CPT and CMS HCPCS codes, analyzing paid data and modeling rate tables based on conversion factor changes. We also provide medical and clinical review as needed as well as review and research stakeholder and advisory committee feedback. In addition to the detailed support from clinical, analytic, business and web development staff in support of the fee schedule, there are additional costs to produce the hardcopy binders. We are seeking approval of an increase to fee schedule costs to better support FAIR Health's work in assisting the Commission to update and distribute the fee schedule on an annual basis

The FAIR Health team is committed to continuing our work. We respectfully submit the following chart of license fees for your approval. Please let us know if you have any questions.

Sincerely,

Donna Smith

Chief Client Officer

Proposed 2022 Fee Schedule license fees and definition of user:

Definition:

Licensing fee schedules is based on the number of users in your organization. A User is an individual who uses information from the ground rules and/or rate tables to make decisions about, to charge or to pay for services related to claims for injured workers.

Examples:

- A physician practice using the fee schedule to bill for services provided to a patient who was injured at work
- Anyone adjudicating a bill whereby the fee schedule is used to price services
- A business analyst interpreting rules and regulations for automation into a software program for bill adjudication, analysis, reporting or other needs
- A claims processor at an insurer/TPA/bill review agency or employer who is reviewing a workers' compensation bill to evaluate appropriate review or payment for medical services
- Reviewing a bill for the purposes of adjusting or completing a potential re-evaluation due to errors, a state or hearing directive or a provider dispute
- Reviewing the fee schedule information for purposes of preparing litigation, attending a hearing or arbitration

The following example would NOT be considered Users of the fee schedule:

- IT staff who load the fee schedule to a company's computer system or software program for use by claims processors or bill reviewers, running reports or other IT functions

User Fees:

2022 South Carolina Medical/facility fee schedule	**Fee per order type**
Hardcopy Book printed	**$ 285**
PDF downloadable format	**$ 210**
per additional user	**$ 60**
Electronic file format *(contains both a spreadsheet with rate tables and a PDF version of the complete fee schedule)*	**$ 400**
per additional user	**$ 60**