A G E N D A

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

1333 Main Street, 5th Floor
Columbia, South Carolina 29201

February 22, 2021, 10:30 a.m.

The meeting will be conducted electronically via Zoom with the Commissioners participating from different locations. The meeting agenda was posted prior to the meeting and proper advance notice was made in compliance with requirements in the Freedom of Information Act. Individuals who want to attend the meeting may do so by contacting Gary Cannon, Executive Director at GCannon@wcc.sc.gov.

1.	CALL TO ORDER	CHAIRMAN BECK
2.	APPROVAL OF AGENDA OF BUSINESS MEETING OF FEBRUARY 22, 2021	CHAIRMAN BECK
3.	APPROVAL OF MINUTES OF THE BUSINESS MEETING OF JANUARY 25, 2021 (Tab 1)	CHAIRMAN BECK
5.	GENERAL ANNOUNCEMENTS	MR. CANNON
6.	APPLICATIONS FOR APPROVAL TO SELF-INSURE (Tab 2)	MS. BOGGS
7.	DEPARTMENT DIRECTORS' REPORTS	
	Human Resources (Tab 3)	MS. STUART
	Information Services (Tab 4)	MS. SPRANG
	Insurance and Medical Services (Tab 5)	MR. DUCOTE
	Claims (Tab 6)	MS. SPANN
	Judicial (Tab 7)	MS. BRACY
8.	DEPARTMENT OF VOCATIONAL REHABILITATION Monthly Report (Tab 8)	MR. CANNON
9.	EXECUTIVE DIRECTOR'S REPORT (Tab 9)	MR. CANNON
10.	FINANCIAL REPORT (Tab 10)	MR. CANNON
11.	OLD BUSINESS Medical Services Provider Manual (Tab 11)	CHAIRMAN BECK
12.	NEW BUSINESS	CHAIRMAN BECK
13.	EXECUTIVE SESSION An Executive Session is requested to discuss a contractual matter, a judicial procedural matter, and receive a legal briefing from the General Counsel	CHAIRMAN BECK
13.	ADJOURNMENT	CHAIRMAN BECK

1	Approval of Minutes of the Business Meeting of January 25, 2021
2	Self-Insurance
3	Human Resources
4	Information Services
5	Insurance and Medical Services
6	Claims
7	Judicial
8	Vocational Rehabilitation
9	Executive Director's Report
10	Financial Report
11	Medical Service Provider Manual

Tab 1

THE
SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION
MINUTES OF THE BUSINESS MEETING

January 25, 2021

A Business Meeting of the South Carolina Workers' Compensation Commission was conducted electronically via ZOOM on Monday, January 25, 2021 at 10:30 AM. The meeting agenda was posted prior to the meeting and proper advance notice was made in compliance with requirements in the Freedom of Information Act. The following Commissioners participated electronically via ZOOM from different locations:

T. SCOTT BECK, CHAIRMAN
SUSAN S. BARDEN, VICE CHAIR
R. MICHAEL CAMPBELL, II, COMMISSIONER
MELODY L. JAMES, COMMISSIONER
GENE MCCASKILL, COMMISSIONER
AISHA TAYLOR, COMMISSIONER
AVERY B. WILKERSON, JR., COMMISSIONER

Also participating electronically from different locations via ZOOM were: Gary Cannon Executive Director; Keith Roberts, General Counsel; Sandee Sprang, Information Technology Director;; Amy Bracy, Judicial Director; Wayne Ducote; Insurance & Medical Services, Claims Director; Emillie Boggs, Self-Insurance Director; David Durant, Attorney; Bridgette Amick, Medical Services; Amy Proveaux, Executive Assistant. Bonnie Anzelmo, Injured Workers Advocates; Chris O' Donnell and Dr. Joel Brill, Fair Health; April Watts , Lexington Health, Inc., were also present.

Chairman Beck called the meeting to order at 10:33 AM.

AGENDA

Commissioner Barden moved that the agenda be approved. Commissioner McCaskill seconded the motion, and the motion was approved.

APPROVAL OF MINUTES – BUSINESS MEETING OF December 14, 2021

Commissioner Barden moved to that minutes of the Business Meeting be approved. Commissioner Taylor seconded the motion, and the motion was approved.

GENERAL ANNOUNCEMENTS

No general announcements

APPLICATIONS FOR APPROVAL TO SELF-INSURE

Self-insurance applications were presented by Emillie Boggs, Self-Insurance Director. Ten (10) prospective members of two (2) funds was presented to the Commission for approval.

New Applications:

SC Municipal Self Insurance Trust Fund
City of Hanahan

South Carolina Home Builders SIF
Acme Construction LLC
Camperos Construction LLC
Extra Mile Home Solutions, LLC
JAG Contractors, LLC
Mart Construction LLC
Porch Conversions of Seneca, LLC
Revive Air LLC
Rolina Homes, LLC
Weldon Construction Company LLC

After examination of the applications, it was determined that each complied with the Commission's requirements and each was recommended for approval. Commissioner Wilkerson made a motion to approve all members and funds application to self-insure, and Commissioner Barden seconded the motion. The motion was approved.

Lexington Health Inc.

Ms. Boggs presented the self-insure application for the Lexington Health Inc. Ms. Boggs recommended that Lexington Health Inc., be approved for self-insure. Commissioner Barden made the motion to accept Ms. Boggs' recommendation with the contingencies that Ms. Boggs described. Commissioner Barden seconded the motion. The motion was approved.

DEPARTMENT DIRECTORS' REPORTS

The Department Directors submitted to the Commission in written form and included in the minutes.

No questions, concerns, or comments were made by the Commission.

VOCATIONAL REHABILITATION

Executive Director, Gary Cannon gave a brief overview of the report.

EXECUTIVE DIRECTOR'S REPORT

There were no questions from the Commission.

ADMINISTRATION – FINANCIAL REPORT

Gary Cannon, Executive Director submitted the Financial Report to the Commission in written form. Mr. Cannon pointed out a few highlights from the report.

OLD BUSINESS

No new business.

NEW BUSINESS

Medical Services Provider Manual

Mr. Cannon presented the Commission with his memorandum and supporting documentation for the recommended changes from Fair Health. Mr. Cannon informed the Commission that documents would be posted on the website, an Advisory Notice would be sent to all stakeholders giving notice of the public comment period.

It was recommended that the Commission schedule a time at the February 2021 Business Meeting to receive public comments on the proposed changes. Finally, a recommendation was made for the Commission to approve any changes to the Conversion and changes to the policy text in the Medical Service Provider Manual at the March Business Meeting with an effective date of April 1, 2021.

ADJOURNMENT

Commissioner Barden made the motion to adjourn. Commissioner McCaskill seconded the motion, and the motion was approved.

The January 25, 2021, meeting of the South Carolina Workers' Compensation Commission adjourned at 10:49 a.m.

Reported February 17, 2021
Amy Proveaux
Office of the Executive Director

Tab 2

Tab 3

State of South Carolina

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Workers' Compensation Commission

TO: Gary Cannon

FROM: Alexa Stuart

DATE: January 29, 2021

SUBJECT: Monthly Human Resources Report for February 2021 Business Meeting

This report summarizes the activities of Human Resources during the period of January 1, 2021 through January 29, 2021.

In January the Commission had 50 full time employees. We have one part-time employee and two legal interns.

- **New Hires:** None
- **Separations or Retirements:** One
- **FMLA Leaves:** Two

In January I processed 13 SCEIS Leave Pool Requests. I created leave statements for every employee and distributed them. I processed 1 separation in SCEIS and posted the opening on the website. In SCEIS, I had 16 SCEIS transactions and 18 SCEIS time transactions. Payroll and time reports were run as scheduled. I distributed W2s to all employees. I did 3 salary analysis with detail.

I revised the Commission's organizational chart and I ran the vacancy report. We sent 32 "All Agency" emails during the month. We processed 3 travel reports in the month of January. I responded to benefit questions and made changes. I received and reviewed 948 emails and sent 553 emails.

We had 1 minor building issues. Corrected parking invoices and submitted them for payment. I corrected the information in the parking company's records. The names were incorrect.

Since March 23rd, I have been reporting to the State HR department data regarding who was working onsite, telecommuting, and taking leave. This is done daily. On a weekly basis I reported any new cases of COVID to State HR.

I coordinated the sanitization of our offices and the common areas since we had a report that an employee who had been working onsite contracted COVID. I gathered and documented the information regarding the COVID report. We continued to obtain and maintain the necessary PPE to safely work onsite as needed. We have plenty of PPE in stock. We provided information on what we have ordered since July 1, 2020 to management for statewide reimbursement.

I continued to track employees work activities from home. Once a week, I receive lists of the daily activities of those working from home. I take that data, summarize daily activities into a weekly summary by employee and add it to a spreadsheet for management's review.

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Workers' Compensation Commission

To: Gary Cannon
SCWCC Executive Director
From: Sandee Sprang, IT Director
Date: February 17, 2021
Subject: IT Department February 2021 Full Commission Report

This report summarizes the activities and accomplishments of departmental projects and initiatives for the IT department during January 2021.

I. Systems Operations, Maintenance and Support

EDI

While we completed the migration of all EDI trading partner accounts in December of 2020, additional security and access issues were completed in January. The team worked with multiple EDI Trading Partners identify specific reasons for data rejections on Claims and POC submissions. We continue our participation in IAIABC conference calls for: Jurisdictions Only meetings, EDI Claims Committee and the XML Taskforces.

Progress

The IT team continues to work on establishing both production and development environments for our Progress system and we are working to re-license the product since support and maintenance had been discontinued in anticipation of the KERMIT project. Liz and Duane continue to provide standard support in producing X-files for the Compliance department as well as support for invoice and check reconciliation issues to end users.

Systems Support

Jason continues to support staff with hardware/software needs and building efficiencies in our work from home processes. He also completed several additional required account management changes related to security and access cards.

The DUO multifactor authentication implementation was completed in January; all staff are enrolled, and all Office 365 and SCEIS DUO policies are enforced.

DTO security changes required after-hours support on 3 weekends in January.

Reporting

Kim completed the COVID report as part of our monthly reporting schedule. Liz made some enhancements to the Claims report developed for outstanding carrier fines. Additionally, we generated several Open Claims reports and Outstanding Carrier Fines for external stakeholders and provided Compliance reports for internal staff.

Hardware
Jason began the mobile device upgrade and continued his work on the laptop replacement. His next steps are to evaluate Dell and HP's laptops.

II. Projects, Enhancements and Development

Legacy Modernization
We continue our working engagement with Microsoft as part of the gap analysis of our KERMIT project.

Tab 5

State of South Carolina

Workers' Compensation Commission

To: Mr. Gary Cannon
SCWCC Executive Director

From: Wayne Ducote, Jr.
IMS Director

Date: 18-Feb-21

Subj: Insurance and Medical Services Department
January 2021 Full Commission Report

Please find attached information provided to summarize the status and workflow of initiatives currently underway within the Insurance and Medical Services (IMS) Department.

In addition to the statistical data provided, please be advised of the following:

Compliance Division	1. Reviewing revenue metrics / projections. 2. Working with staff to review workflow processes and additional training opportunities. 3. Continuing to explore outreach opportunities with stakeholders.
Coverage Division	1. Working with staff to review workflow processes and explore opportunities to enhance service provision. 2. Lapse in Coverage: 25 new registrants; 0 notifications sent.
Medical Services	1. Working with Fair Health on 2021 MSPM updates. 2. Two Medical Bill Reviewer certifications were completed and processing four Medical Bill Reviewer certifications and renewals. 3. Two medical bill pricing reviews were done for the month of January.

While this summary is in no way all-inclusive, it may serve to assist you and our Commissioners in understanding the key initiatives underway in the IMS Department and provide measures by which the Department's effectiveness can be gauged. IMS welcomes any guidance that you and/or our Commissioners can provide concerning our performance and direction.

Employer Rule to Show Cause Hearings and Compliance Activity

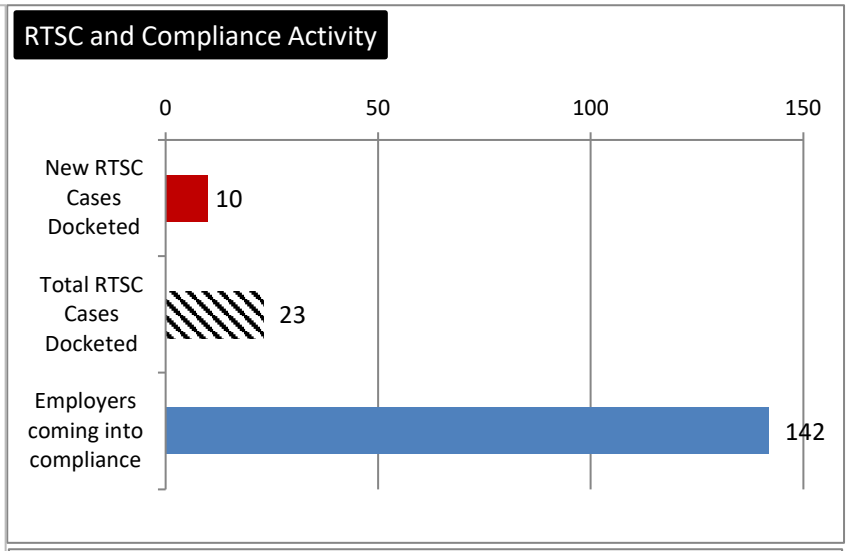
The Compliance Division docketed 4 new RTSC cases and 8 total RTSC cases in the month of January. And, compelled 16 South Carolina employers to come into compliance with the Act. Year to date, 10 new RTSC cases and 23 total RTSC cases have been docketed.

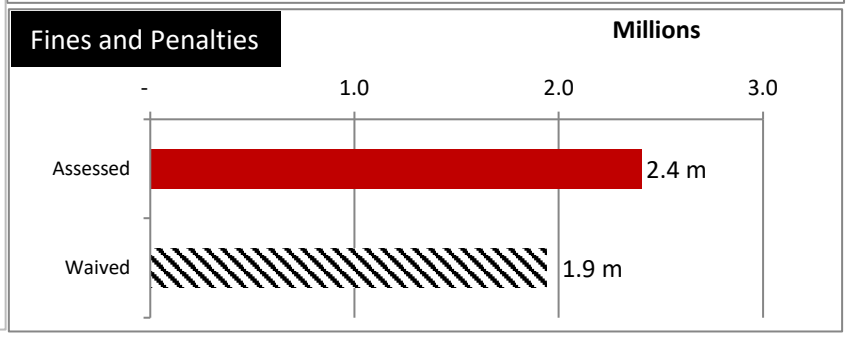
Employers Obtaining Coverage

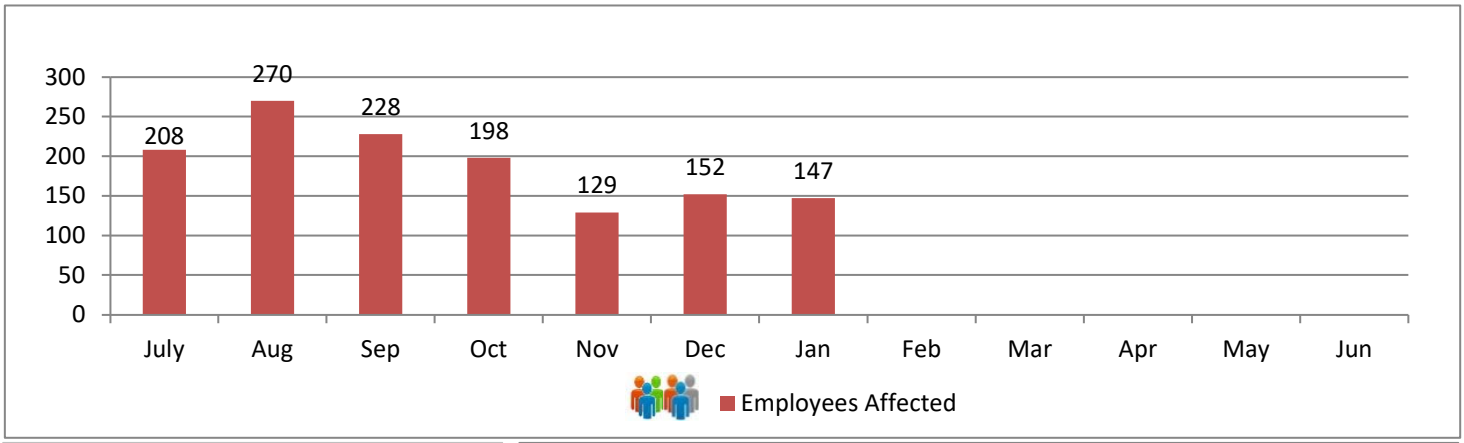
Year to date, the Compliance Division has compelled 142 South Carolina employers to come into compliance with the Act. In so doing, approximately 1,332 previously uninsured workers are now properly covered.

Penalties Waived

Although the Division has assessed $2.4 m in fines this fiscal year, $1.9 m have been waived or rescinded as employers have either obtained insurance coverage or were found not to be subject to the Act.

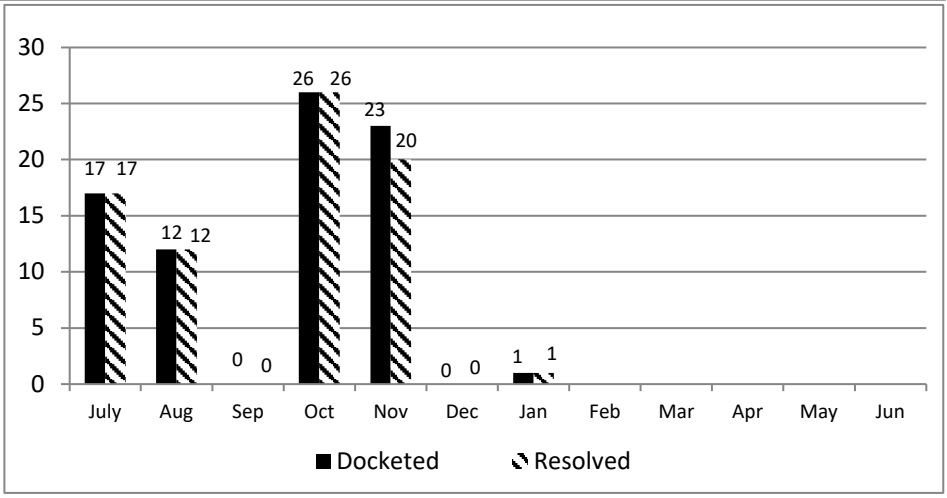






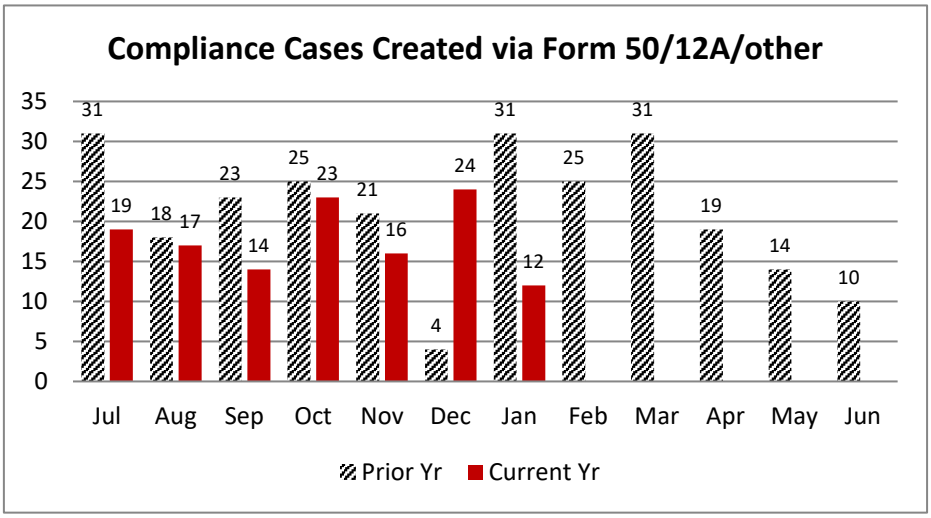
Carrier Rule to Show Cause Hearings

The Compliance Division manages the Rule to Show Cause process involving the recovery of outstanding carrier fines and penalties . In the month of January 2021, 1 carrier RTSC case was docketed; 1 case was resolved. The one case was for a self-insured and payment of past due self-insurance taxes in the amount of $283,570.
Year to date, a total of 79 carrier RTSC cases have been docketed, 76 cases for a total of $89,122 have been resolved.



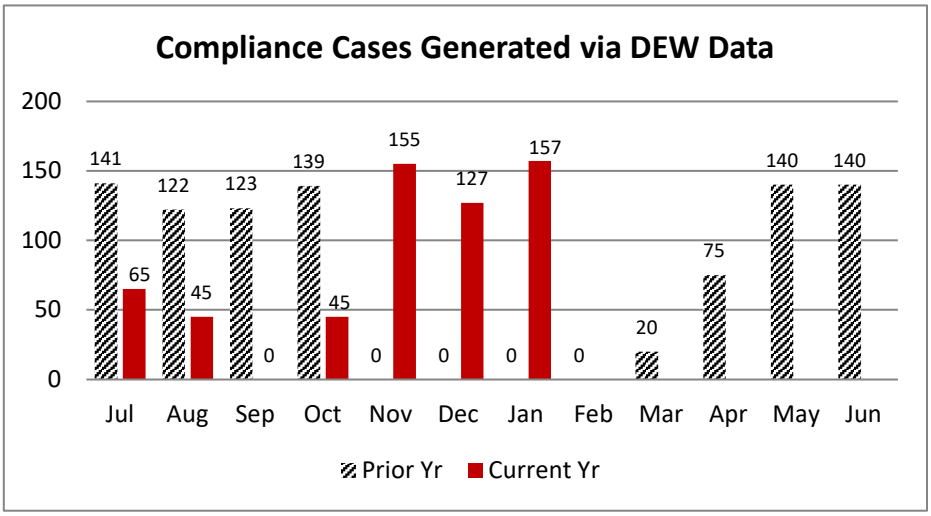
In January 2021, 12 compliance files were created from the combined filings of Form 50's, 12A's, and stakeholder reporting involving uninsured employers.

YTD vs. Prior Year total (252): 50%
Jan 2020 to Jan 2021: 39%
Current Yr End trend: 85% of 2019-2020
YTD 2020-2021 v. YTD 2019-2020: 82%

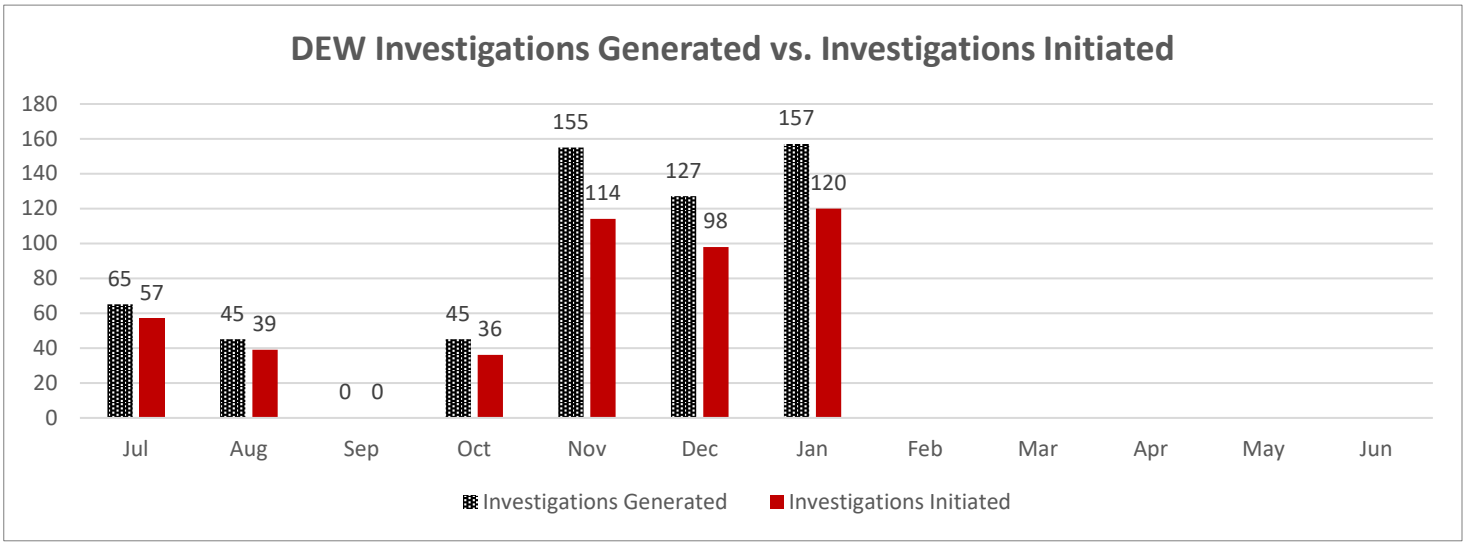


In January 2021, 157 compliance files were generated from the DEW data process.

YTD vs. Prior Year total (900): 66%
Jan 2020 to Jan 2021: NA% +157
Current Yr End trend: 113% of 2019-2020
YTD 2020-2021 v. YTD 2019-2020: 113%



The DEW Data Pool is determined by the total number of potential, non-compliant employers who report wages to DEW with at least 4 employees and who's FEIN does not match with any coverage records in the Commission's coverage database. The investigations generated is the number of compliance investagations generated from the pool. The investigations initiated is the number of compliance investigations initiated from those that were generated.

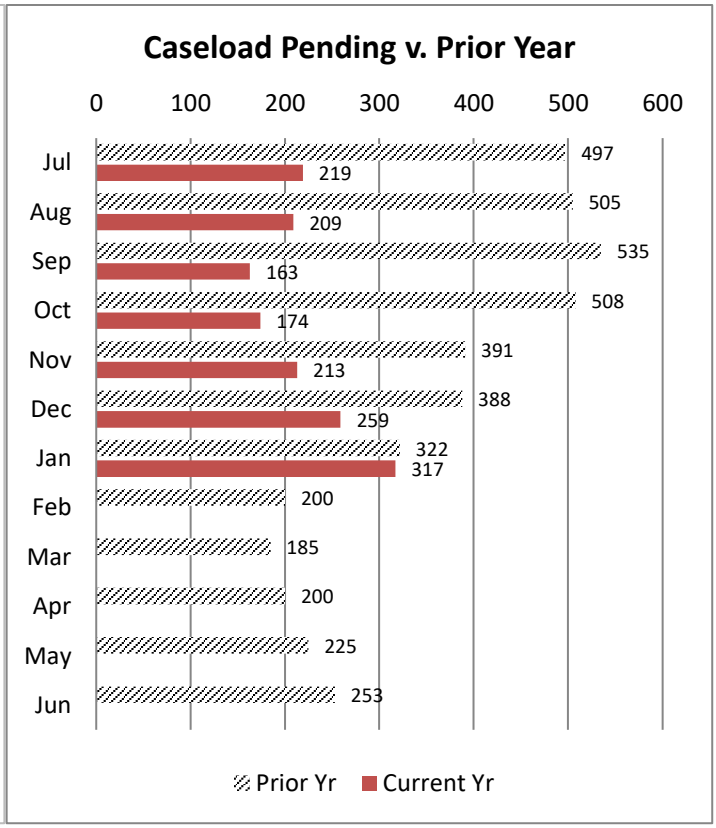


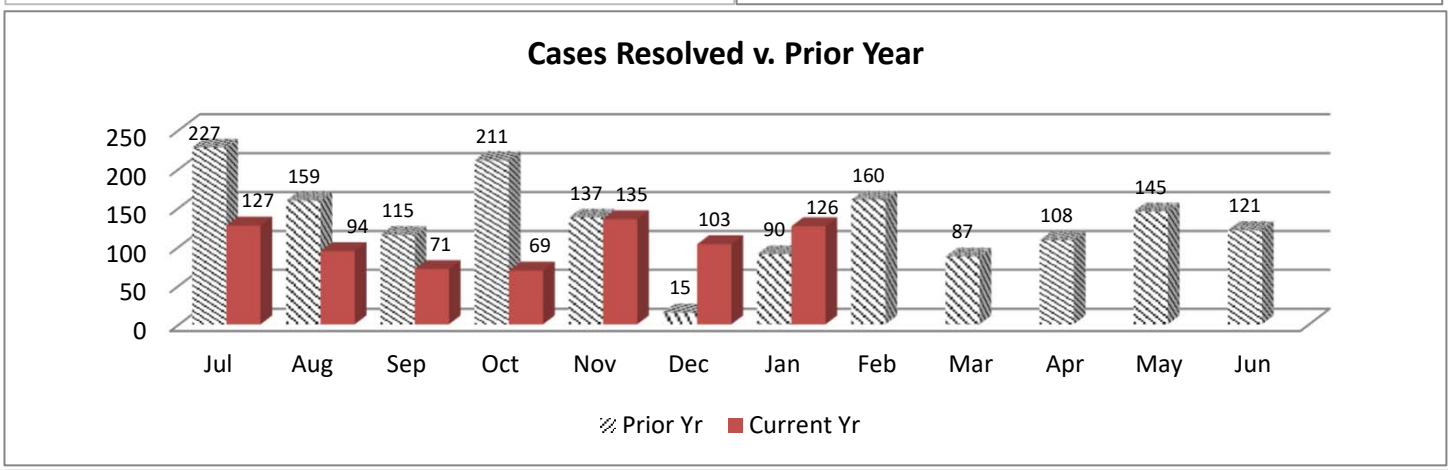
Carryover Caseload:
The Compliance Division closed January 2021 with 317 cases active, compared to an active caseload of 322 at the close of January 2020.

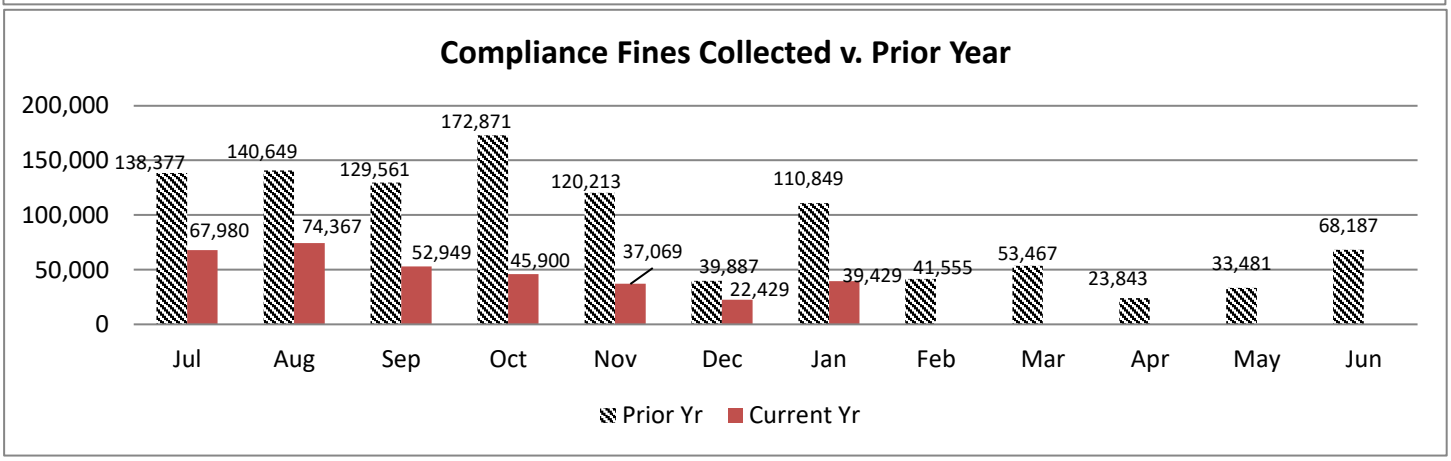
Cases Resolved:
For the month of January 2021, Compliance Division staff closed-out 126 cases.

Compliance Fines:
In January 2021, the Compliance Division collected $39,429 in fines and penalties. Year to Date, the Compliance Division has collected $340,123 in fines and penalties.

Year to Date vs Prior Year Total ($1,072,940): 32%
Jan 2020 vs. Jan 2021: 36%
Current Year End trend is 54% of 2019-2020
YTD 2019-20 (July - Jan) vs YTD 2020-2021: 40%





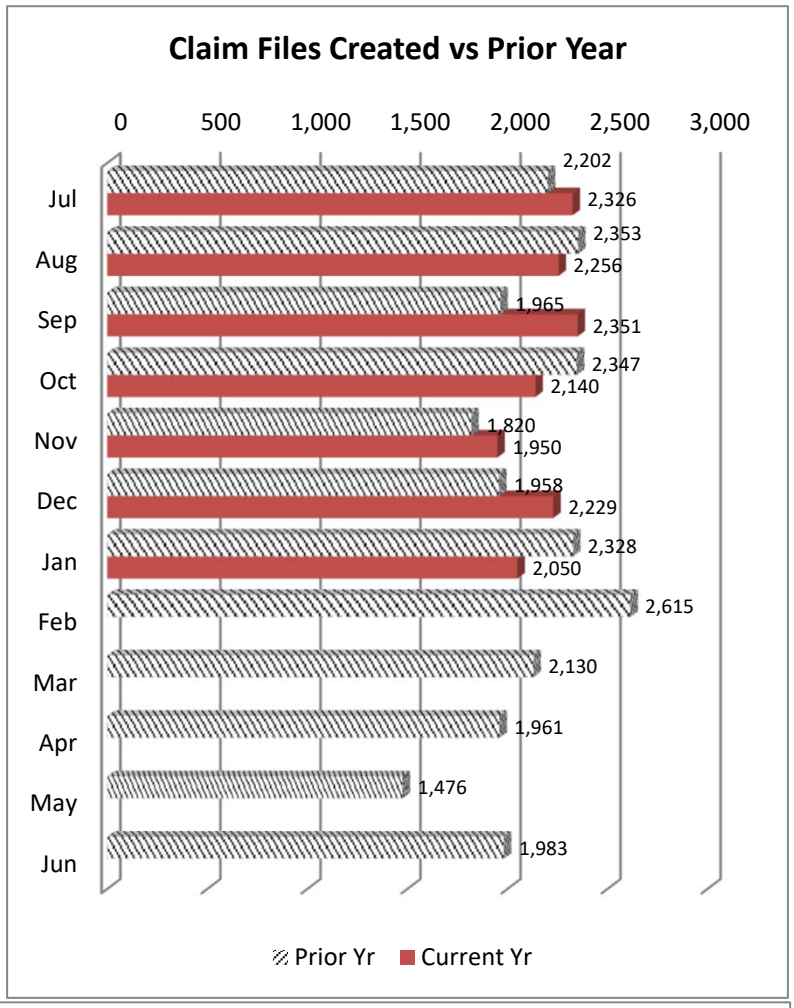


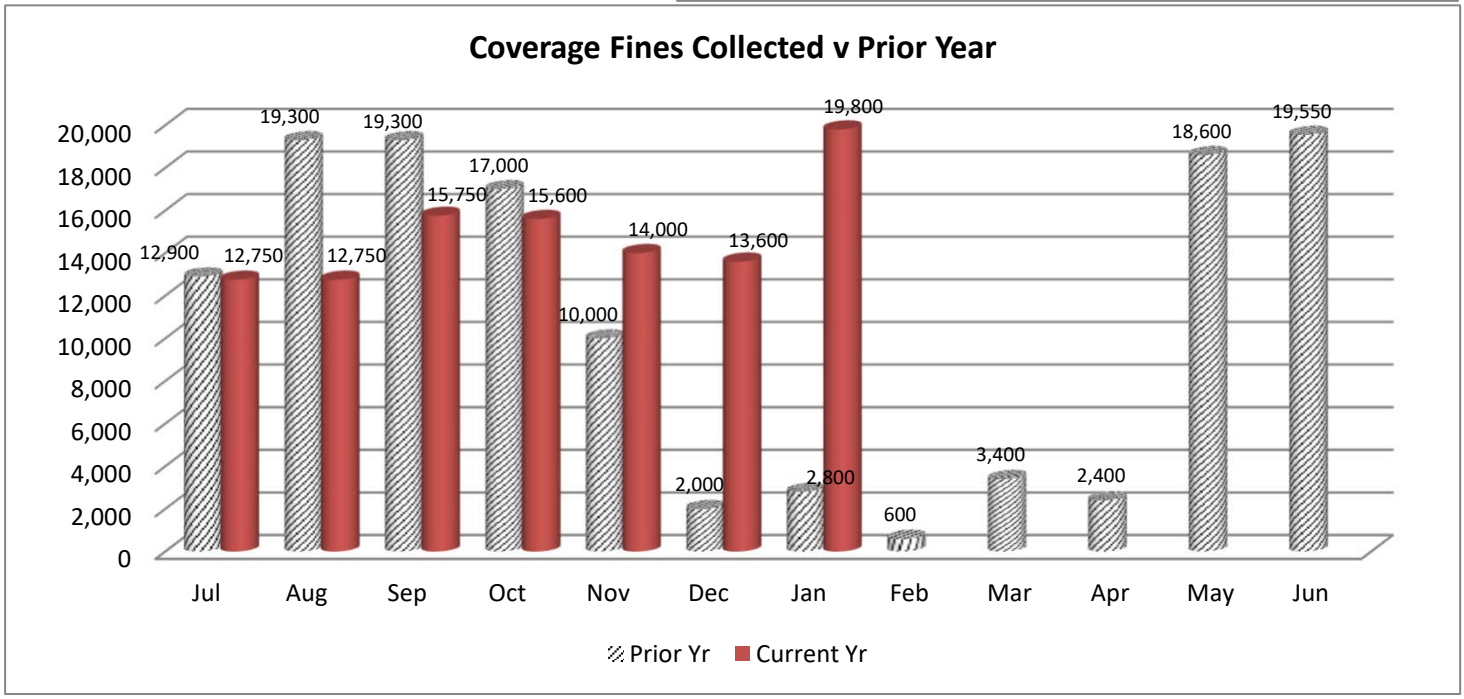
WCC Claim Files:

In January 2021, the Coverage Division received a total of 2,050 WCC Claim files. Of these, 1,845 were created through proper carrier filing of a 12A, and 205 were generated as a result of a Form 50 claim filing. Year to Date 15,302 Claim files have been created which is 61% of claim file volume prior year (25,138).

Coverage Fines:

The Coverage Division collected $19,800 in fine revenue in January 2021, as compared to $2,800 in Coverage fines/penalties accrued during January 2020. Year on Year, Coverage fines are at 82% of collections for prior year.





Tab 6

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Workers' Compensation Commission

MEMORANDUM

To: Gary Cannon, Executive Director

From: Sonji Spann, Claims Director

Date: February 16, 2021

Re: Claims Department January 2021 Full Commission Report

Attached is Claims Department activity for the period ending January 31, 2021. The format of the Claims Department report highlights the key workflow benchmarks. Comparison to last month and last year can be found on the attached excel spread sheet.

Processed	14, 956
Closed	2,377
Reviewed	2,902
Revenue	$29,600
Total Fines	189
Form 18 Fines	187
EDI – 18's	3,281
Emailed -18's	1,633
USPS-18's	95
Form 61's Rec'd	613
Form 61's App	573
Third Party Settlements Rec'd	9
Third Party Settlements Processed	9

Claims Department Statisitcal Report
Statistics For FY20-21

Period ending , January 31, 2021

Claims Services	July	August	Sept	Oct	Nov	Dec	Jan	FY20-21 Total	FY19-20 Total	% Chg same period FY20-21	YTD Diff + (-) FY20 v FY21	FY20-21 Mth Avg	FY19-20 Mth Avg
Forms 15-I	1,203	1,287	1,309	1,310	1,151	1,148	1,015	8,423	8,064	4%	359	1,685	2,746
Forms 15-II/Forms 17	1,032	1,026	1,043	1,163	980	981	954	7,179	6,670	8%	509	1,436	2,305
Forms 16 for PP/Disf	235	257	181	238	173	203	241	1,528	1,450	5%	78	306	2,746
Forms 18	4,720	4,524	4,438	4,305	4,144	4,595	4,980	31,706	32,967	-4%	(1,261)	6,341	2,305
Forms 20	587	623	572	625	598	585	539	4,129	4,647	-11%	(518)	826	501
Form 50 Claims Only	300	283	326	277	263	291	254	1,994	1,981	1%	13	399	11,745
Form 61	765	788	700	723	650	758	613	4,997	4,816	4%	181	999	1,520
Letters of Rep	219	216	259	246	260	205	210	1,615	1,490	8%	125	323	666
Clinchers	890	945	978	972	774	952	825	6,336	5,524	115%	812	1,267	1,692
Third Party Settlements	10	17	11	17	8	17	9	89	87	102%	2	18	502
SSA Requests for Info	35	36	45	48	34	38	37	273	450	-39%	(177)	55	1,996
Cases Closed	2,660	3,162	2,471	2,457	2,163	2,323	2,377	17,613	15,688	-1%	1,925	3,523	33
Cases Reviewed	4,099	3,580	3,247	3,260	2,878	3,301	2,902	23,267	17,727	-1%	5,540	4,653	140
											-	-	-
											-	-	-
Total Fines Assessed	413	309	255	196	195	203	189	1,760	1,061	66%	699	352	-
Form 18 Fines	409	307	166	192	188	201	187	1,650	944	75%	705	330	-
Total Amt Paid	$43,250	$30,800	$ 33,050	$ 29,600	$ 35,400	$ 22,200	$ 29,600	$ 223,900	$ 194,300	15%	$ 29,600	44,780	493

Tab 7

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Workers' Compensation Commission

February 17, 2021

To: Gary Cannon
Executive Director

From: Amy A. Bracy
Judicial Director

RE: Monthly Judicial Report for January 2021

During the month of January, the Judicial Department processed seven hundred sixty-two (762) requests for hearings, one hundred eleven (111) Motions and one hundred eighteen (118) clincher conference requests that were sent to the Jurisdictional Commissioners.

There were thirty (30) Single Commissioner Hearings conducted during the past month, sixteen (16) pre-hearing conferences held and twelve (12) Full Commission hearings held. A total of four hundred sixty-six (466) Orders were served at the single Commissioner level, sixty-four (64) of those were Decision and Orders that resulted from hearings that went on the record and one hundred twenty-five (125) were Motion Orders that were a result of Motions ruled upon by Commissioners.

The Informal Conference system conducted two hundred forty-one (241) hearings during the last month.

There were twenty-two (22) regulatory mediations scheduled and fifty (50) requested mediations. The Judicial Department was notified of fifty-one (51) matters resolved in mediation, with the receipt of Forms 70.

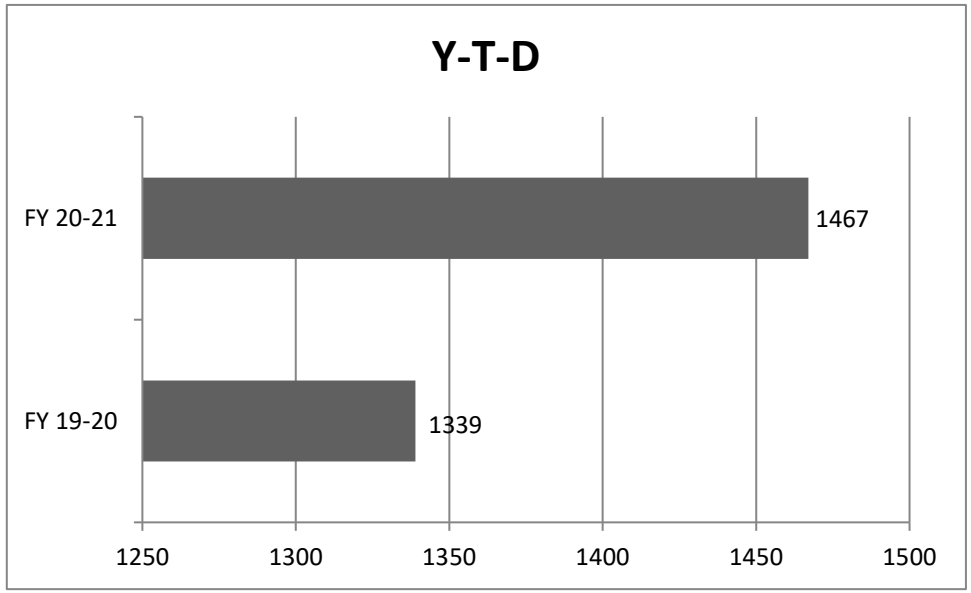
In the month of January, Judicial received zero (0) Notice of Intent to Appeal to the Court of Appeals and zero (0) to the Circuit Court.

Judicial Department Statisitcal Report
Statistics For Fiscal Year 2020-2021

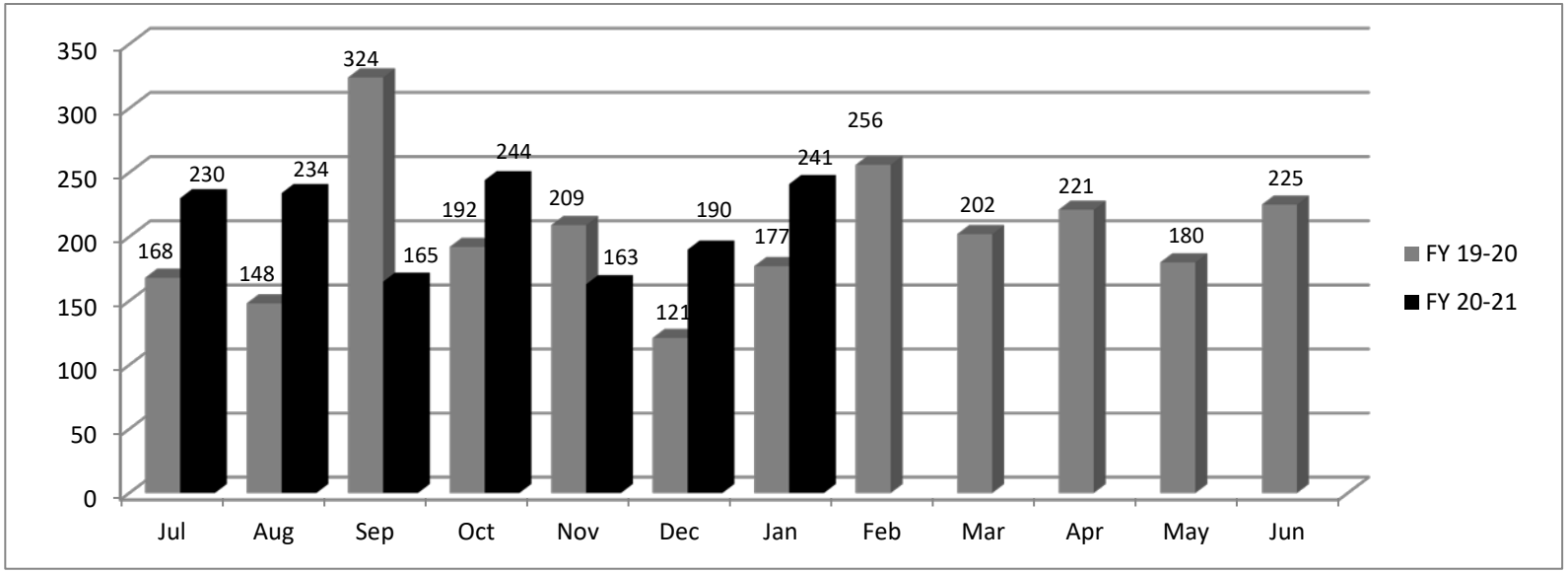
	July	Aug	Sept	Oct	Nov	Dec	Jan	Totals YTD 2020-2021	Totals YTD 2019-2020	% Diff from prev year	YTD Diff + (-)	FY20-21 Mth Avg	FY19-20 Mth Avg
Claimant Pleadings	550	544	567	607	459	445	455	**3,627**	**3806**	**-5%**	(179)	518	544
Defense Response to Pleadings	440	435	497	470	473	423	359	**3,097**	**3117**	**-1%**	(20)	442	445
Defense Pleadings	334	261	288	329	288	287	307	**2,094**	**1907**	**10%**	187	299	272
Motions	133	196	131	117	111	96	111	**895**	**835**	**7%**	60	128	119
Form 30	5	18	11	5	12	10	7	**68**	**74**	**-8%**	(6)	10	11
FC Hearings Held	4	4	5	2	6	1	12	**34**	**47**	**-28%**	(13)	5	7
FC Orders Served	15	4	7	10	4	4	6	**50**	**92**	**-46%**	(42)	7	13
Single Comm. Hearings Held	68	86	82	59	56	63	30	**444**	**450**	**-1%**	(6)	63	64
Single Comm. Orders Served	201	221	169	188	170	154	194	**1,297**	**1465**	**-11%**	(168)	185	209
Single Comm. Pre-Hearing Conf Held	38	18	19	36	24	28	16	**179**	**191**	**-6%**	(12)	26	27
Consent Orders	316	272	283	248	264	261	260	**1,904**	**1887**	**1%**	17	272	270
Adminstrative Orders	13	15	9	18	5	61	12	**133**	**160**	**-17%**	(27)	19	23
Clincher Conference Requested	148	117	162	155	143	156	118	**999**	**973**	**3%**	26	143	139
Informal Conference Requested	304	299	268	269	228	181	297	**1,846**	**2118**	**-13%**	(272)	264	303
Informal Conference Conducted	230	234	165	244	163	190	241	**1,467**	**1339**	**10%**	128	210	191
Regulatory Mediations	38	26	40	43	35	30	22	**234**	**247**	**-5%**	(13)	33	35
Requested Mediations	60	54	47	58	66	30	50	**365**	**333**	**10%**	32	52	48
Ordered Mediations	1	0	2	0	1	0	0	**4**	**10**	**-60%**	(6)	1	1
Mediation Resolved	47	64	37	56	42	64	51	**361**	**357**	**1%**	4	52	51
Mediation Impasse	10	15	12	14	24	22	10	**107**	**117**	**-9%**	(10)	15	17
Mediation Held; Issues Pending	0	0	1	1	2	0	0	**4**	**2**	**0%**	2	1	0
Claim Settled Prior to Mediation	8	8	8	8	6	20	6	**64**	**91**	**-30%**	(27)	9	13
Mediation Not Complete in 60 days	0	3	0	3	1	5	0	**12**	**19**	**-37%**	(7)	2	3

Informal Conf. Conducted

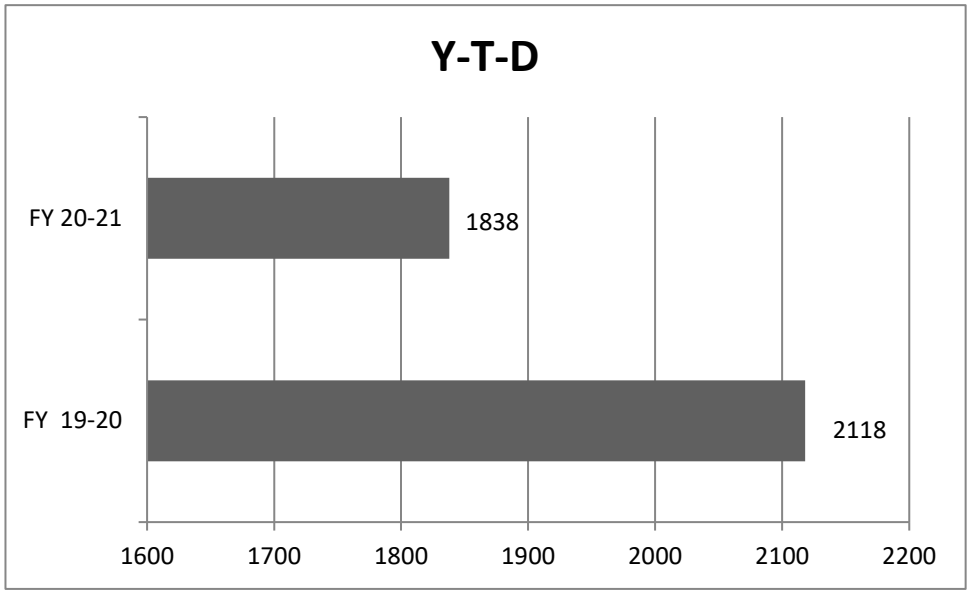
	FY 19-20	FY 20-21
Jul	168	230
Aug	148	234
Sep	324	165
Oct	192	244
Nov	209	163
Dec	121	190
Jan	177	241
Feb	256	
Mar	202	
Apr	221	
May	180	
Jun	225	
Total	**2423**	**1467**



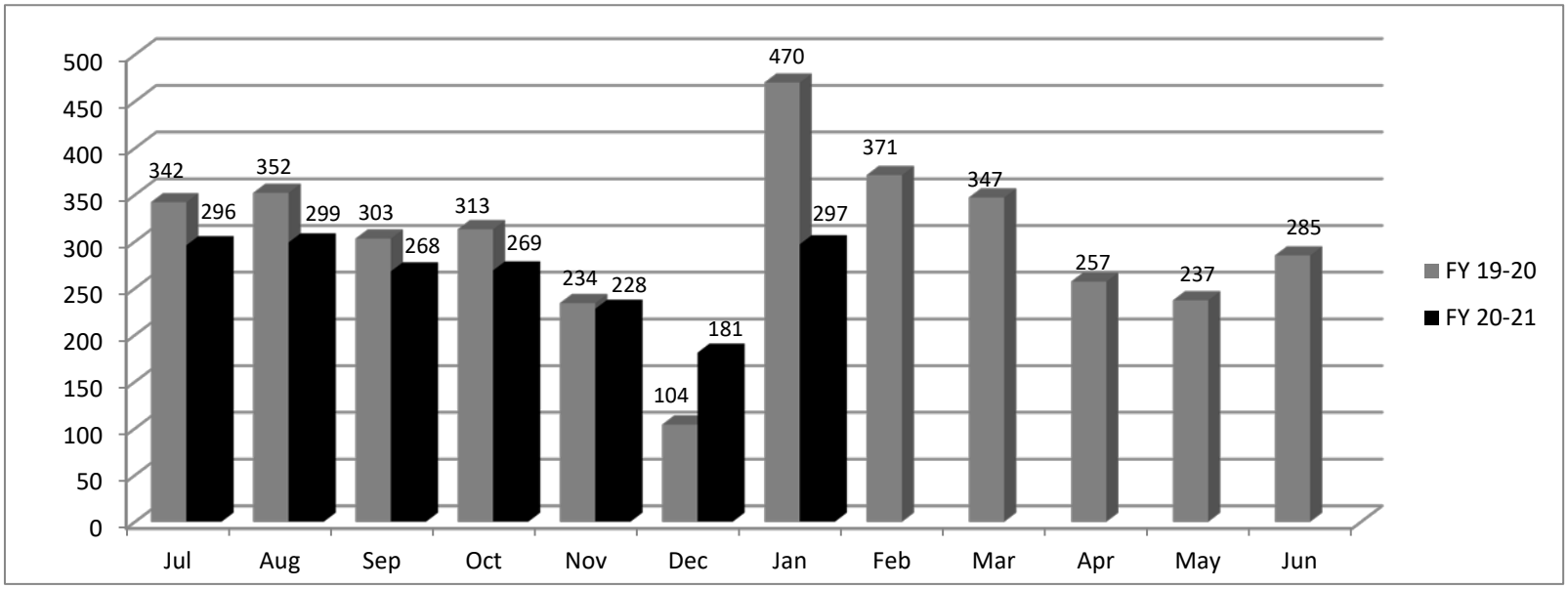
	FY 19-20	FY 20-21
Y-T-D	**1339**	**1467**



	Informal Conf. Requested	
	FY 19-20	FY 20-21
Jul	342	296
Aug	352	299
Sep	303	268
Oct	313	269
Nov	234	228
Dec	104	181
Jan	470	297
Feb	371	
Mar	347	
Apr	257	
May	237	
Jun	285	
Total	**3615**	**1838**



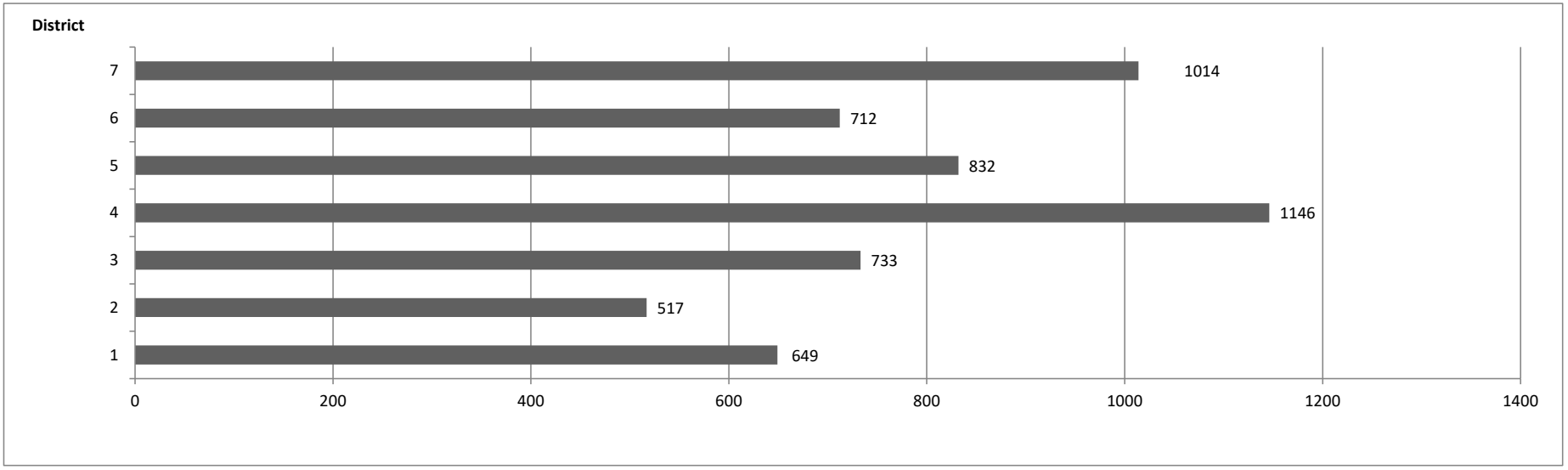
	FY 19-20	FY 20-21
Y-T-D	**2118**	**1838**



Pleadings Assigned - Three Year Comparison by Month

	District 1 Greenville			District 2 Anderson			District 3 Orangeburg			District 4 Charleston			District 5 Florence			District 6 Spartanburg			District 7 Richland		
	20-21	**19-20**	**18-19**	**20-21**	**19-20**	**18-19**	**20-21**	**19-20**	**18-19**	**20-21**	**19-20**	**18-19**	**20-21**	**19-20**	**18-19**	**20-21**	**19-20**	**18-19**	**20-21**	**19-20**	**18-19**
Jul	120	99	88	81	84	98	85	123	114	151	183	183	126	136	147	112	137	110	154	140	144
Aug	88	99	118	73	85	71	105	78	87	142	168	187	125	153	124	95	104	149	133	147	138
Sep	87	101	92	70	77	78	107	98	83	162	174	148	128	108	98	113	104	91	169	131	132
Oct	93	115	112	81	90	98	125	76	115	175	187	204	115	124	119	104	121	130	159	142	160
Nov	92	83	116	88	74	87	100	108	114	176	155	161	96	116	130	104	78	119	134	148	150
Dec	90	81	92	68	65	66	115	80	93	168	140	116	132	99	121	96	104	94	141	117	115
Jan	79	98	89	56	69	69	96	78	114	172	186	170	110	104	104	88	88	114	124	110	134
Feb		91	102		85	80		78	102		143	156		132	111		126	126		166	116
Mar		112	92		96	81		134	97		187	192		131	142		111	115		183	131
Apr		90	84		78	76		90	76		150	157		136	103		100	86		140	123
May		100	112		80	114		80	189		126	211		103	151		104	138		125	183
Jun		112	94		75	103		91	89		170	153		97	121		109	100		175	145
Totals	**649**	**1181**	1191	**517**	958	1021	**733**	1114	1273	**1146**	1969	2038	**832**	1439	1471	**712**	1286	1372	**1014**	1724	1671

Pleadings Assigned by District Year to Date



Tab 8

No Vocational Rehabilitation Report Provided

Tab 9

State of South Carolina

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

Workers' Compensation Commission

Executive Director's Report
February 22, 2021

Return to Work
The Executive Director officially returned to work on January 18, 2021 after an extended period of recovery.

COVID-19
For the period February 1, 2020 through January 31, 2020, there have been 2,724 COVID-related claims filed with the Commission. Two-hundred fifty-seven (257) were filed during the month of January. One fatality was reported during January bringing the total to 20 for the period. Of the cases were have been closed, $223,425 was paid for medical care and $1,193,166 was paid for non-medical care. The counties reporting the highest number of claims were Greenville, Charleston, and Richland. During the reporting period 1,416 were denied. Nurses have reported the highest number of cases.

Meetings/Activities
The Executive Director participated in 3 conference calls with the Microsoft team about the Gap Analysis; 2 conference calls with Fair Health regarding the Medical Services Provider Manual, 2 conference calls concerning the FOIA request, 7 conference calls with the Kermit team, 1 conference call regarding the Judicial Conference agenda, 1 conference call regarding Covid response.

Constituent /Public Information Services
For the period January 1, 2021 to January 31, 2021, the Executive Director's Office and the General Counsel's office had 287 electronic and personal contacts with claimants or constituents, state agencies, federal agencies, attorneys, service providers, business partners, and letters with congressional offices.

Financial Transactions Activity
For the period January 1, 2021 to January 31, 2021, the Director's office processed and approved 6 travel expense reports, 172 invoices, and 34 deposits for DOA to process in the SCIES system.

SCWCC Stakeholder Electronic Distribution List
For the period January 1, 2021 through January 31, 2021 we added three (3) individual. Due to the receipt of email delivery failures, a total of three (3) email addresses were deleted and two (2) individuals requested to be removed due to change of job duties. A total of 772 individuals currently receive notifications from the Commission.

Advisory Notices
During the month of January, the office posted two notices on the Commission's website and emailed it to the distribution list.

Tab 10

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**
Executive Director

DATE: **February 22, 2021**

RE: **FINANCIAL REPORT - Period ending January 31, 2020**

Attached is the Budget vs. Actual Report for the General Fund and Earmarked Fund for the fiscal year period ending January 31, 2020. The benchmark for this period is 58%.

Expenditures

The expenditures for the General Fund are on pages 1-2 of the attached report "Budget vs. Actual Report FY2021. The year-to-day expenditures in the General Fund (10010000) for this period is $1.4 million or 32% of budget.

The Earmarked Fund financials may be found on pages 3-6 of the report. The year-to-date expenditures for the Earmarked Fund (38440000) is $2 million or 37% of budget. The fund has $343,086 of Commitments.

Revenues

The Earmarked Fund received $1.2 in Operating Revenues or 40% of expected revenues through January 31, 2021.

To date we have received $3 million Self-Insurance Tax funds.

South Carolina Workers' Compensation Commission
Earmarked Fund Revenues
FY 2021 As of 1/31/2021
58% of year elapsed

Account	Acct No.	Budget	YTD Actual Revenue	% of Budget
WORKERS' COMP HEARING FEE	4110090000	1,091,322	607,370	56%
W COMP SELF INS APPL FEE	4160040000	26,577	2,375	9%
W COMP FILING VIOL PENALTY	4223030000	1,985,476	619,539	31%
PARKING FEE	4350040000	5,900	3,060	52%
W COMP AWARD REVIEW FEE	4350140000	32,251	10,970	34%
TRNG CONF REG FEE	4380020000	6,000	450	8%
PHOTOCOPYING FEE	4380050000	62,199	25,994	42%
SALE OF SERVICES	4480020000		300	
SALE OF LISTINGS & LABELS	4480060000	4,187	1,214	29%
REFUND PRIOR YR EXPENDITURE	4520010000		738	
RETURN CHECKS	4530010000			
ADJUSTMENT TO AGENCY DEPOSITS	4530020000			
MISC REVENUE	4530030000		200	
Total Revenues		**3,213,912**	**1,272,210**	**40%**
Self Insurance Tax		**2,500,000**	**3,036,163**	**121%**
Total		**5,713,912**	**4,308,373**	**75%**

South Carolina Workers' Compensation Commission
Budget vs. Actual Report
FY 2021 As of 1/31/2021
58% of year elapsed

Fund 10010000 - GENERAL FUND

Administration

Commitment Item	Commitment Item Description	Current Budget	YTD Expenditures	% Used	Commitments	Remaining Balance
501015	DIRECTOR	138,686	80,900	58%		57,786
501058	CLASSIFIED POS	48,034				48,034
512001	OTHER OPERATING	315,587				
	Total OTHER OPERATING:	315,587				315,587
Total Administration:		**502,307**	**80,900**	**16%**		**421,407**

Inform. services

Commitment Item	Commitment Item Description	Current Budget	YTD Expenditures	% Used	Commitments	Remaining Balance
5030067131	PLM- EUC				5,080	
	Total OTHER OPERATING:				5,080	-5,080
Total Inform. services:					**5,080**	**-5,080**

Claims

Commitment Item	Commitment Item Description	Current Budget	YTD Expenditures	% Used	Commitments	Remaining Balance
501058	CLASSIFIED POS	78,767	46,996	60%		31,771
Total Claims:		**78,767**	**46,996**	**60%**		**31,771**

Commissioners

Commitment Item	Commitment Item Description	Current Budget	YTD Expenditures	% Used	Commitments	Remaining Balance
501026	CHAIRMAN	168,057	98,033	58%		70,024
501033	COMMISSIONER	978,964	571,060	58%		407,904
501050	TAXABLE SUBS		42,605			-42,605
501058	CLASSIFIED POS	320,113	200,631	63%		119,482
Total Commissioners:		**1,467,134**	**912,329**	**62%**	**0**	**554,805**

South Carolina Workers' Compensation Commission
Budget vs. Actual Report
FY 2021 As of 1/31/2021
58% of year elapsed

Fund 10010000 - GENERAL FUND

Information Services FY18

Commitment Item	Commitment Item Description	Current Budget	YTD Expenditures	% Used	Commitments	Remaining Balance
561000	Special Item	1,695,084			1,246,396	448,688
Total Information Services FY18:		**1,695,084**			**1,246,396**	**448,688**

Insurance & Medical

Commitment Item	Commitment Item Description	Current Budget	YTD Expenditures	% Used	Commitments	Remaining Balance
501058	CLASSIFIED POS	27,697	17,850	64%		9,847
Total Insurance & Medical:		**27,697**	**17,850**	**64%**		**9,847**

Judicial

Commitment Item	Commitment Item Description	Current Budget	YTD Expenditures	% Used	Commitments	Remaining Balance
501058	CLASSIFIED POS	29,852				29,852
Total Judicial:		**29,852**				**29,852**

Employer Contributions

Commitment Item	Commitment Item Description	Current Budget	YTD Expenditures	% Used	Commitments	Remaining Balance
513000	EMPLOYER CONTRIB	713,269	368,066	52%		345,203
Total Employer Contributions:		**713,269**	**368,066**	**52%**		**345,203**

Total GENERAL FUND:		**4,514,110**	**1,426,141**	**32%**	**1,251,476**	**1,836,493**

South Carolina Workers' Compensation Commission
Budget vs. Actual Report
FY 2021 As of 1/31/2021
58% of year elapsed

Fund 38440000 - EARMARKED FUND

Administration

Commitment Item	Commitment Item Description	Current Budget	YTD Expenditures	% Used	Commitments	Remaining Balance
501058	CLASSIFIED POS	791,985	111,503	14%		680,482
501070	OTH PERS SVC	41,000				41,000
512001	OTHER OPERATING	2,625,713				
5020080000	FREIGHT EXPRESS DELV		26		296	
5020120000	CELLULAR PHONE SVCS		2,172			
5021010005	LEGAL SRV-REPORTER		421			
5021020000	ATTORNEY FEES		217			
5021479207	JANITORIAL		2,489			
5024990000	OTH CNT-NON-IT & REA		831			
5030010000	OFFICE SUPPLIES		3,242		26	
5030010002	OFF SUP - MIN OFF EQ		194			
5030010004	SUBSCRIPTIONS		9,609		7,445	
5030030000	PRINTED ITEMS		2,345		29	
5030067101	PRGM LIC - APP SUPP		18,803		14,821	
5030067130	EQUIP&SUPP- EUC		18		1	
5030067170	EQUIP&SUPP- PRINT EU		3,650		2,200	
5030070000	POSTAGE		15,852		14,360	
5030090000	COMMUNICATION SUPP		-537			
5031479203	JANITORIAL SUPPLIES		95			
5032410000	MED/SCIENT/LAB SUPP		239			
5032820000	INSTRUCTIONAL MAT				1,408	
5033990000	OTHER SUPPLIES		169			
5040010000	OPER LSE-OFC EQ RENT		2,014			
5040057000	IT-OPER LS-CONT RENT				1,023	
5040060000	OPER-RENT-NON ST OWN		273,708		180,768	
5040070000	OPER-RNT-ST OWN RL P		120			
5040490000	OPER LSE-RENT-OTHER		10,413		12,771	
5040490003	OPER LSE-RENT-PO BOX		1,416			
5041010000	DUES & MEMBER FEES		4,835			
5050070000	IN ST-REGISTR FEES		400			
5051540000	LEASED CAR-ST OWNED		18,629			
	Total OTHER OPERATING:	2,625,713	371,370	14%	235,148	2,019,195

South Carolina Workers' Compensation Commission
Budget vs. Actual Report
FY 2021 As of 1/31/2021
58% of year elapsed

Fund 38440000 - EARMARKED FUND

Total Administration:	**3,458,698**	**482,873**	**14%**	**235,148**	**2,740,677**

Inform. services

Commitment Item	Commitment Item Description	Current Budget	YTD Expenditures	% Used	Commitments	Remaining Balance
501058	CLASSIFIED POS		205,638			-205,638
5020077100	SERVICES- APP SUP				972	
5020077130	SERVICES- EUC		3,548			
5020077170	SERVICES- PRINT EU		375			
5020077200	SERVICES- SERVERS		48,011			
5020077220	SERVICES- VOICENET		15,682			
5020077230	IT CONTRACTORS				46,316	
5020077240	DP SERVICES – STATE		99,220			
5020080000	FREIGHT EXPRESS DELV		40		296	
5020120000	CELLULAR PHONE SVCS				1,806	
5021330000	CONTR-GOVT/NONPRFIT		39,000			
5021469316	SECURITY ALARM SRVC		2,625		46	
5021540000	NON-IT OTHER PRO SRV				15,825	
5030010000	OFFICE SUPPLIES		773		685	
5030067101	PRGM LIC - APP SUPP		43		11,367	
5030067130	EQUIP&SUPP- EUC		8,463			
5030067131	PLM- EUC				769	
5030067141	PLM- ITSD		9,590			
5030067170	EQUIP&SUPP- PRINT EU		8,150		5,052	
5030067210	EQUIP&SUPP- STORAGE		118			
5030090000	COMMUNICATION SUPP		569			
5040057000	IT-OPER LS-CONT RENT		717		6,103	
5041010000	DUES & MEMBER FEES		196			
5050070000	IN ST-REGISTR FEES		50			
5050570000	OUT ST-REGISTR FEES		975			
	Total OTHER OPERATING:		238,145		89,237	-327,382
Total Inform. services:			**443,783**		**89,237**	**-533,020**

South Carolina Workers' Compensation Commission
Budget vs. Actual Report
FY 2021 As of 1/31/2021
58% of year elapsed

Fund 38440000 - EARMARKED FUND

Claims

Commitment Item	Commitment Item Description	Current Budget	YTD Expenditures	% Used	Commitments	Remaining Balance
501058	CLASSIFIED POS	280,850	133,958	48%		146,892
512001	OTHER OPERATING	19,700				
5020080000	FREIGHT EXPRESS DELV		8		487	
5020120000	CELLULAR PHONE SVCS				77	
5030010000	OFFICE SUPPLIES		456		848	
5030030000	PRINTED ITEMS		643			
	Total OTHER OPERATING:	19,700	1,107	6%	1,411	17,182
Total Claims:		**300,550**	**135,064**	**45%**	**1,411**	**164,075**

Commissioners

Commitment Item	Commitment Item Description	Current Budget	YTD Expenditures	% Used	Commitments	Remaining Balance
501050	TAXABLE SUBS	70,000				70,000
512001	OTHER OPERATING	230,700				
5020080000	FREIGHT EXPRESS DELV		57		296	
5020120000	CELLULAR PHONE SVCS		10,665		160	
5021010003	LEGAL SRV-TRANSCRIPT		2,773			
5021010005	LEGAL SRV-REPORTER		54,287			
5021410000	EDUC & TRNG-STATE		75			
5021540000	NON-IT OTHER PRO SRV		90			
5030010000	OFFICE SUPPLIES		702		457	
5030067170	EQUIP&SUPP- PRINT EU		2,409			
5031479203	JANITORIAL SUPPLIES		181			
5033990000	OTHER SUPPLIES		311			
5050041000	HR-IN ST-AUTO MILES		13,037		-	
5050070000	IN ST-REGISTR FEES		50			
5050080000	IN ST-SUBSIST ALLOW		2,436			
	Total OTHER OPERATING:	230,700	87,072	38%	912	142,716
Total Commissioners:		**300,700**	**87,072**	**29%**	**912**	**212,716**

South Carolina Workers' Compensation Commission
Budget vs. Actual Report
FY 2021 As of 1/31/2021
58% of year elapsed

Fund 38440000 - EARMARKED FUND

Insurance & Medical

Commitment Item	Commitment Item Description	Current Budget	YTD Expenditures	% Used	Commitments	Remaining Balance
501058	CLASSIFIED POS	459,463	200,658	44%		258,805
501070	OTH PERS SVC	22,881	19,200	84%		3,681
512001	OTHER OPERATING	54,500				
5020080000	FREIGHT EXPRESS DELV		94		487	
5021540000	NON-IT OTHER PRO SRV		11,625		11,398	
5024990000	OTH CNT-NON-IT & REA		470			
5030010000	OFFICE SUPPLIES		143		1,576	
5040060000	OPER-RENT-NON ST OWN				452	
5050070000	IN ST-REGISTR FEES		2,350			
	Total OTHER OPERATING:	54,500	14,682	27%	13,913	25,905
Total Insurance & Medical:		**536,844**	**234,540**	**44%**	**13,913**	**288,391**

Judicial

Commitment Item	Commitment Item Description	Current Budget	YTD Expenditures	% Used	Commitments	Remaining Balance
501058	CLASSIFIED POS	302,294	267,527	88%		34,767
501070	OTH PERS SVC	0	24,846	#DIV/0		-24,846
512001	OTHER OPERATING	12,800				
5020080000	FREIGHT EXPRESS DELV		8		487	
5020120000	CELLULAR PHONE SVCS				116	
5021010003	LEGAL SRV-TRANSCRIPT		171			
5021010005	LEGAL SRV-REPORTER		1,078			
5030010000	OFFICE SUPPLIES		60		1,861	
5050070000	IN ST-REGISTR FEES		50			
	Total OTHER OPERATING:	12,800	1,366	11%	2,464	8,970
Total Judicial:		**315,094**	**293,739**	**93%**	**2,464**	**18,891**

South Carolina Workers' Compensation Commission
Budget vs. Actual Report
FY 2021 As of 1/31/2021
58% of year elapsed

Fund 38440000 - EARMARKED FUND

Employer Contributions

Commitment Item	Commitment Item Description	Current Budget	YTD Expenditures	% Used	Commitments	Remaining Balance
513000	EMPLOYER CONTRIB	695,959	419,579	60%	0	276,380
Total Employer Contributions:		**695,959**	**419,579**	**60%**	**0**	**276,380**

Total EARMARKED FUND:		**5,607,845**	**2,096,650**	**37%**	**343,086**	**3,168,109**

South Carolina Workers' Compensation Commission
Commitments
FY 2021 As of 1/31/2021

Fund 10010000 - GENERAL FUND

Inform. services

Commitment Item	Commitment Item Description	Vendor	Commitment
5030067131	PLM- EUC	SHI INTERNATIONAL CORP	5,080
Total Inform. services:			**5,080**

Information Services FY18

Commitment Item	Commitment Item Description	Vendor	Commitment
5020077230	IT CONTRACTORS	TAPFIN PROCESS SOLUTIONS	1,246,396
Total Information Services FY18:			**1,246,396**

Total GENERAL FUND:	**1,251,476**

Fund 38440000 - EARMARKED FUND

Administration

Commitment Item	Commitment Item Description	Vendor	Commitment
5030010000	OFFICE SUPPLIES	STAPLES BUSINESS ADVANTAGE	26
5030010004	SUBSCRIPTIONS	WEST PUBLISHING CORPORATION	7,445
5030030000	PRINTED ITEMS	PINE PRESS PRINTING	29
5030067101	PRGM LIC - APP SUPP	WEST PUBLISHING CORPORATION	14,821
5030067130	EQUIP&SUPP- EUC	FORMS & SUPPLY INC	1
5030067170	EQUIP&SUPP- PRINT EU	FORMS & SUPPLY INC	1,641
5030067170	EQUIP&SUPP- PRINT EU	MAJOR BUSINESS MACHINES	559
5030070000	POSTAGE	NEOFUNDS BY NEOPOST	1,400
5030070000	POSTAGE	US POSTAL SERVICE	12,960
5032820000	INSTRUCTIONAL MAT	PINE PRESS PRINTING	1,408
5040057000	IT-OPER LS-CONT RENT	XEROX CORPORATION	1,023
5040060000	OPER-RENT-NON ST OWN	GALIUM 1333 MAIN LLC	180,768
5040490000	OPER LSE-RENT-OTHER	REPUBLIC PARKING SYSTEM INC	12,771
Total Administration:			**234,852**

Inform. services

Any items with vendor "Not assigned" are pending financial adjustments. Any commitment on the Budget vs. Actual Report that is missing from this list is a travel commitment.

South Carolina Workers' Compensation Commission
Commitments
FY 2021 As of 1/31/2021

Fund 38440000 - EARMARKED FUND

Commitment Item	Commitment Item Description	Vendor	Commitment
5020077100	SERVICES- APP SUP	BIS DIGITAL, INC.	972
5020077230	IT CONTRACTORS	TAPFIN PROCESS SOLUTIONS	46,316
5020120000	CELLULAR PHONE SVCS	VERIZON WIRELESS	1,806
5021469316	SECURITY ALARM SRVC	SONITROL SECURITY SYSTEMS	46
5021540000	NON-IT OTHER PRO SRV	HYLAND SOFTWARE INC	15,825
5030010000	OFFICE SUPPLIES	FORMS & SUPPLY INC	685
5030067131	PLM- EUC	SHI INTERNATIONAL CORP	769
5040057000	IT-OPER LS-CONT RENT	XEROX	4,409
5040057000	IT-OPER LS-CONT RENT	XEROX CORPORATION	1,693
Total Inform. services:			**72,522**

Claims

Commitment Item	Commitment Item Description	Vendor	Commitment
5020080000	FREIGHT EXPRESS DELV	FEDEX	487
5020120000	CELLULAR PHONE SVCS	VERIZON WIRELESS	77
5030010000	OFFICE SUPPLIES	FORMS & SUPPLY INC	812
5030010000	OFFICE SUPPLIES	STAPLES BUSINESS ADVANTAGE	36
Total Claims:			**1,411**

Commissioners

Commitment Item	Commitment Item Description	Vendor	Commitment
5020120000	CELLULAR PHONE SVCS	VERIZON WIRELESS	160
5030010000	OFFICE SUPPLIES	STAPLES BUSINESS ADVANTAGE	338
Total Commissioners:			**497**

Insurance & Medical

Commitment Item	Commitment Item Description	Vendor	Commitment
5021540000	NON-IT OTHER PRO SRV	A WOMANS TOUCH LLC	2,160
5021540000	NON-IT OTHER PRO SRV	LUMLEY INVESTIGATIONS LLC	756

Any items with vendor "Not assigned" are pending financial adjustments. Any commitment on the Budget vs. Actual Report that is missing from this list is a travel commitment.

South Carolina Workers' Compensation Commission
Commitments
FY 2021 As of 1/31/2021

Fund 38440000 - EARMARKED FUND

5021540000	NON-IT OTHER PRO SRV	TPT INVESTIGATIONS LLC	320
5021540000	NON-IT OTHER PRO SRV	UPSTATE LEGAL SUPPORT SERVICES L	1,625
5021540000	NON-IT OTHER PRO SRV	WHITESELL INVESTIGATIVE SERVICES	6,537
5030010000	OFFICE SUPPLIES	STAPLES BUSINESS ADVANTAGE	790
5040060000	OPER-RENT-NON ST OWN	GALIUM 1333 MAIN LLC	452
Total Insurance & Medical:			**12,641**

Judicial

Commitment Item	Commitment Item Description	Vendor	Commitment
5020080000	FREIGHT EXPRESS DELV	FEDEX	487
5020120000	CELLULAR PHONE SVCS	VERIZON WIRELESS	116
5030010000	OFFICE SUPPLIES	FORMS & SUPPLY INC	1,066
5030010000	OFFICE SUPPLIES	STAPLES BUSINESS ADVANTAGE	795
Total Judicial:			**2,464**

Total EARMARKED FUND:	**343,086**

Any items with vendor "Not assigned" are pending financial adjustments. Any commitment on the Budget vs. Actual Report that is missing from this list is a travel commitment.

Tab 11

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**
Executive Director

DATE: **February 18, 2021**

RE: **Medical Services Provider Manual – Stakeholder Comments**

Attached are the written comments from stakeholders concerning the proposed "2021 Medical Services Provider Manual" and the information from FairHealth provided at the January Business Meeting. The Advisory Notice requesting comments on the MSPM was posted on the Commission's website on and sent to our email distribution list January 25. The following is a list of comments submitted.

Ann Margaret McCraw, Midlands Orthopaedics and Neurosurgery
Ezra Riber, M.D.
Tiffany Grzybowski, HealtheSystems,
Brian Allen, Mitchell
Lee Ann C. Stember, National Council for Prescription Drug Programs (NCPDP)
Kevin C. Tribout, Optum
Joseph A. Schwartz III, Physicians Research Institute
Gregory Grabowski, M.D., SC Orthopaedic Association
Karen Mills, Walmart Claims Services
Robert Wilson, MD and Ezra Riber MD, The Pain Society of the Carolinas

Christine O'Donnell, Dr. Joel Brill and other members of the FairHealth team will be present at the Business Meeting.

After the comments and questions are received at the Business Meeting, staff will prepare a response and recommendations for the Commissioners, giving adequate time for the Commissioners to review before the Business Meeting on March 15.

Understanding the Physician Shortage in SC Workers' Compensation

October 20, 2020

Ann Margaret McCraw
Midlands Orthopaedics & Neurosurgery


R
O
i
RETURN
ON
INVESTMENT

ROI = net benefits / total cost

01

What is the financial benefit received from a particular business investment?

02

What does the practice get back compared to what it put in?

03

How effectively are investments in our practice generating income?

04

Does the revenue generated meet or exceed the investment made?

Complexities of Comp Dictate the Investment Required

- Number of stakeholders: patient, employer, adjuster, NCM, carrier's attorney, patient's attorney, 3rd party networks for ancillary services
- Lack of coordination among stakeholders
- Requests from multiple parties for the same information

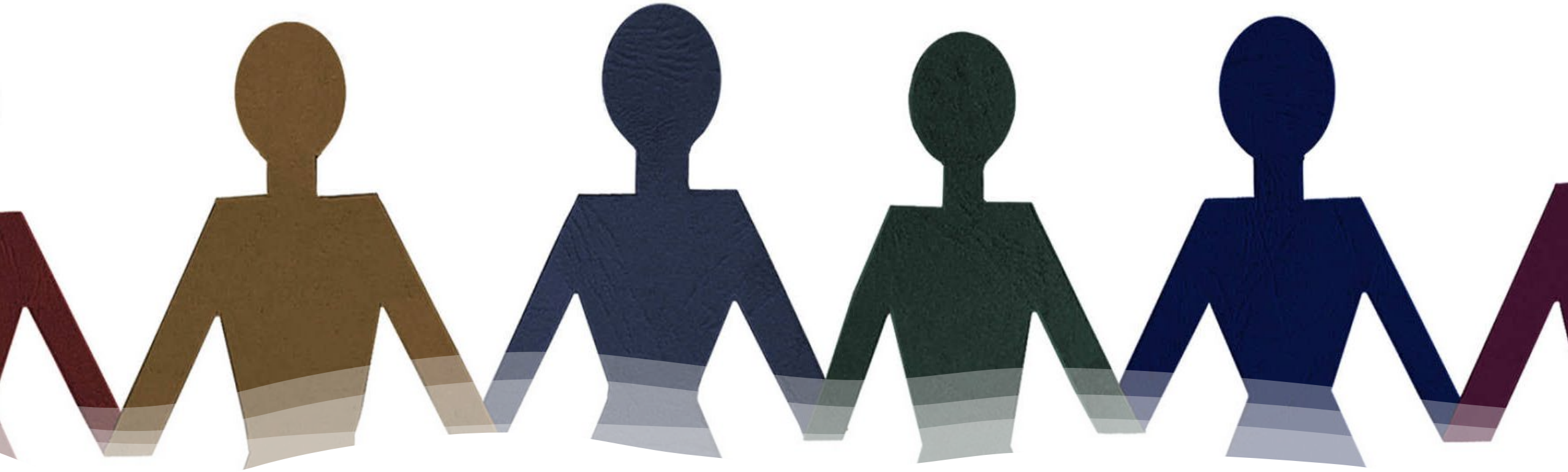
Complexities of Comp Dictate the Investment Required

- Prevalence of third-party networks for imaging/therapy/DME that demand dramatic discounts to fee schedule
- Authorization process: multiple phone calls, emails and/or faxes often required for each service rendered
- Amount of paperwork:
  - Work status forms in addition to standard dictation for each visit to patient, employer, NCM and adjuster
  - Attorney requests
  - Questionnaires from NCM and/or adjusters
  - 14Bs

Complexities of Comp Dictate the Investment Required

Claims Processing:

- Dictation must accompany each claim
- No notification when a claim is settled or deemed to be non-compensable
  - Generally discovered when we receive a claim denial, often weeks or months after settlement or dismissal
  - Meanwhile, a claim for the same service will be denied by private insurance until written proof of denial by comp is provided



Practice Investment to Facilitate Comp Well = PEOPLE

Case Study: Midlands OrthoNeuro

- 20 physicians
- 5 dedicated work comp staff members
- 2 shared A/R staff members
- 3 shared administrative support staff members

Comp Case Study: Midlands OrthoNeuro

10% of claims billed

10% of revenue collected

Labor cost per comp claim: $15.49

Labor cost per all other claims: $6.11

Comp Case Study: Midlands OrthoNeuro

Comp revenue:

5% (avg) more per claim than all others

Comp labor cost:
250% more than all others

Benchmarks for services billed by MidOrthoNeuro

Average SC comp payment: 112% of 2020 State Health Plan

Average SC comp payment: 138% of 2020 Medicare

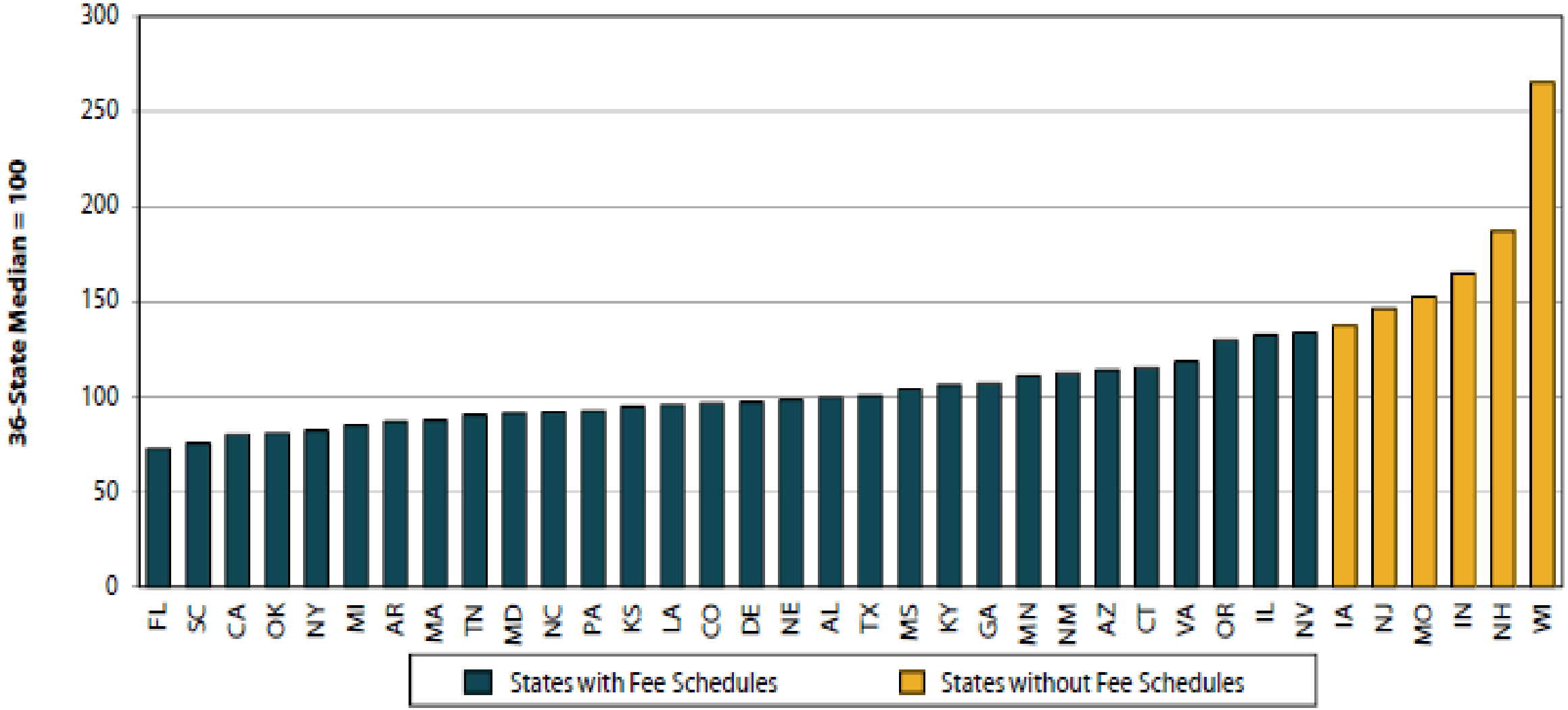
Benchmarks

from

WCRI Medical Price Index for Workers' Compensation
12th Edition

An index for actual prices paid for medical professional services based on a market basket of the most used services in work comp treatment. The 36 states included in the study represent 88% of work comp benefits paid in the US.

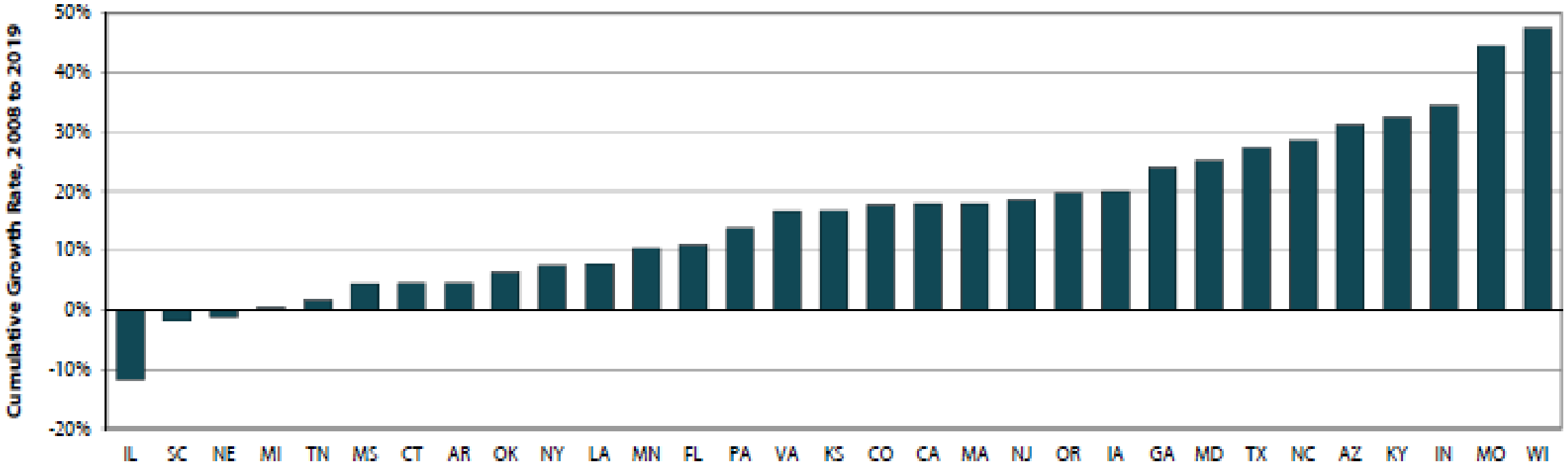
Figure 2 Interstate Comparison of Prices Paid for Professional Services, WCRI MPI-WC in 36 States, 2019[9]



WRCI 2019 Fee Regulation Types & Medical Price Index

Fee Regulation Type	State	Medical Price Index	36-State Ranking (1 = highest)
Fee schedule states	FL	72	36
	SC	76	35
	CA	80	34
	OK	81	33
	NY	82	32
	MI	85	31
	AR	87	30
	MA	88	29
	TN	90	28
	MD	91	27
	NC	92	26
	PA	92	25
	KS	95	24
	LA	96	23
	CO	96	22
	DE	97	21
	NE	98	20
	AL	99	19
	TX	101	18
	MS	104	17
	KY	106	16
	GA	107	15
	MN	111	14
	NM	112	13
	AZ	114	12
	CT	115	11
	VA	119	10
	OR	130	9
	IL	132	8
	NV	134	7
Non-fee schedule states	IA	137	6
	NJ	146	5
	MO	153	4
	IN	165	3
	NH	187	2
	WI	265	1

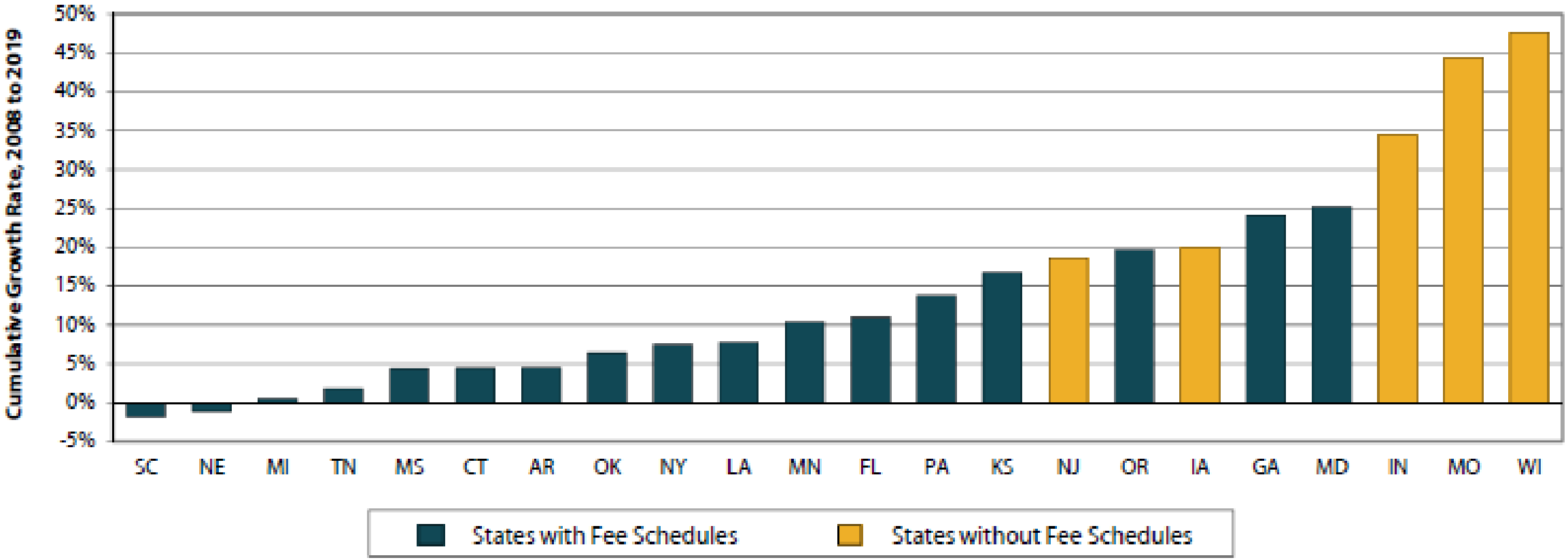
Figure 3 Comparison of Cumulative Growth Rate in Prices Paid for Professional Services across 31 Study States, 2008 to 2019[P]



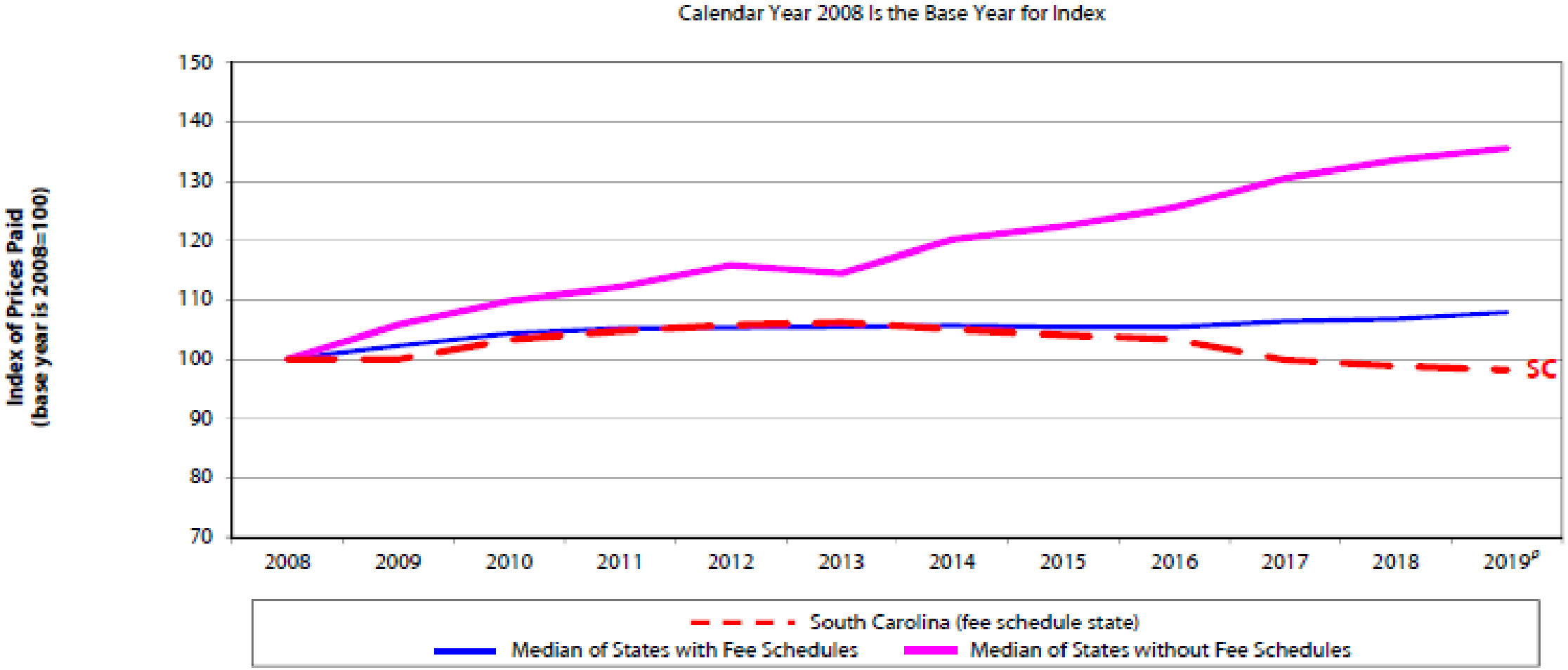
	IL	SC	NE	MI	TN	MS	CT	AR	OK	NY	LA	MN	FL	PA	VA	KS	CO	CA	MA	NJ	OR	IA	GA	MD	TX	NC	AZ	KY	IN	MO	WI
Growth rate in prices paid for professional services	-12	-2	-1	1	2	4	4	4	6	7	8	10	11	14	17	17	18	18	18	19	20	20	24	25	27	29	31	32	34	44	48

22 states with no substantial changes in fee schedule from 2008-2019

Figure 4 Comparison of Cumulative Growth Rate in Prices Paid for Professional Services across 22 Study States, 2008 to 2019[p]



	SC	NE	MI	TN	MS	CT	AR	OK	NY	LA	MN	FL	PA	KS	NJ	OR	IA	GA	MD	IN	MO	WI
Growth rate in prices paid for professional services	-2	-1	1	2	4	4	4	6	7	8	10	11	14	17	19	20	20	24	25	34	44	48


Calendar Year 2008 Is the Base Year for Index
Index of Prices Paid
(base year is 2008=100)
150
140
130
120
110
100
90
80
70
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019p
SC
South Carolina (fee schedule state)
Median of States with Fee Schedules
Median of States without Fee Schedules

ROI = net benefits / total cost

Volume & Revenue / Staff Labor Cost & MD Time

Conclusions

Revenue derived from SC workers' compensation care does not adequately offset the cost of providing that care given the administrative complexities inherent in the system.

Only practices with established work comp infrastructure are likely to welcome this patient population.

To the extent any practice can maximize its schedules with patients insured by less administratively burdensome coverage; work comp is becoming increasingly less attractive.

Suggestions

Increase rates.

Reduce administrative complexity.

Ann Margaret McCraw

Midlands Orthopaedics & Neurosurgery

Columbia, SC

annm@midorthoneuro.com

From: Ezra Riber
To: Proveaux, Amy; Cannon, Gary
Subject: [External] Proposed Changes to Medical Services Provider Manual
Date: Wednesday, February 17, 2021 4:45:33 PM

February 17, 2021

T. Scott Beck, Chairman
South Carolina Workers' Compensation Commission
Post Office Box 1715
1333 Main Street, Suite 500
Columbia, South Carolina 29202-1715

RE: Proposed Changes to the 2021 South Carolina Workers' Compensation 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 focus has been on efficiently diagnosing and safely treating injured workers to bring them to maximum medical improvement (MMI) as quickly as possible. I began dispensing medications out of my office many years ago to offset insurance-related delays my patients encountered when getting medications that I prescribed from a pharmacy. My interest in streamlining treatment is shared by all parties involved and point of care dispensing allows the injured workers I treat to begin treatment immediately without delay. As a result, I am concerned with proposed changes that would limit my ability to provide timely, appropriate care to the injured workers I treat.

The suggested change to the pharmacy section of the Manual (Section 10) provides that "opioids/scheduled controlled substances that are prescribed for treatment shall be provided through a pharmacy." I respectfully ask that the Commission consider either striking the language altogether or limiting it to Schedule II and III controlled substances.

Dispensing allows me to review the indication, expected benefits, and potential side effects with the patient on the spot and answer any questions. This occurs right at the time of the office visit and so there are no misunderstandings. Furthermore, this allows me to monitor the patient's compliance with his or her treatment regimen which is also critical for safety.

My training includes board certification in anesthesiology pain management 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.). While the majority of the medications I dispense to my patients are non-controlled medications, in limited instances, a Schedule IV or V medication is medically necessary. As such, I would ask that if the Commission intends for certain controlled substances to go through a pharmacy that it be narrowed to the Schedule II and III

medications.

Point of care treatment is more important today than ever and should be used to facilitate recovery and avoid unnecessary trips to the pharmacy. Imposing additional hurdles that delay care and take all or parts of a treatment plan out of the hands of physicians *will only create additional hardship for injured workers in South Carolina.*

For the foregoing reasons, I respectfully oppose the proposed rule requiring opioids/controlled substances be provided through a pharmacy. Thank you for your consideration.

Ezra B. Riber, M.D.

February 17, 2021

Amy Proveaux, Executive Assistant, Office of the Executive Director
South Carolina Workers' Compensation Commission
P.O. Box 1715 | Columbia, SC 29202
Email: aproveaux@wcc.sc.gov

RE: 2021 Medical Services Provider Manual (MSPM)

Dear Ms. Proveaux,

Healthesystems is a Pharmacy and Ancillary Benefit Manager supporting workers' compensation insurance carriers, third-party administrators, and self-insured employers in the state of South Carolina. We appreciate the opportunity to offer feedback on the proposed Medical Services Provider Manual. Our comments will focus on the changes to the Pharmacy Section with recommendations relating to the Commission's State-Specific Category Codes for Prescription Strength Topical Compounds.

Healthesystems supports the Commission in its endeavor to revise the Medical Services Provider Manual. More specifically, the revised policy updates to the Pharmacy Section now provides additional detail and clarity for reimbursing prescription medications, including repackaged drugs and compounds. However, we wanted to share our concerns regarding the use of State-Specific Category Codes I-III SC0801, SC0802, and SC0803.

Most pharmacies and payers use and rely on national billing standards for workers' compensation pharmacy transactions. These billing standards were created by the National Council for Prescription Drug Programs (NCPDP) and include the Workers Compensation/Property & Casualty Universal Claim Form (WC/PC UCF) for paper transactions and the Telecommunication Standard Version D.0 for electronic transactions. The proposed State-Specific Category Codes are not currently supported by either of these standards. If the State-Specific Category Codes were to be adopted, pharmacies and payers would have to develop a manual workaround to successfully process a pharmacy bill for those specific prescriptions. This workaround creates an administrative burden to impacted stakeholders by increasing processing time and potential delays to the injured worker when receiving their medications.

Alternatively, we recommend the Commission eliminate the State-Specific Category Codes and preserve the monetary limits for reimbursement on those three categories. This would allow providers and payers alike to utilize the standards already in place and prevent unnecessary administrative burden on the system. Many other states, such as Ohio and Mississippi, have successfully adopted reimbursement limits for prescription drugs, including compound products, without the use of state-specific billing codes. We believe this is the best approach to avoid adding complexity to an already efficient and standardized process.

Thank you for considering our feedback and allowing Healthesystems the opportunity to review and comment on the proposed Medical Services Provider Manual.

Sincerely,
Tiffany Grzybowski

Tiffany Grzybowski
Analyst, Advocacy and Compliance

Mitchell
6220 Greenwich Drive
San Diego, CA 92122
858.368.7000
mitchell.com

February 17, 2021

South Carolina Workers' Compensation Commission
Attn: Amy Proveaux
PO Box 1715
Columbia, SC 29202

Re: Medical Services Provider Manual Comments

Dear Ms. Proveaux:

Mitchell is a leading provider of workers' compensation services across the country. We appreciate this opportunity to provide comments on the draft version of the manual. Our comments are focused on the prescription drug section of the manual.

We support the changes regarding the prescribing of opioids. We also support the changes in the definition of repackaged drugs and compounded medications.

We note the suggested addition of RedBook as an average wholesale pricing source. While we are not opposed, we question the necessity of two sources being specified. It will likely lead to additional administrative work when a difference exists between the two sources.

Regarding the topical compound section, we support the Commission's effort to rein in the pricing on topical compounds. Across the country the use of topical compounds has been a significant cost driver with a lack of medical evidence regarding efficacy of the compounds. That said, the use of unique codes presents a challenge when using electronic billing. The NCPDP e-billing standard does not support state-specific codes and will require the development of a "work-around" that falls outside both the NCPDP and IAIABC e-billing standards. We recommend pulling together a work group of experts to analyze how you might achieve the important goal of limiting the cost of these compounds while still allowing for the appropriate use of the current industry e-billing standards.

Thank you for considering our comments. If you have questions or need additional information, please feel free to contact me at Brian.Allen@mitchell.com or at 801-661-2922.

Sincerely,

Brian Allen
Vice president Government Affairs

February 16, 2021

Amy Proveaux
Executive Assistant, Office of the Executive Director
South Carolina Workers' Compensation Commission

Via email: aproveaux@wcc.sc.gov

RE: NCPDP Comments to South Carolina Workers' Compensation Commission on Proposed Changes to Medical Services Provider Manual

Dear Ms. Proveaux:

The National Council for Prescription Drug Programs (NCPDP) is a not-for-profit, American National Standards Institute (ANSI) accredited Standards Developer (ASD) consisting of more than 1,700 members who represent drug manufacturers, chain and independent pharmacies, drug wholesalers, insurers, mail order prescription drug companies, pharmaceutical claims processors, pharmacy benefit managers, physician services organizations, prescription drug providers, software vendors, telecommunication vendors, service organizations, government agencies, professional societies and other parties interested in electronic standardization within the pharmacy services sector of the healthcare industry. NCPDP provides a forum wherein our diverse membership can develop solutions, including ANSI-accredited standards, and guidance for promoting information exchanges related to medications, supplies and services within the healthcare system.

NCPDP creates the standards that facilitate the interchange of data among pharmacies, physicians, pharmacy benefits managers, payers, processers and manufacturers - including the Telecommunication Standard Version D.0, the Universal Claim Form (UCF) and the Workers' Compensation/Property and Casualty Universal Claim Form (WC/PC UCF). NCPDP's Work Group 1 (WG1) P and C/WC Monitoring, Billing and Education Task Group is responsible for maintaining the standards and guidance specific to workers' compensation and other property/casualty lines of insurance.

NCPDP WG1 P and C/WC Monitoring, Billing and Education Task Group is writing in response to the proposed changes to the Workers' Compensation Commission's Medical Services Provider Manual. Specifically, NCPDP is writing to recommend the Commission not adopt the proposed Commission-specific billing codes for certain prescription strength topical compound drug categories.

The Commission-specific category codes being proposed are not currently supported by either the NCPDP paper billing (WC/PC UCF) or electronic billing (Telecommunication Standard) standards used by most pharmacies and payers/processors within the system. Adoption of these new unsupported codes will create a situation in which pharmacies and payers/processors are forced to utilize manual methods to process a pharmacy bill as required by Commission rules using state-specific codes.

NCPDP recommends these Division-specific billing codes (SC0801, SC0802 and SC0803) be omitted from the requirements as it is not possible for providers and payers/processors to use these codes to identify products when using the NCPDP industry-adopted national standards. Pharmacy providers and payers/processors rely on the standards for the submission and processing of pharmacy transactions. If these Commission-specific codes are adopted, the industry would be forced to use the alternate and more time-consuming one-off manual process, adding to delays in the processing of billings for medications and additional time and costs for both sides of the transaction (provider and payer).

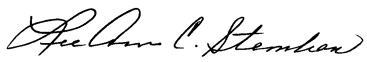
It is also important to note that reimbursement could still be based on the Commission's proposed methodology to cap expenditures on these products without the use of the Division-specific codes, just as with any other maximum fee schedule set by regulation. The use of these codes for billing is not required to ensure reimbursement is capped at the proposed levels. Other states have adopted unique reimbursement rates for similar types of compound products within their workers' compensation systems but have not had to mandate use of state-specific billing codes.

For historical context, the Colorado Division of Workers' Compensation adopted similar state-specific compound categories and their own Division-specific codes several years ago, which created processing issues for pharmacies and payers/processors within the system for many years that are still not completely resolved. Those codes were adopted prior to discussion with NCPDP, so it was not possible for pharmacies to bill in a compliant fashion and still use the standards. Later accommodations were made by NCPDP to permit billing those Division-specific codes for paper billing on the WC/PC UCF and more recently using electronic billing in the Telecommunication Standard; however, this process took time to develop and is not ideal. Pharmacies still cannot bill electronically using the Division-specific codes and instead use standards-compliant stand-in codes that represent or map to them.

Should the Commission want to add new Commission-specific codes or make other types of unsupported billing related changes as part of this or future rulemaking, we strongly encourage Commission staff to reach out to NCPDP well in advance of proposed changes so we can work together toward standards-compliant solutions. This will avoid the adoption of new billing requirements with which pharmacies cannot comply while using the national pharmacy billing standards.

Thank you for consideration of our comments. Please reach out to us with any questions or concerns.

Sincerely,



Lee Ann C. Stember
President & CEO
National Council for Prescription Drug Programs (NCPDP)
9240 E. Raintree Drive
Scottsdale, AZ 85260

For direct inquiries or questions related to this letter, please contact:

Paul Wilson

Technical Analyst, Standards Development
NCPDP
standards@ncpdp.org

cc:
NCPDP Board of Trustees

February 12, 2021

Amy Proveaux
South Carolina Workers' Compensation Commission
P.O. Box 1715
Columbia, SC 29202

Via email: aproveaux@wcc.sc.gov

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

Optum Workers' Compensation and Auto No-fault (Optum) appreciates the opportunity to comment on proposed changes to the Medical Provider Services Manual. We support the Commission's efforts to update and keep current the provider manual which better serves treating providers and injured workers. In general we support the proposed changes in Section 10, Pharmacy. We offer questions for clarification which will help stakeholders with post adoption implementation and some slight language modifications which we believe will strengthen proposed modifications. However, while we support efforts to control compounded topical medications we remain highly concerned with the addition of state specific and unique billing codes and requirements. These concerns are outlined within the body of our comments for your consideration.

Section 10. Pharmacy

Any proposed addition of language by Optum shall appear as underline
Any proposed deletion of language by Optum shall appear as ~~strikethrough~~

Reimbursement:
Page 65 – *"Opioids/scheduled controlled substances that are prescribed for treatment shall be provided through a pharmacy."*

Optum Comment: We support this language as it will ensure greater visibility to the pharmacy/pharmacist and PBM as to the totality of opioids/controlled substances being prescribed to the injured worker. The only clarification we request is does this requirement apply to all opioids, opioids that are controlled substances or all opioids and controlled substances. The current language may be a bit confusing and open to interpretation.

Page 65 – *"In case of a dispute on AWP values for a specific NDC, the parties should take the lower of their referenced published values."*

Optum Comment: While we understand the WCC's intent, to provide savings in the overall pharmacy spend, we believe it could lead to abuses and exacerbate fee disputes. At present we believe existing regulatory language on billing *"Bills submitted for reimbursement shall be based upon the original manufacturer's AWP for the drug product on the date the drug dispensed"* does not require a billing entity to submit the lowest of their reference published values. AWP values based on an NDC can vary on a daily basis across many AWP sources, including those cited by the WCC. Providers and PBMs may utilize one source and payers or bill review entities utilize another source. With numerous references for AWP and varying AWP rates across these references the above proposed language is certain to cause confusion and increase fee disputes. Existing rule language calls for reimbursement to be AWP + $5.00 or a contracted rate below fee

schedule. Thus we believe usage of the AWP source found in Medi-Span as a single AWP source provides clarity and we respectfully suggest the proposed language above be stricken.

Repackaged Drugs:
Page 65

Optum Comment: We support the proposed language but with a minor suggest clarification.

"The entity packaging two or more products together . . . and shall be billed at the individual ingredient level utilizing ~~as individual line items identified by~~ the original AWP and NDC."

Compound Drugs:
Page 65

Optum Comment: We support the proposed changes in order to control cost and utilization of compound medications.
Page 65 – *"All medications must be reasonably necessary to cure and relieve the injured worker from the effects of the injury."*

Optum Comment: We support the addition of this language, however based upon various regulatory language controlling compounds in other states we suggest the following modification.

"All medications must be ~~reasonably~~ reasonable and medically necessary to cure and relieve the injured worker from the effects of the injury."

Prescription Strength Topical Compounds
Page 65 – 66

Optum Comment: We support the proposed language as a way to control over utilization and skyrocketing costs of these "unique" medications which are often not clinically appropriate and provide little to no substantiated treatment efficacy. However, as this subsection of the proposed rule is completely new we have several questions for clarification and suggested changes to various language.

Page 65
"In order to qualify as a compound under this section, the medication must require a prescription . . . a medication tailored to the needs of the individual patient."

Optum Comment: We support this proposed language but seek clarification from the WCC. We request clarification that the requirement of this section applies only to prescription strength topical compounds and not OTC topical compounds?

If the proposed language applies only to prescription strength topical compound medications we remain apprehensive the WCC may be missing a large portion of the problem, OTC topical medications. As various states such as Florida, Colorado, Mississippi, Texas worked to address this very same issue, data highlights the fact that the general mix of topical medications causing system problems is roughly a 50/50 mix of medications requiring an Rx and medications

which are “prepackaged” OTC topical medications. While we are not urging the WCC to presently address this issue we wish to provide insight for future rule-making efforts.

If this proposed language applies only to prescription strength topical medications which actually require an Rx to be written and transmitted to the pharmacy before any medication is dispensed, then we suggest the WCC should consider requiring similar authorization as required for non-topical compounded medications. We propose the following modification:

Insert after the end of the first sentence of the paragraph – *“. . . tailored to the needs of the individual patient. Prescription strength topical compounds must be preauthorized for each dispensing. All ingredient materials must be listed . . . “*

Page 65
“The 30-day Maximum Fee Schedule value shall be fractioned down to the prescribed and dispensed amount given to the injured worker.”

Optum Comment: We suggest a minor change to ensure proper interpretation and application of the WCC’s intent.

“The 30-day Maximum Fee Schedule value shall be fractioned down to the ~~prescribed and~~ actual days’ supply of the medication dispensed ~~amount given~~ to the injured worker.”

Page 65 – 66
“All topical compounds shall be billed using the South Carolina Worker’s Compensation Commission code corresponding with the applicable category as follows: Category 1 – Code SC0801; Category 2 – Code SC0802 and Category 3 – Code SC0803 . . . “

Optum Comment: While we support various categories of topicals and reimbursement rates assigned to each category, we remain deeply concerned over the assignment of unique state billing codes which we believe will have a major impact on the ability of pharmacies, PBMs and other stakeholders to comply with proposed coding and billing requirements.

At present most marketplace stakeholders involved in dispensing, processing, billing and paying for pharmacy services utilize the most current National Council for Prescription Drug Programs (NCPDP) Workers’ Compensation/Property and Casualty Universal Claim Form (WC/PC UCF) which has been specifically designed by collaborating stakeholders to address the needs of billing and reimbursement within workers’ compensation pharmacy care. Moreover the norm in pharmacy electronic billing, payment and processing systems is utilization of the NCPDP Telecommunication Version D.0 electronic billing format. This too has been modified in certain aspects to meet the needs of workers’ compensation stakeholders. We noticed that current SC-WCC rules do not mandate a specific pharmacy billing form/format, thus we argue that across stakeholders the NCPDP form/format is the most common process for billing workers’ compensation pharmacy transactions in South Carolina.

In general the WC/PC UCF and D.0 do not support the proposed state specific codes for prescription strength topical compounds. While the WC/PC UCF can be manually modified to *potentially* comply, there is no ability to modify the D.0 without petitioning NCPDP to make such a change. Past modifications to the D.0 format to address state specific workers’ compensation billing requirements (including to accommodate similar state-specific, non-standard codes

adopted by Colorado) took between 18 to 24 months to complete. The currently proposed codes will create a situation in which pharmacies and payers/processors will either be non-compliant when billing for these transactions or forced to reduce a current no-touch electronic billing process to a manual hands-on costly process.

It is important to note that though it will not be possible to bill using these newly proposed codes, reimbursement can still be based on the WCC proposed methodology to cap expenditures on these products, just as with any other maximum fee schedule set by rules. The use of these codes for billing is not required to ensure reimbursement is capped at the WCC proposed levels. Other states such as Michigan and Mississippi have adopted unique reimbursement rates for similar types of products but have not mandated usage of a state specific billing code(s). Without modification to the NCPDP billing form/formats or other existing pharmacy billing systems providers and payers/processors will be forced to move to use an alternate and more time-consuming one-off manual process. This will add delays in the processing of medications and additional time and costs for both sides of the transaction (provider and payer). This will slow billing and reimbursement, care to injured workers and possibly increase billing disputes.

We respectfully request the WCC to reach out to NCPDP about the process and time-frame which would be associated with modifying the paper form and electronic format to comply with the proposed state specific billing codes. As this process could be lengthy we would also respectfully request the WCC remove the state specific billing codes until a time where the most commonly used billing forms/formats for workers' compensation claims can be properly vetted and modified.

Again, we are grateful to the Commission for this opportunity to provide feedback and submit our comments on the proposed changes. We look forward to a continuing dialogue and should you have any questions or comments, please feel free to reach out to me at any time.

Sincerely,

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

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

February 17, 2021

T. Scott Beck, Chairman
South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
Columbia, SC 29202-1715

Dear Chairman Beck:

The Physicians Research Institute (PRI) was founded for the purpose of supporting doctors in the private practice of medicine. At the current time, 37 State Medical Societies are members of PRI including the South Carolina Medical Association.

PRI believes that one change in the proposed regulations relating to the Medical Fee Schedule is contrary to South Carolina law which recognizes the right of physicians to dispense medication. Specifically, Section 10 (Pharmacy) at page 691 provides as follows: "**Opioid/scheduled controlled drugs that are prescribed for treatment shall be provided through a pharmacy. The dispensing provider shall keep a signature on file indicating the injured worker or his/her authorized representative has received the prescription**."

This provision is in conflict with the longstanding practice of allowing South Carolina physicians to dispense medication. One surgical way to correct this sentence is to replace the word "**shall**" with the word "**may**". With this change the "dispensing provider" (whether a physician or a pharmacist) would still be required to keep a signature on file indicating receipt of the prescription by the injured worker or his/her authorized representative.

PRI would request that this language either be deleted or edited appropriately.

Respectfully submitted,

Joseph A. Schwartz, III
President

JAS:jsm
cc: Richele Taylor, Senior Vice President, South Carolina Medical Association
Amy Proveaux, South Carolina Workers' Compensation Comm
Gary Cannon, South Carolina Workers' Compensation Comm
PRI Board of Directors

February 16, 2021

Mr. Gary Cannon
Executive Director
Workers' Compensation Commission
1333 Main Street
Post Office Box 1715
Columbia, South Carolina 29202

Dear Commissioners,

The South Carolina Orthopaedic Association (SCOA) appreciates the opportunity to comment on the proposed update to the Medical Services Provider Manual. While we value the Commission's commitment to annual updates, the budget-neutral instructions provided to Fair Health prohibit the consideration of reasonable increases in medical costs over time and creates an unsustainable situation for medical providers. We strongly believe a more realistic approach that anticipates annual increases in costs to provide services to injured workers is needed if access to care for injured workers is going to improve in South Carolina.

Our organization and individual members have consistently expressed concern over the comparatively low reimbursement for physician services in South Carolina versus all other states which is verified annually through data published from the Workers Compensation Research Institute. We have consistently stated that the reimbursement levels established in the Provider Manual suppress access to care for injured workers. Limited access to care translates into higher costs elsewhere in the system as return to work and optimized rapid recovery are delayed.

One of our practice leaders, AnnMargaret McCraw from Midlands Orthopaedics & Neurosurgery, recently had an opportunity to comment on the Physician Shortage in SC Workers' Compensation during a meeting of the South Carolina Workers Compensation Education Association. She shared her practice's experience with Workers Compensation as a case study to address the labor and reimbursement realities that lead many physician practices to avoid or limit their exposure to treating injured workers.

The take home message from her presentation was that while South Carolina Workers Compensation generates 5% more revenue per claim on average when compared to other payers, it requires 250% more labor costs per claim than the average of all other payers. A complete copy of her presentation and labor cost analysis is attached.

Given the administrative expense of treating injured workers, we believe the Commission must consider the negative impact a budget-neutral approach to provider reimbursement is having on access to care. Additionally, we urge the Commission to consider how its oversight and influence could be leveraged to reduce administrative burdens on medical providers, thereby making participation in the system more manageable.

South Carolina Orthopaedic Association, Inc
319 S. Glen Arven Avenue, Temple Terrace, FL 33617
scoa@cobbemanagement.com

We are eager to work with the Commission and all stakeholders to pursue a reimbursement strategy that appropriately values medical treatment while facilitating lower overall costs to the system by incentivizing rapid access to care and return to function for injured workers in our state. We truly believe these priorities are complementary, not mutually exclusive.

Sincerely,

Gregory Grabowski M.D.

Gregory Grabowski, MD
President
South Carolina Orthopaedic Association

South Carolina Orthopaedic Association, Inc
319 S. Glen Arven Avenue, Temple Terrace, FL 33617
scoa@cobbemanagement.com

Walmart Claims Services

PO Box 14731
Lexington, KY 40512-4731
Phone 123.456.7890
Fax 123.456.7890

February 12, 2021

Amy Proveaux
SC Workers' Compensation Commission
aproveaux@wcc.sc.gov
P.O. Box 1715
Columbia, SC 29202

Dear Amy:

I am writing regarding the current SC Fee Schedule and the request to provide feedback. Here are a few specific requests we believe would be beneficial to address in the upcoming Fee Schedule update in April.

- Per the Fee Schedule page 12. Submitting Claims for Payment: There is no specific time frame to submit an initial bill. However, the provider has 2 years from the Original billing to submit for a reconsideration. We would like to suggest a reasonable time frame for the submission of the original to be required 1 year from the date of service. Also, 1 year from the original denial or payment for reconsiderations.
- Per Fee Schedule page 15: Insurers and Self-insurers should inquire about and negotiate rates with out-of-state providers prior to authorizing care, except in Emergency situations. We would like to propose that they are paid per treating state's fee schedule if one exists and negotiate only if there is no fee schedule. This would be beneficial for both the payer and the provider.
- It could also be beneficial for both parties if there is no specific methodology listed in the South Carolina Fee schedule that the maximum reimbursement is based on Medicare guidelines and methodologies.
- The current Fee schedule does not address all Modifiers. For example, modifier 54 is used when a physician or other qualified health care professional performs a surgical procedure and does not preform pre-operative or post-operative visits. The use of this modifier would pay the surgical procedure only at 69% of the Fee Schedule value per Medicare National Fee Schedule.

Please feel free to reach out if you need further clarification or have additional questions.

Sincerely,

Karen Mills
Analyst 1, Specialty Compliance and Ethics (AK, NC, SC, RI & WV)
(479) 621-2697

Karen.Mills@walmart.com
Walmart Claims Services, Inc.
P.O Box 14731
Lexington, KY 40512-4731

Unsigned copy more legible

The Pain Society of the Carolinas

T. Scott Beck, Chairman
South Carolina Workers' Compensation Commission (SCWCC)
Post Office Box 1715
1333 Main Street, Suite 500
Columbia, South Carolina 29202-1715

February 17, 2021

RE: Proposed Changes to the 2021 South Carolina Workers' Compensation Medical Services Provider Manual

Dear Mr. Chairman and Members of the Commission,

On behalf of the physician and provider members of the Pain Society of the Carolinas, please accept the following objection to the proposed changes to the 2021 South Carolina Workers' Compensation Medical Services Provider Manual ("Manual") scheduled to take effect April 1, 2021.

The SCWCC has proposed adding language to Section 10 ("Pharmacy") of the Manual that states as follows: "Opioids/scheduled controlled substances that are prescribed for treatment shall be provided ***through a pharmacy***. The dispensing provider shall keep a signature on file indicating the injured worker or his/her authorized representative has received the prescription." While we agree with the concept of physicians not dispensing Schedule II medications from their office, this quoted change unnecessarily limits a physician's ability to provide appropriate medical care to their injured-worker-patient when medically necessary to provide medicine at the time of the patient visit.

Physicians strive to get injured workers back to work or to maximum medical improvement as expeditiously as possible by providing medically appropriate treatment. Point of care dispensing is one of the tools that physicians can utilize to provide streamlined oversight and care to injured workers. When physicians are able to dispense, injured workers can begin their medication treatment immediately and in a supervised environment (as opposed to sending injured workers to the pharmacy where they have no oversight by his or her physician, can encounter insurance related delays, cannot get to a pharmacy due to injury or transportation issues, etc.). In addition, an injured worker's monitored compliance with the treatment plan can facilitate a quicker recovery and an earlier return to work.

As we continue to navigate our way through the coronavirus pandemic, point of care treatment such as in-office medicine dispensing, is more critical today than ever and is a tool to help injured workers limit Covid-19 exposure and avoid unnecessary trips to the pharmacy. Imposing additional hurdles that delay care and take all or parts of a treatment plan out of the hands of physicians *will only create additional hardship for injured workers in a system that strives for more efficiency, better outcomes and a quicker return to work.*

For the foregoing reasons, we respectfully oppose the proposed rule requiring certain medications be provided through a pharmacy. We would enjoy the opportunity to work together and believe that we can come up with solutions that meet your objectives and satisfy patient needs. Thank you for your consideration.

Robert Wilson MD
President

Ezra B. Riber MD
Past President

145 Kimel Park Drive #330 | Winston-Salem, NC 27103 I Tel: (844) 524-PAIN (7246) I Fax: (727) 362-6210

The Pain Society of the Carolinas

T. Scott Beck, Chairman
South Carolina Workers' Compensation Commission (SCWCC)
Post Office Box 1715
1333 Main Street, Suite 500
Columbia, South Carolina 29202-1715

February 17, 2021

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Robert Wilson, MD

Robert Wilson MD
President

Ezra B. Ribet MD
Past President

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Workers' Compensation Commission

MEMORANUM

TO: **COMMISSIONERS**

FROM: **Gary Cannon**
Executive Director

DATE: **January 18, 2021**

RE: **Medical Services Provider Manual**

The Commission is required to update the Medical Services Provider Manual annually, with the new rates and policy changes effective April 1. In order to provide you ample time to review the recommended changes and allow the stakeholders to provide public comment we present the recommended changes at the January Business Meeting. Wayne Ducote and Bridgette Amick of our staff have been working with representatives of Fair Health a national, independent, not-for-profit organization since September 2020. Fair Health representatives include Christine O'Donnell, Dr. Joel Brill, Linda Stelmach, Lydia Muna and Donna Smith.

Attached you will find the following documents

- Fee Schedule Analysis 2021
- Summary of Changes to the Medical Services Provider Manual for 2021
- An Analysis of the Anesthesia Conversion Factor 2021
- A copy of "Medical Services Provider Manual 2021", with changes to the policy text

Staff will post these documents on the Commission's website and send an Advisory Notice to all stakeholders giving notice of the public comment period and the documents availability on the Commission's website.

Staff recommends the Commission schedule a time at the February Business Meeting to receive public comment from stakeholders on the proposed changes. Further we recommend the Commission approve any changes Conversion Factor and changes to the policy text in the Medical Services Provider Manual at the March Business Meeting.

Fee Schedule Analysis

January 13, 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 (2019 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 2021 fee schedule.

FAIR Health received paid amounts from NCCI for the 2019 calendar year, aggregated at the procedure code/modifier level. FAIR Health used the data from 2019 to:

1. Develop a "fee schedule-neutral" conversion factor designed to reflect a similar level of spending based on 2020 MAP amounts; and
2. Project paid amounts for 2021 based on multiple conversion factor alternatives.

For 2021, CMS increased RVUs for office visits for new and established patients, CPT codes 99202-99205 and 99212-99215. These codes reflect some of the most frequently performed services in the South Carolina workers' compensation program. To maintain budget neutrality and offset the increased reimbursement for evaluation and management services, CMS significantly reduced the 2021 conversion factors for both professional services and anesthesia. The South Carolina statutory cap of +/- 9.5% on changes from rates from the prior year's MSPM in part controls some of these changes. The updated RVUs and South Carolina caps on rate changes are embedded in the projections presented below.

On December 27, 2020 the Consolidated Appropriations Act, which includes pandemic relief and national budget provisions, was signed into law. The Act includes provisions that defer use of a complexity adjustment for evaluation and management procedures and mandates an increase to the Medicare conversion factors for 2021. To comply with these changes and maintain budget neutrality, CMS recalculated the conversion factors for 2021, which were updated on January 7.

The information in this report is based on conversion factors published by CMS on January 7, 2021.

2019 Paid Data and Frequencies
The following is a summary of the 2019 data received from NCCI:

NCCI Data Call - 2019 Calendar Year (Before Validation)

Service Type	Total Paid	Total Charged	Transactions	Units
CPT (Without Anesthesia)	$56,724,510.07	$121,604,885.32	693,636	962,897
Anesthesia*	$1,595,861.29	$9,166,281.92	6,072	666,175
HCPCS (Without Ambulance)	$16,816,157.03	$24,016,642.04	69,062	1,595,262
Ambulance**	$2,613,438.44	$4,792,517.52	13,917	346,230
Total	$77,749,966.83	$159,580,326.80	782,687	3,570,564

* 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 2019 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 2019 occurrences and adjusted MAP amounts.

Fee Schedule-Neutral Conversion Factor- 2020 Projections
- Total dollar amounts were projected based on 2019 occurrences and 2020 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 2019 level for each service area.
- The total fee schedule budget neutral conversion factor is 41.09.
- Ambulance data is paid at 100% of Medicare and is not included in this analysis.
- Please see the separate analysis for anesthesia data.

2020 Projections

Category	Frequency	Total 2020 RVUs	NCCI Payment	Budget Neutral Conversion factor
Evaluation and Management	127,182	307,602	$13,815,061.31	44.91
HCPCS Level II	179,967	147,573	$5,044,921.00	34.19
Medicine & Injection	14,830	28,971	$1,336,460.26	46.13
Pathology & Laboratory	12,064	9,758	$499,016.75	51.14
Physical Medicine	705,857	622,537	$22,684,937.91	36.44
Radiology	51,896	89,301	$4,571,755.77	51.19
Special Reports	1,114	1,281	$58,787.28	45.89
Surgery	34,520	253,559	$11,997,981.53	47.32
Total	1,127,430	1,460,582	$60,008,921.81	41.09

The relatively low conversion factor in this analysis is influenced by payments that are lower than fee schedule MAPs for certain high frequency codes in the physical medicine and HCPCS service areas. The lower payments in the physical medicine section may be related to network contracts. Payment for boxes of alcohol wipes and pairs of electrodes at rates lower than fee schedule MAPs may be influencing the conversion factor for the HCPCS section. In addition, NCCI paid data reflect significant payments for codes that are paid based on "individual consideration".

Because the HCPCS and Physical Medicine sections have high frequencies relative to other service areas, these anomalies have a large influence on the budget neutral conversion factor.

Comparison of Alternate Conversion Factors – 2021 Projections

- The projections of paid amounts for the 2021 fee schedule are based on 2019 frequencies and 2021 RVUs, to which conversion factors of 48.85* (equal to 140% of the CMS conversion factor), 49, 50, 50.3 (the current South Carolina conversion factor), 51 and 52 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.

  * While not mandated, the South Carolina conversion factor has generally been targeted to 140% of the CMS conversion factor (or 48.85)

- The 2021 MAP values used for these projections include certain changes in how services not covered under the Medicare Professional Fee Schedule were valued:
  - 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 FAIR Health benchmark values or FAIR Health's FH® Medicare GapFill PLUS product.
  - FAIR Health does not recommend that the State establish gap fill values for new codes effective January 1, 2021 that were not valued by Medicare. Setting a gap fill value before actual claims information has been received could set an inappropriate baseline against which the +/-9.5% cap would be applied in future years. FAIR Health will evaluate those codes and, based on the claims received during calendar year 2021, propose gap fill values for the 2022 MSPM.

2021 Projections

Category	Total $ 2021 with CF = 48.85	CF48.85	Total $ 2021 with CF = 49	CF49	Total $ 2021 with CF = 50	CF50	Total $ 2021 with CF = 50.3	CF50.3	Total $ 2021 with CF = 51	CF51	Total $ 2021 with CF = 52	CF52
Evaluation and Management	$16,580,930	45.50	$16,597,120	45.5	$16,704,653	45.8	$16,736,705	45.9	$16,792,843	46.1	$16,841,034	46.2
HCPCS Level II	$7,586,940	51.10	$7,592,333	51.1	$7,628,523	51.3	$7,639,381	51.4	$7,664,718	51.6	$7,699,361	51.8
Medicine & Injection	$1,521,768	48.50	$1,524,799	48.6	$1,544,866	49.3	$1,550,826	49.5	$1,562,423	49.8	$1,576,597	50.3
Pathology & Laboratory	$503,374	49.30	$504,869	49.4	$513,738	50.3	$516,728	50.6	$523,477	51.2	$529,189	51.8
Physical Medicine	$31,026,622	48.80	$31,109,533	48.9	$31,671,765	49.8	$31,840,650	50.0	$32,231,889	50.7	$32,791,291	51.5
Radiology	$4,532,432	49.10	$4,545,890	49.2	$4,634,765	50.2	$4,661,234	50.5	$4,717,725	51.1	$4,782,935	51.8
Special Reports	$65,075	48.90	$65,270	49.0	$66,565	50.0	$66,952	50.3	$67,860	51.0	$69,150	52.0
Surgery	$12,921,333	49.00	$12,959,079	49.1	$13,209,367	50.1	$13,284,334	50.4	$13,454,249	51.0	$13,677,471	51.8
Grand Total	**$74,738,474**	**48.26**	**$74,898,893**	**48.36**	**$75,974,242**	**49.06**	**$76,296,810**	**49.27**	**$77,015,184**	**49.73**	**$77,967,028**	**50.34**

Upon approval of a conversion factor for 2021, FAIR Health will provide an updated Medical Services Provider Manual, which will include any 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)

Summary of Changes

2021 Medical Services Provider Manual

January 13, 2021

FAIR Health has completed the revisions to the fee schedule under the direction of the South Carolina Workers' Compensation Commission (WCC). The codes in the existing fee schedule have been brought current by including codes established for 2021 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 2021 Medical Services Provider Manual (MSPM). Page numbers refer to the pages in the South Carolina MSPM effective April 1, 2020.

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

1. **Chapter II. General Policy**

Copies of Reports and Records (Page 9) - Language is updated to provide clarity and match the Copies of Reports and Records text on page 483 of in Section 8, Special Reports and Services.

COPIES OF REPORTS AND RECORDS
Providers are entitled to charge for the cost of copying records and reports except when such documents are requested by the Commission or for the purpose of substantiating a charge and/or medical necessity. (See Appendix A for S.C. Code Section 42-15-95 and Regulation 67-1301.)

~~The maximum charge for providing records and reports other than for substantiating medical necessity is $25.00 for a clerical fee plus $0.65 per page for the first 30 pages *in* **Print or Electronic** *format*, and $0.50 per page thereafter provided *in an electronic format*, which may not exceed $150.00 per request, plus sales tax, and actual cost for postage to mail the documents. Providers must respond to a request for copies within 14 days of receipt or face a penalty of up to $200.00. Section 42-15-95 of the S.C. Code, which governs charges for copies, can be found in Appendix A.~~

Providers are required to include supporting documentation when submitting claims, or when required by an insurance carrier, self-insured employer, or the Commission to submit substantiating documentation, and may not charge for these required reports. (See Regulation 67-1302 B(2).) However, when the records or reports are not for the purposes listed above, providers may charge for copying costs. Copying charges are $0.65 per page for the first 30 pages provided in *electronic format*, and $0.50 per page thereafter provided *in an electronic format, which may not exceed $150.00* per request, plus a clerical and handling fee of $25.00 plus tax and actual postage costs. Providers must respond to a request for copies within 14 days of receipt or face a penalty of up to $200.00. Section 42-15-95 of the S.C. Code, which governs charges for copies, can be found in Appendix A. Providers are entitled to charge for the cost of copying records and reports except when such documents are requested by the Commission or for the purpose of substantiating a charge and/or medical necessity.

Providers are required to include supporting documentation when submitting claims, or when required by an insurance carrier, self-insured employer, or the Commission to submit substantiating documentation, and may not charge for these required reports. (See Regulation 67-1302 B(2).)

However, when the records or reports are not for the purposes listed above, providers may charge for copying costs. Copying charges are $0.65 per page for the first 30 *printed* pages, and $0.50 per *printed* page thereafter, *which may not exceed $200.00 per request*, plus a clerical and handling fee of $25.00 plus tax and actual postage costs. Providers must respond to a request for copies within 14 days of receipt or face a penalty of up to $200.00. Section 42-15-95 of the S.C. Code, which governs charges for copies, can be found in Appendix A. Providers are entitled to charge for the cost of copying records and reports except when such documents are requested by the Commission or for the purpose of substantiating a charge and/or medical necessity.

A facility or provider may charge a patient or the patient's representative no more than the actual cost for duplicating an x-ray film or digital image. Actual cost means the cost of materials and supplies used to duplicate the x-ray film or digital image and the labor and overhead costs associated with the duplication.

Providers who use a medical records company to make and provide copies of medical records or x-ray images must ensure that neither the Commission nor the reviewer is billed for the cost of copies when the purpose of the copies is to substantiate a charge and/or medical necessity.

Note: Providers do not need to obtain authorization from the injured worker to release medical records relating to a workers' compensation claim. An employee who seeks treatment under the provisions of the Workers' Compensation Act is considered to have given consent for the release of medical records relating to the examination or treatment.

2. **Part II: Fee Schedule**

Icons (page 31) – Language is added to the icon for state-specific code to bring attention to a change in code numbers for state specific codes. An additional icon, an asterisk (*), has been added to identify codes that are eligible to be performed via telemedicine.

∞ State-specific code. This code is unique to South Carolina Workers' Compensation Commission. Note that state-specific codes have been assigned new code numbers in the 2021 *Medical Services Provider Manual*.

* Telemedicine-eligible code. This code may be reimbursed when provided via telemedicine.

Telemedicine Policy (page 32) – A temporary telemedicine policy is inserted after the Surgical Assistant section.

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 an asterisk (*) 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 (Page 33)**

Language is included to reflect a change to E/M office visits for new and established patients (CPT 99202-99205 and 99211-99215), effective January 1, 2021, which are defined based on the level of medical decision making defined for each service or the total time spent on the date of service.

Documentation must support the level of E/M service reported.
For complete instructions on identifying and billing E/M services, please refer to the Evaluation and Management Services Guidelines of the ~~2020~~ 2021 CPT book.

~~E/M service descriptors have seven components. These components are: history, examination, medical decision-making, counseling, coordination of care, nature of presenting problem, and time.~~ The appropriate level of E/M service is based on the level of medical decision making defined for each service or the total time spent on E/M services on the date of service.

Evaluation and Management Time
~~The times listed in the code descriptors are averages. Actual time spent by the provider may be slightly higher or lower depending upon the actual clinical circumstances; however, providers should select the CPT code that best describes the amount of time actually spent.~~ Beginning in 2021, time alone may be used to select the appropriate code level of office or other outpatient evaluation and management services, codes 99202-99205 and 99212-99215. For office visits and other outpatient visits, time is based on the amount of time spent face to face with the patient and not the time the patient is in an examining room.

For inpatient hospital care, time is based on unit floor time. This includes the time the physician is present on the patient's hospital unit and at the bedside rendering services. This also includes time spent reviewing the patient's chart, writing additional notes, and communicating with other professionals and/or the patient's family.

Additional codes may be reported with the office or other outpatient visit codes to indicate a prolonged visit.

Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the ***other*** E/M services when counseling and/or coordination of care dominates the service. The appropriate time should be documented in the medical record when it is used as the basis for code selection.

~~Time is used as the controlling factor to select a level of service when more than 50 percent of the patient encounter is spent in counseling and coordination of care. Time spent counseling and the extent of the counseling and/or coordination of care must be documented.~~

4. **Section 3: Surgery (Page 69)**

Correcting a typographical error in the numbering of modifiers for bilateral and multiple procedures.

~~51~~ 50 Bilateral Procedure

~~52~~ 51 Multiple Procedures

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

Special Reports (Page 483) – Update the language in the first two paragraphs as follows:

A special report may be billed and paid when the provider furnishes information above and beyond that which is required by Commission policy or by the laws and regulations of the South Carolina Workers' Compensation Act. ~~Special Reports~~, CPT® code 99080, special reports, should not be used to bill for completing a report which is included in the CPT descriptor of the service provided ~~or for reporting the results of an impairment rating made during an E/M service.~~ However, CPT code 99080 *may* be billed in conjunction with, and in addition to, CPT code 99455, work related or medical disability examination, to report the results of an impairment rating ~~made~~ developed during the examination.

Payment for a special report is $55.00 for a checklist-type report which requires a review of the medical record, and $70.00 for a written report or for completing the Commission's Form 14B. Prepayment for form or report completion is prohibited.

The purpose of WCC Form 14B Physician's Statement is to consolidate medical information, already existing in the patient's medical file, onto a single, easily referenced document. The Form 14B is a summary of information generated from the patient's previous medical exams, including the diagnosis, date of maximum medical improvement, permanent impairment, work restrictions, retained hardware, and need for future medical care and treatment. The Form 14B must be signed by the treating physician, who is a qualified physician or surgeon.

The Form 14B is required to be submitted when an employer's representative requests an informal conference to approve settlement on a Form 16A pursuant to R.67-802(A)(1)(a); when an employer's representative requests a Form 16A be approved in accordance with R.67-802(A)(2)(a); and when an employer's representative requests an informal conference to approve settlement on a full and final, clincher basis in accordance with R.67-803(B)(1)(a).

The Workers' Compensation Act provides that "…a physician or hospital may not collect a fee from an employer or insurance carrier until the physician or hospital has made the reports required by the Commission in connection with the case." S.C. Code Ann. § 42-15-90(A) (1976, as amended).

Copies of Reports and Records (Page 483) – Update language to provide clarity and match the Copies of Reports and Records language in the General Policies section on page 9.

COPIES OF REPORTS AND RECORDS
Providers are required to include supporting documentation when submitting claims, or when required by an insurance carrier, self-insured employer, or the Commission to submit substantiating documentation, and may not charge for these required reports. (See Regulation 67-1302 B(2).) However, when the records or reports are not for the purposes listed above, providers may charge for

copying costs. Copying charges are $0.65 per page for the first 30 pages provided in ~~Print or~~ *electronic format*, and $0.50 per page thereafter provided *in an electronic format, which may not exceed $150.00* per request, plus a clerical and handling fee of $25.00 plus tax and actual postage costs. Providers must respond to a request for copies within 14 days of receipt or face a penalty of up to $200.00. Section 42-15-95 of the S.C. Code, which governs charges for copies, can be found in Appendix A. Providers are entitled to charge for the cost of copying records and reports except when such documents are requested by the Commission or for the purpose of substantiating a charge and/or medical necessity.

Providers are required to include supporting documentation when submitting claims, or when required by an insurance carrier, self-insured employer, or the Commission to submit substantiating documentation, and may not charge for these required reports. (See Regulation 67-1302 B(2).) However, when the records or reports are not for the purposes listed above, providers may charge for copying costs. Copying charges are $0.65 per page for the first 30 *printed* pages, and $0.50 per *printed* page thereafter, *which may not exceed $200.00 per request*, plus a clerical and handling fee of $25.00 plus tax and actual postage costs. Providers must respond to a request for copies within 14 days of receipt or face a penalty of up to $200.00. Section 42-15-95 of the S.C. Code, which governs charges for copies, can be found in Appendix A. Providers are entitled to charge for the cost of copying records and reports except when such documents are requested by the Commission or for the purpose of substantiating a charge and/or medical necessity.
Providers who use a medical records company to make and provide copies of medical records must ensure that neither the Commission nor the reviewer is billed for the cost of copies when the purpose of the copies is to substantiate a charge and/or medical necessity.

Note: Providers do not need to obtain authorization from the injured worker to release medical records relating to a workers' compensation claim. An employee who seeks treatment under the provisions of the Workers' Compensation Act is considered to have given consent for the release of medical records relating to the examination or treatment.

Medical Testimony (Page 484) – Update to reflect new codes, which are not part of the American Medical Association's (AMA) schema.

MEDICAL TESTIMONY
Medical testimony by personal appearance of a physician, whether before a Commissioner or in a court of law, is reported using ~~CPT code 99075~~ South Carolina specific ~~code 99076~~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 ~~CPT~~ South Carolina specific code ~~99075~~SC001 to report the initial hour, and South Carolina specific code ~~99076~~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 ~~99077~~SC003.

Medical testimony by deposition of a physician is reported using South Carolina specific service codes ~~99072~~ SC004 and ~~99073~~SC005. Use South Carolina specific code ~~99072~~SC004 to report the initial hour and code ~~99073~~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 ~~99074~~SC006.

6. **Section 10: Pharmacy (Page 691)**

This section stipulates only those policies and procedures that are unique to Pharmacy. Additional policies and procedures that apply to all providers are listed in Part I of this *Medical Services Provider Manual*.

PRESCRIPTION DRUG MONITORING PROGRAM

Treating physicians prescribing medication or drugs must comply with the requirements of Act 91 enacted by the SC General Assembly May 31, 2017.

REIMBURSEMENT

Payment for prescription drugs is limited to the lesser of the amount established by the following formula, or by the pharmacist's or health care provider's usual and customary charge. The formula applies to both brand name and generic drugs. However, all prescriptions must be filled using generic drugs, if available, unless the authorized treating physician directs that it be dispensed as written. Opioids/scheduled controlled substances that are prescribed for treatment shall be provided through a pharmacy. The dispensing provider shall keep a signature on file indicating the injured worker or his/her authorized representative has received the prescription.

Average Wholesale Price + $5.00

All bills under this section shall be itemized for proper reimbursement. Bills submitted for reimbursement shall be based on the original manufacturer's Average Wholesale Price (AWP) of the drug product on the date the drug was dispensed, and must include the National Drug Code (NDC) of the product dispensed. Medi-Span, published by Wolters-Kluwer Health, or IBM Micromedex RED BOOK, shall be used as the source for determining the average wholesale price (AWP). Where the AWP of a medication is not published by Medi-Span or REDBOOK, any nationally published pharmacy price index may be used as a secondary source. In case of a dispute on AWP values for a specific NDC, the parties should take the lower of their referenced published values. If published AWP data becomes unavailable, substitute Wholesale Acquisition Cost (WAC) + 20%. Any issue arising as to the source of average wholesale price may be administratively reviewed by the Commission's Medical Services Division.

Any medication or drugs not specifically prescribed by the treating physician shall not be reimbursed. In the event the treating physician recommends and/or prescribes a particular drug or medication that can be purchased over-the-counter (without a prescription), and the injured employee pays for the drug or medication, the injured employee is entitled to reimbursement for the purchase upon submission of the appropriate receipts to the employer/insurance carrier.

The price determined by the formula will be the maximum allowable payment a provider can be paid under the Workers' Compensation Act. In instances where the pharmacy's charge is lower than the maximum allowable payment, or where the pharmacy has agreed by contract with an employer, insurance carrier, or their agent to a contractual amount that is lower than the maximum allowable amount, reimbursement shall be made at the lower amount in accordance with the terms of the contract.

REPACKAGED DRUGS

The entity packaging two or more products together makes an implied claim that the products are safe and effective when used together and shall be billed as individual line items identified by their original AWP and NDC. Bills for repackaged drug products must include the original manufacturer or distributor's stock package NDC used in the repackaging process. Reimbursement for a drug that has been repackaged or relabeled shall be calculated by multiplying the number of units dispensed times the per-unit AWP set by the original manufacturer for the underlying drug, plus a single ~~$5.00~~ dispensing fee of $5.00, **except** where the carrier/payer has contracted for a different amount. A repackaged NDC Number shall not be used and shall not be considered the original manufacturer's NDC Number.

If the original manufacturer's or distributor's stock package NDC information is not provided or is unknown, the payer shall select the most reasonable and closely associated AWP to use for reimbursement of the repackaged drug. In no case shall the repackaged or relabeled drug price

exceed the amount otherwise payable had the drug not been repackaged or relabeled. Supplies are considered integral to the package and are not separately reimbursable. Manufacturers of a repackaged or relabeled drug shall not be considered an "original manufacturer."

COMPOUND DRUGS

All medications must be reasonably needed to cure and relieve the injured worker from the effects of the injury. Compound drugs must be preauthorized for each dispensing. ~~and shall be billed by listing each drug included in the compound by NDC, and calculating the charge for each drug separately.~~ Any compounded drug product billed by the compounding pharmacy or dispensing physician shall be identified at the ingredient level and the corresponding quantity by their original manufacturer's National Drug Code (NDC) when submitted for reimbursement. Payment for compounded prescription drugs shall be ~~based on~~ the sum of the average wholesale price by gram weight ~~fee~~ for each ingredient, plus a single dispensing fee of $5.00. ~~If the NDC for any compounded ingredient is a repackaged medication NDC, reimbursement for the repackaged ingredient(s) shall be calculated as provided above.~~ A compounded NDC Number shall not be used and shall not be considered the original manufacturer's NDC Number. ~~No payment shall be required for an ingredient not identified by an NDC.~~ Any component ingredient in a compound medication for which there is no NDC shall not be reimbursed. Any component ingredient in a topical compound medication that is not FDA approved for topical use shall not be reimbursed.

PRESCRIPTION STRENGTH TOPICAL COMPOUNDS

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. Category fees include materials, shipping and handling, and time. Regardless of how many ingredients or what type, compounded drugs cannot be reimbursed higher than the Category III fee. The 30-day Maximum Fee Schedule value shall be fractioned down to the prescribed and dispensed amount given to the injured worker. Automatic refilling is not allowed. All topical compounds shall be billed using the South Carolina Worker's Compensation Commission code corresponding with the applicable category as follows:

Category I SC0801, $80.00 per 30-day supply

Any anti-inflammatory medication or any local anesthetic single agent.

Category II SC0802, $160.00 per 30-day supply

Any anti-inflammatory agent or agents in combination with any local anesthetic agent or agents.

Category III SC0803, $240.00 per 30-day supply

Any agent(s) other than anti-inflammatory or local anesthetic agents, either alone, or in combination with other anti-inflammatory or local anesthetic agents.

ADMINISTRATION KITS

Administration kits packaged by the manufacturer and assigned a single National Drug Code (NDC) may be reimbursed the Average Wholesale Price (AWP) of the kit without additional markup. Kits packaged by the provider or other source are considered to be part of the administration of the pharmaceutical and are not separately reimbursed even if reported with an NDC or HCPCS Level II code. Only those supplies and materials over and above those usually provided in the office of the physician or other qualified health care professional may be reported in addition to the pharmaceutical drug and administration as discussed above and in Part I Chapter III of the ~~*2020*~~ *2021 Medical Services Provider Manual.*

The following section has been ADDED to packet on 2/22/2021

Analysis of Anesthesia Conversion Factor

January 13, 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 2020
- 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

For 2021, CMS increased RVUs for office visits for new and established patients, CPT codes 99202-99205 and 99212-99215. To maintain budget neutrality and offset the increased reimbursement for evaluation and management services, CMS reduced the 2021 conversion factors for both professional services and anesthesia. The current South Carolina anesthesia conversion factor of $30 is equal to 139.15% of the 2021 national Medicare anesthesia conversion factor of $21.56 and 144.02% of Medicare's 2021 South Carolina anesthesia conversion factor of $20.83. This relationship is similar to the South Carolina professional conversion factor, which is 144.16% of the Medicare 2021 conversion factor.

On December 27, 2020 the Consolidated Appropriations Act, which includes pandemic relief and national budget provisions, was signed into law. The Act includes provisions that defer use of a complexity adjustment for evaluation and management procedures and mandates an increase to the Medicare conversion factors for 2021. To comply with these changes and maintain budget neutrality, CMS recalculated the anesthesia and professional services conversion factors for 2021.

The information in this report is based on conversion factors that were updated by CMS on January 7, 2021.

	Anesthesia – National Comparison	Anesthesia – South Carolina Comparison	Other Professional Services
South Carolina Conversion Factor	$30.00	$30.00	$50.30
2021 Medicare Conversion Factor	$21.56 (National)	$20.83 (Adjusted by CMS for South Carolina)	$34.8931
Ratio	139.15%	144.02%	144.16%

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 select or "cherry pick" 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 2019 through June 2020 and allowed benchmarks are based on imputed allowed amounts from claims incurred during calendar year 2019.

		Percentiles												
Type	Average	5th	10th	15th	20th	25th	30th	35th	40th	45th	50th	60th	70th	80th	90th
Billed Anesthesia	128.33	50.77	60.64	70.28	79.70	88.65	97.09	104.44	109.89	114.70	119.72	131.95	154.66	172.99	190.32
Allowed Anesthesia	60.14	24.79	29.44	34.13	39.32	43.17	46.66	49.60	52.19	54.39	56.93	62.20	70.24	81.59	88.56

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 $56.93) is the median conversion factor value in the private insurance data and the average allowed conversion factor benchmark is $60.14.

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 2020 study from the ASA website at https://monitor.pubs.asahq.org/journal.aspx. A copy of the ASA Monitor newsletter containing the 2020 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. In the 2019 survey, an insufficient number of responses were received to include state-level results for South Carolina.

	National		Southeast Region		South Carolina		
Conversion Factor	2019	2020	2019	2020	2018	2019*	2020
Low	23.73	31.50	33.34	32.00	26.60	N/A	33.00
Median	72.00	73.00	77.00	78.68	80.00	N/A	72.00
Average	77.01	82.14	81.16	87.33	86.77	N/A	82.02
High	256.50	323.22	256.50	184.50	185.00	N/A	162.00

* In 2019, there were too few respondents to report results at the South Carolina state level, so comparisons to 2018 are included.

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	$56.82
Colorado	$46.50
Florida	$29.49
Georgia	$60.08
Kentucky	$78.53
Louisiana	$50.00
Maryland	$21.69
Mississippi	$50.00
North Carolina	$58.20 – first 60 min $30.75 – after 60 min
Oklahoma	$48.50
North Dakota	$64.92
Tennessee	$75.00
Virginia (6 regions)	$49.00 - $77.00

FAIR Health assists Colorado, Georgia, Kentucky, Mississippi, North Dakota and Oklahoma 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 144.02% of the 2021 Medicare conversion factor for South Carolina and 139.15% of the national Medicare conversion factor.
- The ratio of the South Carolina workers' compensation anesthesia to Medicare is generally aligned with the 144.16% ratio of the conversion factor for other professional services ($50.30) in comparison to Medicare ($34.8931). 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 – 2020* appears on the following pages.

American Society of Anesthesiologists

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ASA Monitor®

THE LEADING SOURCE FOR PERIOPERATIVE HEALTH CARE NEWS

Remimazolam: Is the Sedative of the Future Here?

Dibash K. Das, PhD

Sedative and anesthetic safety is continuously reviewed as part of quality assessments. Yet, the market for sedation and anesthesia has been short on pharmaceutical development, and standard options for moderate sedation medications have not changed in three decades.

Typically, either propofol or a benzodiazepine (e.g., midazolam) with or without a narcotic (e.g., fentanyl) is used to obtain sedation for procedures. Both strategies have pros and cons. A disadvantage of propofol is the requirement of constant monitoring by an anesthesia provider due to its potential for respiratory- and cardio-depressive effects, which results in additional costs and higher risks, since there is no reversal agent available for propofol to be able to quickly stop sedation if required. For midazolam, although these side effects are less pronounced, there is a slower onset and a longer duration of action that can impact patient throughput and overall efficiency. Consequently, the search for an elusive ideal anesthetic remains.

Remimazolam (BYFAVO™), developed by PAION AG, is a novel moleculer, water-soluble, ultra-short-acting intravenous benzodiazepine that was developed to address the shortcomings of current sedation strategies. A key feature of remimazolam

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Severe Sequelae, Chronic Headache Linked to PDPH

Jessica Ansari, MD Pamela Flood, MD, MA

Post-dural puncture headache (PDPH) is a well-known complication of neuraxial anesthetic procedures resulting in an acute postural headache within five days of a dural puncture (*Minerva Anestesiol* 2019;85:543-53). Patients generally experience a severe, dull, frontal or occipital headache, often associated with neck pain, tinnitus or

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ASA Survey Results: Commercial Fees Paid for Anesthesia Services, 2020

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

Summary

Based on the 2020 survey results, the national average commercial conversion factor was $82.14, ranging between $76.09 and $85.75 for the five contracts. The national median increased to $73.00, ranging between $69.00 and $77.25 for the five contracts (Figure 1, Table 1). In the 2019 survey, the mean conversion factor ranged between $73.79 and $80.76, and the median ranged between $69.00 and $78.00. In contrast, the current national Medicare conversion factor for anesthesia services is $22.2016, or about 27.03% of the

Continued on page 26

Payment and Practice Management

Continued from page 1

2020 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 $310-$330. 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 238 practices in 43 states. The 2019 survey results included data from 270 practices in 43 states.

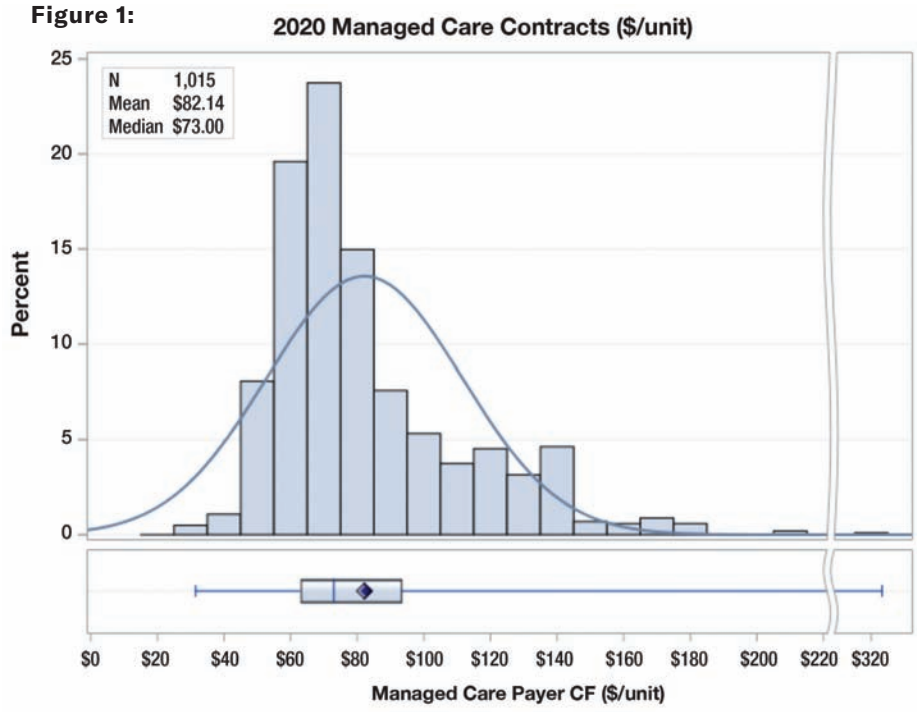
Methodology

The survey was disseminated in June and July 2020. 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 particpants provide data that were at least three months old. In addition, the following three conditions must be met:

1. There are at least five providers reporting data upon which each disseminated statistic is based, and
2. No individual provider's data represent 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 states that submitted sufficient data to be compliant with DOJ and FTC principles, and we provide state-specific data for only those states. We have 17 Eligible States this year.

Figure 1:



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CEO, Stead Health Group, Inc.

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

"Based on the 2020 survey results, the national average commercial conversion factor was $82.14, ranging between $76.09 and $85.75 for the five contracts."

This is the tenth year 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 Weekly (all-member 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 246 unique practices. However, due to respondents providing incomplete data, we excluded eight responses from the overall analysis. Our results are based on the data from 238 practices.

Results

Table 2 presents respondent information for 197 practices (41 practices did not provide us with 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:

Table 1: National Managed Care Anesthesia Conversion Factors ($/unit), 2020

Conversion Factors	Contract 1	Contract 2	Contract 3	Contract 4	Contract 5	ALL
Mean	$76.09	$80.73	$85.30	$85.06	$85.75	$82.14
Low	$33.00	$31.50	$41.00	$39.00	$32.00	$31.50
25th Percentile	$60.72	$63.00	$63.55	$64.00	$65.00	$62.95
Median	$69.00	$72.00	$75.00	$74.75	$77.25	$73.00
75th Percentile	$85.00	$90.00	$98.47	$97.50	$104.00	$93.61
High	$209.75	$166.00	$323.22	$184.50	$211.71	$323.22
Number of Responses	238	227	209	188	153	1,015
Percentage of Managed Care Business	21.1%	9.14%	5.41%	3.65%	2.74%	9.34%

Table 2: Respondent Information by Major Geographic Region, 2020

Region	Practices	Cases	Mean Units/ FTE MD	Mean Units/ Case	FTE MD	FTE Nurse Anesthetist	FTE AA
Eastern	35	1,540,302	11,865	10.98	1,555.5	1,056.2 (253.0)	11 (65)
Midwest	42	1,907,427	16,652	10.46	1,171.7	1,200.7 (136.2)	40 (0)
Southern	70	2,990,754	21,244	10.16	1,767.0	2,334.4 (415.0)	491.5 (0)
Western	50	1,930,614	8,742	11.01	2,678.5	503.7 (73)	15 (15)
ALL	**197**	**8,369,097**	**15,310**	**10.58**	**7,172.7**	**5,094.8 (877.2)**	**557.5 (80)**

(Number in brackets indicate the number of non-employed FTEs)
Note: 197 of the 238 practices reported case, unit or FTE data.

- 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 197 practices employ or contract with 7,172.7 full-time equivalent (FTE) physician anesthesiologists, 5,094.8 FTE nurse anesthetists, and 557.5 FTE anesthesiologist assistants (AAs). The practices also work with an additional 877.2 FTE nurse anesthetists and 80 FTE AAs for whom the practice does not directly pay compensation (i.e., facility hires or contracts the nurse anesthetist or AA).

The 238 practices reported a total of 1,015 managed care contracts. This is fewer than the 1,125 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 eighty-two (982) of the contracts are based upon a 15-minute unit, 11 upon a 12-minute unit, 16 are based upon a 10-minute unit and six are based upon an 8-minute unit. We normalized all contract conversion factors with 8- 10- and 12-minute time units to the typical 15-minute time unit using an adjustment factor of 1.4208 for 8-minute units, 1.2404 for 10-minute units and 1.1202 for 12-minute units (Table 4).

Table 3: Respondent Information by Minor Geographic Region, 2020

Region	Practices	Cases	Mean Units/ FTE MD	Mean Units/ Case	FTE MD	FTE Nurse Anesthetist	FTE AA
CAAKHI	16	904,090	8,528	13.06	1,332.3	106 (58.0)	0 (0)
Eastern Midwest	37	1,420,934	19,245	11.04	866.0	910.9 (135.0)	40 (0)
Lower Midwest	29	1,332,869	19,921	9.87	928.8	1287 (0)	88 (0)
Mid Atlantic	9	273,780	13,747	13.29	253.1	236.0 (45.5)	0 (0)
North Atlantic	18	1,068,794	11,422	10.51	1,160.7	707.4 (90.5)	11 (65)
Northeast	6	101,307	8,161	9.75	90.5	34.8 (42)	0 (0)
Northwest	18	729,777	9,343	10.09	963.2	314.7 (0)	0 (0)
Rocky Mountain	16	296,747	8,271	10.12	383.0	83.0 (15)	15 (15)
Southeast	40	1,650,512	21,190	10.31	837.4	1034.5 (490)	403.5 (0)
Upper Midwest	8	590,287	6,506	6.66	357.7	380.8 (1.2)	0 (0)
ALL	**197**	**8,369,097**	**15,310**	**10.58**	**7,172.7**	**5,094.8 (877.2)**	**557.5 (80)**

(Number in brackets indicate the number of non-employed FTEs)
Note: 197 of the 238 practices reported case, unit or FTE data.

Table 4: Conversion Factor Adjustment Based on Time Units, 2020

Time Units	Time Units	Sum of Base and Time Units	CF Value Ratio based for 15-minute units
CMS PSPS 2018[1]			
Mean Base Units	5.211		
Minutes/Case	72.405		
8-minute time units	9.051	14.262	1.4208
10-minute time units	7.241	12.452	1.2404
12-minute time units	6.034	11.245	1.1202
15-minute time units	4.827	10.038	1.0000

1. Mean Minutes per Case and Base Unit is determined from the 2018 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, 2020

	Flat Fee (Any)	Labor & Delivery	Cataracts	Endoscopy	Pain	Other
Eastern	21	17	0	3	1	7
Midwest	25	19	0	13	0	1
Southern	32	25	0	6	2	4
Western	10	9	1	4	1	3
Total	**88**	**70**	**1**	**26**	**4**	**15**

Others include cosmetic and plastic surgery, bundled surgical procedures, Total Joint Replacement, spine surgery, general surgery, invasive monitoring and open heart surgery.

"The highest conversion factor reported was $323.22. In 2019 the highest conversion factor reported was $256.50."

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 (asamonitor.pub/3gRrtQD), which represents over 21 million anesthesia claims.

The mean time was 72.405 minutes and mean base units per case were 5.211 base units. Making the same calculations described above, the adjustment factors are very similar to last year: 1.411 for 8-minutes units, 1.235 for 10-minute units, and 1.117 for 12-minute units.

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Payment and Practice Management

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Groups continue to report flat fee contracts for certain procedures. Table 5 shows respondents who identified that they had flat fee contracts. 88 of the 158 groups (55.7%) responding to this question negotiated at least one flat fee contract. 44.3% of the respondents have flat fee contracts for Labor and Delivery.

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 (238), but also the highest average percentage of managed care business (21.1%, 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.

"In the 2019 survey, the Medicare conversion factor was 28.9% of the overall commercial mean. In this year's survey, it has fallen to 27.03%."

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

This is the sixth year we are presenting state-specific data. Although we had respondents from 43 states, only 17 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 2021 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 $82.14, while the median, $73.00 and the range of mean values increased from a range of $73.79 - $80.76 in 2019 to a range of $76.09 - $85.75 in 2020.
- As was the case in our 2018 and 2019 surveys, the Eastern Region has the highest mean this year. The Eastern Region mean in 2019 was $86.73 and this year it is $97.85.

Table 6: Major Region Managed Care Anesthesia Conversion Factors ($/unit), 2020

	Contract 1	Contract 2	Contract 3	Contract 4	Contract 5	ALL
Eastern	n=47	n=44	n=40	n=38	n=33	n=202
Mean	$91.61	$91.98	$106.37	$101.10	$100.50	$97.85
Low	$53.00	$54.83	$51.00	$45.00	$52.43	$45.00
25th Percentile	$69.00	$68.67	$81.45	$75.00	$72.00	$72.00
Median	$91.24	$90.03	$100.50	$97.00	$89.68	$93.00
75th Percentile	$105.00	$112.42	$123.57	$130.00	$131.00	$120.00
High	$209.75	$144.00	$323.22	$173.60	$211.71	$323.22
Midwest	n=50	n=48	n=45	n=41	n=34	n=218
Mean	$68.34	$72.54	$71.41	$71.47	$68.01	$70.44
Low	$49.37	$46.00	$48.00	$46.62	$47.05	$46.00
25th Percentile	$60.72	$64.00	$60.00	$61.00	$57.00	$60.72
Median	$65.00	$70.13	$69.00	$66.80	$65.00	$67.82
75th Percentile	$72.00	$76.25	$75.00	$74.25	$76.00	$74.25
High	$136.00	$144.00	$136.00	$117.60	$124.00	$144.00
Southern	n=86	n=83	n=75	n=63	n=46	n=353
Mean	$70.87	$80.06	$82.11	$84.14	$87.82	$80.00
Low	$33.00	$42.00	$43.00	$45.00	$32.00	$32.00
25th Percentile	$54.00	$58.00	$60.00	$60.00	$65.00	$59.04
Median	$65.00	$72.00	$72.00	$71.00	$83.41	$72.00
75th Percentile	$83.00	$88.54	$95.00	$102.83	$104.00	$90.50
High	$169.00	$162.00	$184.50	$184.50	$155.00	$184.50
Western	n=55	n=52	n=49	n=46	n=40	n=242
Mean	$78.03	$79.85	$85.73	$85.17	$86.27	$82.70
Low	$40.75	$31.50	$41.00	$39.00	$57.85	$31.50
25th Percentile	$63.20	$62.00	$67.00	$69.00	$68.50	$66.00
Median	$69.75	$71.27	$79.54	$76.96	$76.63	$74.48
75th Percentile	$80.00	$83.62	$95.00	$90.45	$94.63	$90.45
High	$166.00	$166.00	$166.00	$166.00	$166.00	$166.00

Table 7: Minor Region Managed Care Anesthesia Conversion Factors ($/unit), 2020

MGMA Minor Region	Contracts	Low	25th Percentile	Median	Mean	75th Percentile	High
CAAKHI	79	$39.00	$67.91	$78.73	$94.20	$126.00	$166.00
Eastern Midwest	190	$46.00	$60.00	$64.03	$67.73	$72.50	$144.00
Lower Midwest	140	$40.00	$54.50	$64.19	$70.64	$76.50	$169.00
Mid Atlantic	43	$53.10	$66.17	$75.00	$82.09	$87.00	$169.00
North Atlantic	105	$45.00	$80.00	$100.00	$105.37	$127.00	$323.22
Northeast	40	$51.00	$85.50	$94.96	$97.45	$110.00	$144.00
Northwest	90	$53.00	$64.15	$69.53	$72.45	$77.91	$132.00
Rocky Mountain	73	$31.50	$68.00	$76.00	$82.89	$97.00	$144.00
Southeast	216	$32.00	$65.00	$78.68	$87.33	$104.00	$184.50
Upper Midwest	39	$65.00	$70.00	$74.25	$83.25	$91.00	$136.00

"We will continue to monitor the trends in the commercial conversion factor survey results and will launch the survey again in June."

- The highest conversion factor reported was $323.22. In 2019 the highest conversion factor reported was $256.50.
- In the 2019 survey, the Medicare conversion factor was 28.9% of the overall commercial mean. In this year's survey, it has fallen to 27.03%.

Conclusions

This year's survey was challenged as many practices were coping with the COVID-19 pandemic. Our sample size was slightly less this year, but still represents a significant portion of US practicing anesthesiologists, nurse anesthetists and anesthesiologist assistants. We were pleased to have respondents report across a broad geographic basis, allowing us to provide detailed regional responses. The number of practices reporting allowed us to report state-specific data from 17 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 the trends in the commercial conversion factor survey results and will launch the survey again in June 2021. It is important that as many practices as possible participate in the 2021 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 2020 results. ■

Table 8: Eligible States Managed Care Anesthesia Conversion Factors ($/unit), 2020

State	Contracts	Low	25th Percentile	Median	Mean	75th Percentile	High
AL	12	$55.00	$63.00	$63.00	$71.13	$75.75	$104.00
CA	71	$39.00	$71.00	$82.20	$97.54	$129.29	$166.00
FL	65	$32.00	$74.00	$104.00	$103.98	$127.35	$184.50
GA	52	$49.86	$72.50	$81.88	$87.68	$100.90	$153.00
IN	30	$49.37	$64.00	$74.00	$74.10	$78.00	$114.75
KS	28	$55.00	$65.00	$73.00	$78.83	$80.00	$139.50
LA	38	$42.00	$52.00	$53.50	$53.91	$55.50	$72.00
MI	65	$47.05	$59.45	$60.72	$61.93	$64.00	$131.75
MS	21	$34.00	$50.00	$57.00	$52.60	$58.00	$61.00
NY	55	$45.00	$95.00	$120.00	$122.01	$137.00	$323.22
OH	64	$46.00	$62.75	$69.00	$68.90	$72.67	$144.00
OK	24	$52.00	$60.00	$63.71	$63.88	$67.00	$81.47
PA	33	$50.00	$59.00	$69.36	$74.90	$89.00	$139.50
SC	33	$33.00	$65.00	$72.00	$82.02	$88.54	$162.00
TX	34	$40.00	$60.93	$82.50	$85.21	$117.00	$169.00
UT	20	$31.50	$70.66	$74.50	$74.25	$79.33	$96.75
WA	70	$53.50	$64.00	$69.00	$71.28	$79.00	$104.00

Figure 2:

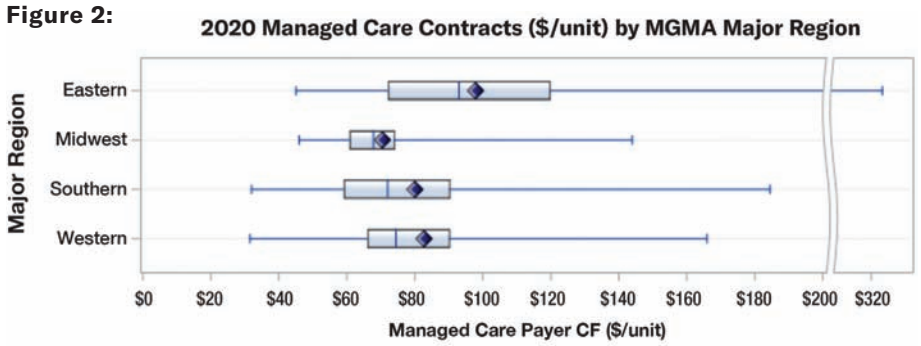

Figure 3:

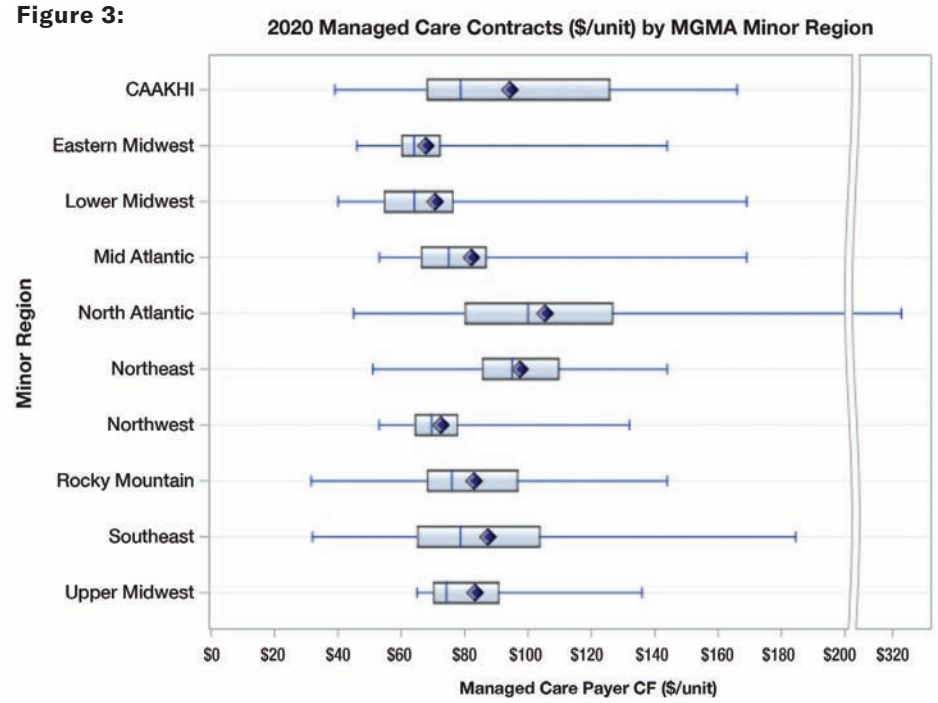

Figure 4: 2020 Managed Care Contracts ($/unit) by Eligible States