# Idaho Crime Victims Compensation Program
## Medical Fee Schedule

The definitions associated with terms in this document can be found by visiting Idaho Code § 72-1003 and 17.10.01 – Administrative Rules Under the Crime Victims Compensation Act.

**Allowable Payments for Medical Services**. Pursuant to Section 72-1026, Idaho Code, the Commission adopts the following medical fee schedule and will pay providers the allowable for medical services in accordance with said schedule.

**Adoption of Standard**. The Commission hereby adopts the Resource-Based Relative Value Scale (RBRVS), published by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services, as amended, as the standard to be used for determining the allowable payment under the Crime Victims Compensation Act for medical services provided by providers other than hospitals and ASCs. The standard for determining the allowable payment for hospitals and ASCs shall be:

- For large hospitals: Eighty-five percent (85%) of the reasonable inpatient charge.
- For small hospitals: Ninety percent (90%) of the reasonable inpatient charge.
- For ambulatory surgery centers (ASCs) and hospital outpatient charges: Eighty percent (80%) of the reasonable charge.
- Surgically implanted hardware shall be reimbursed at the rate of actual cost plus fifty percent (50%).
- Subsection -Services without a CPT Code, RVU or Conversion Factor - does not apply to hospitals or ASCs. The Commission shall determine the allowable payment for hospital and ASC services based on all relevant evidence.

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

The Idaho Crime Victims Compensation Program’s Medical Fee Schedule Begins on the next page.

| MEDICAL FEE SCHEDULE | | |
|---|---|---|
| **DESCRIPTION** | **CODE RANGE(S)** | **CONVERSION FACTOR** |
| Anesthesia | 00000 - 09999 | $60.05 |
| Surgery - Group One | 22000 - 22999 Spine<br>23000 - 24999 Shoulder, Upper Arm, & Elbow<br>25000 - 27299 Forearm, Wrist, Hand, Pelvis & Hip<br>27300 - 27999 Leg, Knee, & Ankle<br>29800 - 29999 Endoscopy & Arthroscopy<br>61000 - 61999 Skull, Meninges & Brain<br>62000 - 62259 Repair, Neuroendoscopy & Shunts<br>63000 - 63999 Spine & Spinal Cord | $144.48 |
| Surgery - Group Two | 28000 - 28999 Foot & Toes Nerves & Nervous System<br>64550 - 64999 | $129.00 |
| Surgery - Group Three | 13000 - 19999 Integumentary System<br>20650 - 21999 Musculoskeletal System | $113.52 |
| Surgery - Group Four | 20000 - 20615 Musculoskeletal System<br>30000 - 39999 Respiratory & Cardiovascular<br>40000 - 49999 Digestive System<br>50000 - 59999 Urinary System<br>60000 - 60999 Endocrine System<br>62260 - 62999 Spine & Spinal Cord<br>64000 - 64549 Nerves & Nervous System<br>65000 - 69999 Eye & Ear | $87.72 |
| Surgery - Group Five | 10000 - 12999 Integumentary System Casts & Strapping<br>29000 - 29799 | $69.14 |
| Radiology | 70000 - 79999 Radiology | $87.72 |
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| MEDICAL FEE SCHEDULE | | |
|---|---|---|
| **DESCRIPTION** | **CODE RANGE(S)** | **CONVERSION FACTOR** |
| Pathology & Laboratory | 80000 - 89999 Pathology & Laboratory | To Be Determined |
| Medicine - Group One | 90000 - 90749 Immunization, Injections, & Infusions<br>94000 - 94999 Pulmonary / Pulse Oximetry<br>97000 - 97799 Physical Medicine & Rehabilitation<br>97800 - 98999 Acupuncture, Osteopathy, & Chiropractic | $46.44 |
| Medicine - Group Two | 90750 - 92999 Psychiatry & Medicine Assessments & Special Procedures E / M & Miscellaneous Services<br>96040 - 96999<br>99000 - 99607 | $66.56 |
| Medicine - Group Three | 93000 - 93999 Cardiography, Catheterization, & Vascular Studies<br>95000 - 96020 Allergy / Neuromuscular Procedures | $72.24 |

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

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

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

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

- Modifier 50: Additional fifty percent (50%) for bilateral procedure.
- Modifier 51: Fifty percent (50%) of secondary procedure. This modifier will be applied to each medical or surgical procedure rendered during the same session as the primary procedure.
- Modifier 80: Twenty-five percent (25%) of coded procedure.
- Modifier 81: Fifteen percent (15%) of coded procedure. This modifier applies to MD and non-MD assistants.

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