

***Workers' Compensation  
Medical Services Review Committee  
Meeting Minutes***

February 23, 2015

**I. Call to order**

The Medical Services Review Committee was called to order at 9:04 am on Monday, February 23, 2015, in Anchorage, Alaska.

**II. Roll call**

The following Committee members were present, constituting a quorum:

Dr. Mary Ann Foland	Jane Griffith	Dr. Robert Hall
Tammi Lindsey	Dr. William Pfeifer	Pamla Scott
Kevin Smith		

Member Vince Beltrami was absent

**III. Approval of Agenda**

A motion to approve the agenda was made by member Smith and seconded by member Foland. The agenda was approved unanimously.

**IV. Approval of Minutes**

The minutes from the January 15-16, 2015 meeting, and the January 29, 2015 meeting were distributed to the members. However, members did not receive the minutes in advance and did not have adequate time to review them, so deferred to take action on these until after lunch.

**V. Chair's Report**

The chair distributed an action item list and a summary of draft recommendations through the January 29, 2015 meeting.

- There is a correction at item 1-h of the draft recommendations. The inpatient acute care conversion factors were based on an outlier adjustment of -13% for case, and -7% for implants – not 15%.
- The committee members are strongly encouraged to review the minutes and their notes to make sure the chair has accurately stated the member's recommendations to date.
- The chair reviewed the action items yet to be addressed by the committee.
  - Member Hall stated he would like to see the payment issue related to pain blocks added as an action item.
  - Member Griffith stated the committee had not yet made a final recommendation on inpatient outlier payment methodology.
- Member Lindsey proved Optum with some inpatient bills to review under the proposed fee schedule, but Mr. Anderson needed more information, which the chair was unable to provide before the meeting. The chair said he would work with Mr. Anderson and member Lindsey to get the necessary information.

- Once the committee reaches consensus on final recommendations, the chair would ask Optum to prepare an analysis on fee schedule impacts to the top frequency procedures for inpatient, outpatient, and professional service areas.

## **VI. Review of Updated Optum Analysis of Facility Medical Data**

Eric Anderson reviewed Optum's revised outpatient analysis.

- The latest outpatient spreadsheet evaluates the conversion factor as a percentage of Medicare assuming a wage index of 1.3064. Optum's analysis of CMS data concluded that 95% of billed charges were at this lower wage index. This calculates out to 252.7% above the 2015 Medicare allowance. By comparison
  - Using a wage index of 1.9343, the base rate is 115.70, which is 191.7% of 2015 Medicare
  - Using a straight average wage index, the base rate is 101.72, which is 218% of 2015 Medicare
  - Using a weighted average wage index, the base rate is 88.86, which is 249.6% of 2015 Medicare
- If a weighted average wage index is used to give a nudge to rural providers, and to achieve the same 252.7% of Medicare that is calculated using the 1.3064 wage index, the conversion factor would have to increase from \$221.79 to \$224.55. Optum opined that the weighted average is the fairest approach since the data is weighted so strongly in favor of the urban wage index.
- Member Griffith said that a year down the road the State may be able to pull data from the all payer claims database for inpatient and outpatient facilities which is supposed to be produced in 2015.
- The chair noted that he has received feedback from some ambulatory surgical centers that the proposed conversion factor drops their rates below their current reimbursement rates, which exceed 300% of Medicare. Member Griffith said that she has received the same comments from hospital association members. She said her own analysis of Providence workers' compensation data indicates that most payments are at the 90<sup>th</sup> percentile or above, and closer to 300% of Medicare than the 218% being proposed.
- The chair noted the committee's draft recommendation on outpatient implants from the last meeting was if the implant exceeds \$2,500 the payer may request an invoice and may limit payment to invoice plus 20%. After further discussion, the committee's draft recommendation is to pay for implants at invoice plus 10%, with no fixed dollar threshold.
- Member Hall would like to see a more "user friendly" analysis that compares "old" fee schedule rates with the proposed "new" fee schedule rates for the most frequently utilized procedures.
- Member Smith stated that the committee needs to build a narrative on how they came up with their recommendations. Optum agrees, and says they will assist in drafting. He recommends letting Optum go through all the discussions to date and double check the numbers to ensure everyone is on the same page before taking a vote.

Eric Anderson reviewed Optum's revised inpatient analysis.

- The committee needs to decide whether it is OK with the 13% adjustment for the billing outlier and the 7% adjustment for the implant outlier.
- There was discussion on the payment methodology for outliers. Member Griffith noted that the CMS payment rule is [(billed charges x cost to charge ratio) minus (fixed cost outlier threshold)] x 80%. Optum recommends adopting a rule based on the PC Pricer, which calculates these values.

Break 10:20am-10:38am

- For inpatient implant outlier pricing, Eric commented that Connecticut pays at 175% above Medicare and uses the PC Pricer tool in a similar fashion. If the cost of an implant is more than the allocated Medicare price, the provider can ask for 130% of the implant's cost. For example, if a procedure costs \$100,000 and CMS says the implant portion is \$25,000, but the actual implant cost is \$50,000, CT would subtract \$25,000 from the allowed price, take \$50,000 time 130% and add that back to the allowable cost for a total allowance of \$140,000. There are two ways of getting at the implant's cost: ask for an invoice, or use the implant cost to charge ratio.
- The chair noted that Idaho's inpatient rule on implants is that a hospital can bill separately if the device's cost is greater than \$10,000, it can be billed separately at cost plus 10% of invoice, not to exceed \$3,000 above invoice. The outpatient rule on implants is that a facility can bill separately if the device's cost is greater than \$500, it can be billed separately at cost plus 10% of invoice, not to exceed \$1,000 above invoice.
- Member Griffith asked if any states back out implants and pay separately. Eric noted Minnesota is taking that approach. They subtract the implant portion from the billed amount, and calculate the inpatient payment on the balance, then calculate the implant allowance based on a percent of cost, and add that back to the total allowable payment. The committee liked this approach, stating implants could be billed at invoice plus 10% - just like in outpatient facilities.
- Similar to the facility outpatient process, Optum will write up a narrative on how the committee came up with their recommendations on the inpatient fee schedule.

## VII. Public Comment

Misty Steed, PACBLU

- The National Correct Coding Initiative (NCCI) should be adopted by the committee. Almost all payers follow NCCI edits. These doesn't affect facilities - just physicians. Ms. Steed says chiropractic care is an area where NCCI edits prevent payers from paying for the same procedure more than once.
- *The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. The CMS annually updates the National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual). The Coding Policy Manual should be utilized by carriers and FIs as a general*

*reference tool that explains the rationale for NCCI edits. Centers for Medicare and Medicaid Services.*

### **VIII. Review of Updated Optum Analysis of Facility Medical Data (continued)**

- Member Griffith stated there are several hospitals in Alaska that are classified as sole community providers or demonstration hospitals. These do not fall under the critical access hospital exemption, so are likely subject to regulation under HB316.
- The committee discussed status codes, and which should have a state specific exemption. The chair noted that Idaho had adopted the follow rules regarding status codes.
  - Status code N items (other than implantable hardware) or items with no CPT or HCPCS code shall receive no payment.
  - Two or more medical procedures with a status code T on the same claim shall be reimbursed with the highest code paid at 100% of the APC calculated amount and all other status code T items paid at 50%.
  - Status code Q items with an assigned APC weight will not be discounted.
- Eric stated status codes that have been problematic in other states are status codes C, E, and P. He believes if these are addressed by rule, the other status codes will be fine.
  - Status code C says that the procedure should only be done in an inpatient setting. While this may be true in an older Medicare population, the same is likely not true in workers' compensation. States have addressed this by adopting a rule that pays at a percentage of billed charges, such as 80%, or a rule that says payment is at a negotiated rate.
  - Status code E is similar to C, in that CMS does not pay on an outpatient basis. Again, states adopt a rule to pay at a percentage of billed charges or at a negotiated rate.
  - Status code P provides that the procedure is to be paid at a per diem rate, and CMS will likely not have a relative weight for that procedure. Again, states adopt a rule to pay at a percentage of billed charges or at a negotiated rate.
- Eric said another status code that may need to be looked at down the road is status code J1, which just went into effect this year. It is too early to tell if a state specific rule will be needed.
- Member Pfeifer stated HB316 did not task the committee with adopting CMS payment rules, just CMS relative values. He suggested that the committee not adopt CMS payment rules and instead stay with the payment rules as they were set out in the prior fee schedule. The chair noted that the Idaho rule follows "...the coding guidelines published by the Centers for Medicare and Medicaid Services and by the American Medical Association, including the use of modifiers."
- Optum recommended being very specific when adopting rules because many may not apply to a workers' compensation environment. Optum will provide a survey of how other states are handling status codes.

*Lunch Break 11:55am-1:33am*

## **IX. Review of Updated Optum Analysis of Facility Medical Data (continued)**

- The chair distributed guidelines and payment rules from the existing fee schedule.
- The committee discussed a proposed rule for status codes C, E, and P, and other services without a CPT code or relative value. They asked Optum to provide a survey of how other states are addressing these issues for both outpatient and professional services.
- Member Hall asked if Optum could calculate a conversion factor that would bring outpatient up to 300% of Medicare. Member Griffith said she would like to see that same calculation done for inpatient procedures.

The committee discussed the general goals of the committee, i.e. whether the intent is to produce a budget neutral fee schedule or whether the intent is to lower costs. The chair opined that the term “budget neutral” would be better stated as “fee schedule neutral”. Optum’s analysis has produced conversion factors that transition the existing 2010 usual and customary workers’ compensation fee schedule to a relative value fee schedule based on CMS 2015 relative values, then compared the derived values to 2014 FairHealth data. The 2010 fee schedule was produced at the 90<sup>th</sup> percentile of FairHealth data. The comparative analysis shows that the proposed conversion factors align allowable fees between the 70<sup>th</sup> and 75<sup>th</sup> percentile of 2014 FairHealth data.

## **X. Review of Updated Optum Analysis of Non-Facility Medical Data**

- Carla from Optum reviewed her updated spreadsheet, containing additional analysis of CLAB, DME, ASP (average sale price), and PEN (Parenteral and Enteral Nutrition Items and Services), and ambulance services. The fee schedule approach for these service areas is to come up with a percentage rate above the Medicare fee schedule. The spreadsheet allows committee members to plug in percentage rates to see how they compare to FairHealth data.
- There was discussion on whether LAB should also be paid at a percentage of Medicare like CLAB, but Carla noted that CMS produces relative values for LAB, so the committee can have a conversion factor for LAB and treat CLAB separately.
- The goal is to come up with a percentage that equates to the 75<sup>th</sup> percentile of the FairHealth data. Carla will work up those numbers and submit them to the committee.

## **XI. Fee Schedule Development Discussion**

- Optum will be providing the committee a survey of other states handling of status codes.
- Optum will provide the committee information on how other states are handling compounding. Member Smith stated New Mexico’s rule is that compounding is only allowed if an indicated first line therapy was tried and failed, or if the patient has an allergy to an active ingredient of a more traditional form of medication. The committee agreed that compounding should only be allowed if medically necessary.
- The committee deferred taking action on the minutes from the previous meetings until the next meeting.

- The committee discussed billing rules and modifiers, and whether services provided by a physician assistant or advanced practice registered nurse should be at a discounted rate. The current fee schedule pays at 85%. Stephanie said Optum can send a list of the commonly adopted modifiers.
- Member Pfeifer presented some information from the national chiropractic society where their organization has had billing issues with payers who have adopted NCCI edits.
- The chair said that two issues he working on are moving the effective data from July 1, 2015 to January 1, 2016, and whether to move forward on developing an air ambulance fee schedule.

The committee selected March 16<sup>th</sup> as their next meeting date.

*Meeting Adjourned 3:19 pm*