

**Workers' Compensation
Medical Services Review Committee
Meeting Minutes
January 29, 2015**

I. Call to order

The Medical Services Review Committee was called to order at 9:02 am on Thursday, January 29, 2015, in Anchorage, Alaska.

II. Roll call

The following Committee members were present, constituting a quorum:

Vince Beltrami	Dr. Mary Ann Foland	Jane Griffith
Dr. Robert Hall	Tammi Lindsey	Dr. William Pfeifer (telephonic)
Pamla Scott	Kevin Smith	

III. Review of Updated Optum Analysis of Facility Medical Data

Eric Anderson reviewed Optum's revised inpatient analysis.

- The revised analysis evaluates the Medicare volume for each of the 9 acute care hospitals, and converts that percentage to the NCCI stays. The weighted average conversion factor calculates to about the same as the straight average analysis, both calculation methods coming in at approximately 239% above Medicare.
- Each hospital's per claim disproportionate share (DSH) rate was then added to the conversion factor, and adjusted by the average weight for all claims to arrive at a DSH adjusted conversion factor.
- The DSH adjusted conversion factor was then adjusted for an outlier set aside (-13.0% of total payments) and an implant set aside (-7% of total payments), for a new adjusted conversion factor for each hospital. Eric noted that when he analyzed the 2012 and 2013 NCCI data, the total outlier amount totaled \$1.1 to \$1.2 million
 - Providence Alaska Medical Center - \$17,085.40
 - Mat-Su Regional Medical Center - \$15,326.64
 - Bartlett Regional Hospital - \$14,615.18
 - Fairbanks Memorial Hospital - \$15,972.59
 - Alaska Regional Hospital - \$15,413.63
 - Yukon Kuskokwim Delta Regional Hospital - \$28,315.11
 - Central Peninsula General Hospital - \$14,385.49
 - Alaska Native Medical Center - \$22,681.05
 - Mt. Edgecumbe Hospital - \$19,621.32
- The analysis then lists out the fee schedule rates by DRG for each hospital based on their distinct conversion factor times the MSDRG weight.
- Member Smith noted that the outlier adjustment is based on data from just a few years, so the number may fluctuate significantly over time.
- Member Griffith opined that based on observational information, the distribution of volume using Medicare by facility isn't very accurate. There was discussion whether the chair should see if NCCI can identify hospitals in their data to ensure accurate

volume distribution. Rather than doing that, Member Griffin said she will contact the hospital group and validate the numbers with them.

- The committee reserved a decision on identifying the dollar threshold for outlier cases and outlier implants.
- Optum recommends a rule adopting the use of the PC Pricer, which will make the outlier calculations much easier for payers.

Break 10:15am-10:30am

IV. Review of Updated Optum Analysis of Facility Medical Data (continued)

Eric Anderson reviewed Optum's outpatient analysis.

- Optum adjusted the worksheet to calculate fees based on the wage index selected by the committee. The wage index options are \$1.3064 (urban) or \$1.9343 (rural).
- The conversion factor of \$221.79, calculates to 218% of Medicare using the base rate of 101.74, which uses an averaged wage index. Optum noted that the majority of cases actually take place at facilities using a wage index of \$1.3064, which would calculate to a percentage of Medicare of 249.6%.
- A discussion followed whether the committee wishes to recommend a single conversion factor using an average or weighted average wage index, or two conversion factors based on the two wage indexes of \$1.3064 and \$1.9343. There was also discussion concerning ANMC's wage index of \$1.9343, as that facility is located in Anchorage. Using the \$221.79 conversion factor
 - 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
 - Using a wage index of 1.3064, the base rate is 87.77, which is 252.7% of 2015 Medicare
 - Using a wage index of 1.9343, the base rate is 115.70, which is 191.7% of 2015 Medicare
- The committee raised the question whether the outpatient fee schedule would apply to all hospitals, including critical access hospitals, or whether outpatient care at a critical access hospital would be exempt just as are inpatient care at these facilities. HB316 would appear to exempt critical access hospitals from all fee schedules being proposed by the committee and the board.
- The committee confirmed that the proposed ASC rate would be 95% of the outpatient fee schedule.
- The committee discussed the need to adopt rules around status codes for outpatient facilities. For procedures that CMS says should not be done in an outpatient setting, Optum recommends adopting a rule based on a percentage of billed charges.

V. Public Comment

Sheila Hansen, Corvel

- Ms. Hansen recommended that the rules continue to require invoice for outlier payments on implants. Without the invoice, payers won't know what they are paying for.

VI. Review of Updated Optum Analysis of Non-Facility Medical Data

- Optum reviewed their data analysis on anesthesia. NCCI data is based on the current fee schedule anesthesia conversion factor of \$121.82. Procedure codes and unit values are derived from the *Relative Value Guide* produced by the American Society of Anesthesiologists.
- Optum's analysis shows that the average unit charge is \$145.5271 and the average unit payment is \$121.4667. Optum recommends continued use of the existing conversion factor of \$121.82.
- The committee will need to consider which modifiers to adopt, including state specific rule on unsupervised anesthesia by certified registered nurse anesthetists (CRNA).
- Carla would produce analysis for the next meeting on LAB, CLAB, and DMEPOS for the committee's review and discussion. Conceptually, she would see where the average fee schedule changes fall in the other service categories, and use that average change to produce recommends above or below CMS schedules.
- Member Foland stated there was a state regulation that limits insurers from paying below the 80th percentile, and asked whether workers' compensation is subject to that same rule. Chair Monagle said the fee schedules recommended by the committee and the board would not be subject to healthcare rules, other than what is specifically set out in HB316 and the Workers' Compensation Act.

Lunch Break 11:44pm-1:30pm

VII. Fee Schedule Development Discussion

- The committee discussed the dollar threshold on inpatient outlier cases. The committee's draft recommendation is \$30,000, paid at 80% of the charge over the MSDRG allowance, based on the PC Pricer calculation. An outlier can be determined by either billed charges or the cost of an implant.
- Member Lindsey volunteered to send some actual billing data to Optum to analyze under the proposed inpatient fee schedule.
- The committee discussed outlier threshold for implants in an outpatient setting. Idaho's threshold is \$500, with payment at invoice plus 10%, up to a maximum of \$1,000 over invoice. The committee's draft recommendation is \$2,500, paid at invoice plus 20%. If the implant is less than \$2,500, the amount is paid at billed.
 - Member Pfeifer suggested a rule whereby implants are paid as billed. If the implant exceeds \$2,500, the payer may request an invoice and may limit payment to invoice plus 20%.
- There was further discussion on whether implants above \$2,500 should be paid at cost, since the APC rate factors in some allowance for the implant item. The committee recommended checking with Idaho to see how this rule works in that state.
- The committee will need to review status codes for outpatient, and come up with state specific rules.
- The chair asked the committee members whether their constituency groups had any feedback on the proposed professional fees
 - Evaluation & Management \$85.00

- Medicine \$85.00
- Surgery \$205.00
- Radiology \$280.00
- Member's Pfeifer and Hall said their respective groups did not object to these recommendations. Member Hall said his group is concerned that if they continue to see 7-10% reductions each year, access to care may become an issue. Member Pfeifer reiterated his objection to multiple conversion factors, but finds the proposed transitory conversion factors are acceptable. Member Foland stated The Academy of Family Physicians also supports the proposed transitory conversion factors.
- The committee agreed to recommend separate relative values for professional services provided in facilities and non-facilities.
- As mentioned earlier, Optum will be producing an analysis for the next meeting on LAB, CLAB, and DMEPOS for the committee's review and discussion.
- The committee will need to recommend a rule for gaps.
- For prescription drugs, the committee recommends manufacturer's wholesale price plus a \$5 dispensing fee for brand, and manufacturer's wholesale price plus a \$10 dispensing fee for generic. For compounds, Delaware pays at manufacturer's wholesale price for each drug in the compound, listed separately by NDC, plus a \$10 dispensing fee. There was some general discussion whether compounds can be excluded unless medical necessity is provided, in which case Delaware's fee schedule approach be adopted. Optum will see how other states are handling.
- The committee will need to recommend rules for modifiers and bill payment. Should CMS payment rules be adopted, with state specific exemptions? Member Pfeifer stated he would check with his national association to see if there were concerns with adopting national guidelines, such as the CMS National Correct Coding Initiative.
- The chair will speak with the Commissioner to determine whether to move forward on a proposed fee schedule for air ambulance services.

VIII. Other Discussion

- The next meeting is scheduled for February 23rd. Eric will send out his revised analysis, and Carla will provide an analysis of CLAB, LAB, and DMEPOS.
- The chair will send out a draft summary of recommendations.
- The chair will speak with the Commissioner about seeking an extension from July 1, 2015 to January 1, 2016. Optum noted that if the date is pushed, the fee schedules will have to be based on CMS 2016 relative values. There was a discussion whether the recommended rules need to specify which CMS relative values and schedules are to be used, or whether there can be a more general rule that says the workers' compensation fees are based on CMS values and schedules in place at the time of treatment. Carla suggested the committee also adopt ICD-10.

Meeting Adjourned 3:15 pm