

***Workers' Compensation
Medical Services Review Committee
Meeting Minutes
January 15-16, 2015***

January 15, 2015

I. Call to order

The Medical Services Review Committee was called to order at 9:03 am on Thursday, January 15, 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
Pamla Scott	Kevin Smith	

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

A motion to approve the minutes from the December 12, 2014 meeting was made by member Scott and seconded by member Foland. A correction was made to the first bullet on page 7 of 8, noting that Optum's analysis does include modifiers 50 and 51. The corrected minutes were approved unanimously.

V. Chair's Report

The Committee's packet includes a letter from Guardian's legal counsel objecting to the adoption of an air ambulance fee schedule. Counsel opines that any such action is precluded by the Airline Deregulation Act of 1978. The Alaska Department of Law has reviewed the letter and informally does not disagree with the legal arguments set forth by counsel. Given the directive of HB316, Law has advised the Committee whether to move forward is a policy decision. Chair Monagle stated that it is his intention to move forward, as mandated by HB316.

VI. Review of Updated Optum Analysis of Facility Medical Data

Eric Anderson reviewed Optum's inpatient analysis.

- Optum's analysis was based on NCCI's 2012 and 2013 data, CMS FY13 relative weight data, and CMS FY15 base rates.
- The 2013 NCCI data calculates to a base rate of \$21,449.74, which is 239.8% of average CMS FY15 base rate of \$8,944.40 for the 9 Alaska acute care hospitals. It was noted that the NCCI data does not identify hospitals, so a comparison can only be made to the CMS average base rate.

- Optum ran a validity check, and this calculation is consistent with workers' compensation rates in other states.
- Member Hall noted that the calculated base rate of \$21,449.74 would be more appropriately referred to as the adjusted workers' compensation base rate.
- The CMS FY15 base rates range from \$7,498.69 for the Central Peninsula General Hospital in Soldotna to \$12,991.50 for the Yukon Kuskokwim Regional Hospital in Bethel. The differences reflect variances between hospitals, such as wage index by location.
- A policy decision the Committee will have to make is whether to use an average base rate, a weighted base rate to account for rural hospitals, or specific base rates for each of the 9 acute care hospitals. If a single conversion factor is used, some hospitals will do better than others.
- Member Griffith noted that Anchorage area hospitals received a significant CMS reduction in the wage index in FY15, which lowered base rates.
- If the committee chooses to use each hospital's distinct base rate, this can be calculated fairly easily by using CMS' PC Pricer application. This is a free download from CMS. Mr. Anderson walked the Committee through several examples using the PC Pricer tool.
- Member Griffith commented she had received input from the Alaska State Hospital and Nursing Home Association (ASHNHA) earlier in 2014, and the consensus was that workers' compensation hospital rates needed to be between 300% and 400% of Medicare to recoup costs.
- Mr. Anderson asked the committee how whether they want to address Medicare allowance for disproportionate share hospitals (DSH). Disproportionate share is an allowance for those hospitals that have a high percentage of Medicaid or low income patients. Member Griffith estimated DSH payments total approximately \$10-\$12 million/year in Alaska, predominately to rural providers. Optum estimates accounting for DSH payments would raise the calculated base rate from \$21,449.74 to approximately \$23,211.
- Member Pfeifer noted that this isn't an issue for workers' compensation patients. Member Griffith acknowledged this, but questioned whether it needs to be considered as it is part of Medicare's overall inpatient pricing scheme.
- Member Pfeifer noted that the NCCI data includes all hospitals, including critical access hospitals. He wondered how the data is influenced by including critical access hospitals. Mr. Anderson noted that national trends indicate that critical access hospitals make up about 5% of the case mix, and he suspects that would hold true in Alaska. He opined that even if the critical access hospital data was removed from Alaska's analysis, based on national trends, it likely would like change the calculated base rate significantly.
- Member Griffith pointed out that another factor in CMS pricing that has not yet been discussed is outliers. These are cases where the cost of treatment exceeds CMS pricing by more than \$25,000. In outlier cases, CMS allows a hospital to recover a portion of their costs above the outlier threshold.
- Optum recommends adjusting the calculated base rate by the projected percentage of total payments for DSH and outliers to retain fee schedule neutrality. Assuming a

10% payment factor, this would reduce the calculated base rate to \$19,304.76. Member Griffith agreed that this would be a fair approach – not making payers pay for DSH/outliers when not applicable, but reimbursing providers when applicable on a case by case basis.

Break 10:30am-10:45am

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

Eric Anderson reviewed Optum's outpatient analysis.

- Outpatient fees are based on common procedure terminology (CPT) codes, not diagnostic related groups.
- The only factor that is adjusted in OPSS is the wage index. There are two in Alaska (1.3064 and 1.9343), but since the NCCI data doesn't indicate which facility provides treatment, Optum used an average to determine the comparison base rate of \$101.72.
- The 2013 NCCI data calculates to a conversion factor of \$221.79, which is 249.6% of the average CMS FY15 outpatient rate.
- The committee will have to consider which payment status indicators to adopt, and which to address by separate rule. For example, an outpatient clinic or ambulatory surgical center (ASC) may provide treatment that CMS considers non-billable as an outpatient procedure, which may have to be paid on a percentage of charge basis.

VIII. Public Comment

Sheila Hansen, Corvel

- Ms. Hansen expressed concern over rising overutilization of drug screening tests. These tests can be very expensive, especially employers are being billed for multi panel tests, even when drug abuse is not indicated.
- *A 2012 study from the California Workers' Compensation Institute showed that the number of drug tests ordered for injured workers increased from 4,012 in 2004 to 186,023 in 2011. CWI estimates that drug testing payments rose from \$142,481 in 2004 to \$27.4 million in 2011. The average test charge rose to \$206.89 in 2011 from \$80.77 in 2004.*
- California and Washington state have established HCPCS G code payment rules for drug screening.
- *Washington State's rule:*
 - *CPT® billing codes 80100, 80102 and G0431 are only payable to laboratories that don't require a CLIA certificate of waiver.*
 - *HCPCS billing code G0434 is limited to one unit per day per patient encounter regardless of the CLIA status of the laboratory.*
- Optum acknowledged that states are just now catching up to the issue, and are adopting various payment rules to address.

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

- The committee has a couple of decision points
 - Is the outpatient fee schedule going to be a percentage above Medicare?
 - Which wage index does the state want to use its base rate calculation? Upper? Lower? Average? Weighted average? Both (2 conversion factors)?
 - Should there be an outlier adjustment?

- How to address status codes, particularly those codes where CMS denies payment for a procedure performed on an outpatient basis?
- How to address CMS transition from CPT codes to HCPCS codes for outpatient procedures?
- CMS allowance for ASC's is 68%. Should ASC's be paid a percentage of allowable CMS outpatient fees? If so, what percent?
- How should implants be treated. Bundled? Threshold amount for separate billing?
- How should rehab hospitals be treated?
- Member Hall noted that there is no ASC reduction under the current workers' compensation outpatient fee schedule.
- Member Griffith believes there are two rehab units in Alaska, but could probably be covered under the same conversion factor for acute care hospitals.

Lunch Break 11:51pm-1:30pm

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

Carla Gee reviewed Optum's updated non-facility analysis.

- The calculated conversion factors are revenue neutral based on CMS 2015 non-facility relative values, as recently updated.
- The clinical lab (CLAB) and durable medical equipment, prosthetics, orthotics & supplies (DME-POS) conversion factors are based on relative values backed into using the existing fee schedule. However, since CMS does not produce relative values, CLAB and DMEPOS can be dealt with by providing a percent of the CMS CLAB or DME files.
- For unlisted codes or "gaps", the committee will have to decide they want to handle these, whether having Optum build gap fill relative values or by percentage of billed charges.
- Ms. Gee walked the committee through the spreadsheet, showing them how to "play" with the spreadsheet by adjusting conversion facts to see the impact on pricing.
- Member Smith asked if Optum could adjust the data up 25% to account self-insured employers whose data is not captured by NCCI. Ms. Gee responded that while the data doesn't include self-insureds, what that number is could be estimated by looking at the percentage of total fee schedule payments as a percentage of total fee schedule allowance.
- Member Foland asked what percentage general health was paying at in 2013, which is what the FairHealth data is based on. She thought it was the 80th percentile. The chair reminded the committee that the FairHealth data is non-discounted billed rate, so it is full charge data – not data at the 80th percentile.
- Member Pfeifer opined he would like to see code descriptions added to the worksheet.
- Chair Monagle asked whether Optum could produce a worksheet on anesthesia data. Ms. Gee will take a look at this and produce an analysis on her findings. She not anticipating much change, as the relative values published by the American Society of Anesthesiologists (ASA) have not changed much since 2010.

- Member Pfeifer asked if a column could be added that would show the percentage change from the current fee schedule. He threw out for consideration whether the committee wishes to adopt a rule that caps the fee for a particular procedure at a prescribed percentage increase or decrease. Ms. Gee said that some states have implemented caps during the initial transitional years. This might be something Alaska wishes to consider, as there are some substantial swings in the proposed fee schedule.

XI. Fee Schedule Development Discussion

Chair Monagle identified several discussion items for the committee to consider.

- Should there be a single conversion factor or multiple conversion factors?
 - Member Pfeifer opined an alternate approach might be to have a single conversion factor, with the aforementioned caps. Chair Monagle stated that for today, he wants to identify issues for the committee to discuss tomorrow.
- Should the committee have more than a single geozip for the entire state?
- Should there be a single professional fee schedule or separate schedules for services provided in an office and at a facility?
- How to address gaps in coding and relative values?
- Which modifiers should be adopted? If so, do we match CMS rules, or have Alaska specific rules?
- How to address category II and III HCPCS codes?
- For outpatient care
 - Is Optum's wage index midpoint acceptable?
 - Rules for status codes?
 - Rules for implants?
 - Should ASC's be paid at 68% CMS? 75%? Higher?
 - Rules for addressing rehabilitation and physical therapy under professional services?
- For inpatient care
 - Single conversion factor or specific ones for each hospital?
 - Allowance for disproportionate share?
 - Allowance for outlier cases?
 - Rules for addressing rehabilitation and physical therapy under professional services?
- Anesthesiology conversion factor based on American Society of Anesthesiologists?
 - Modifiers?
 - Adjustment for unsupervised anesthesiology by CRNA?
- Air ambulance fee schedule
- Durable medical equipment
 - Provide for outlier above what \$\$ dollar value for implants?
 - Manufacturer's invoice plus ? markup
- Prescription drugs - Must be original manufacturer's invoice plus a dispensing fee and markup
 - What method to determine original manufacturer's price? AWP? WAC? Other?

- Laboratory & Pathology Fees
 - CMS schedule plus markup?
 - Free standing radiology & pathology labs (define through narrative)
- Rules for physical therapy/chiropractic frequency

Break 2:59pm-3:17pm

XII. Presentation on Prescription Drug Fee Schedules by Lisa Anne Forsythe, Coventry

Presenting with Lisa was Don Woodby

- Prescription patterns in Alaska mirror patterns on a national level.
- Pain medications lead the list of most frequently prescribed drugs in workers' comp
- There are 3 components that make up each state's fee schedule
 - data benchmark - Average Wholesale Price (AWP), Wholesale Acquisition Cost (WAC), or Maximum Allowable Cost (MAC). Widest used is AWP. Manufacturer's Average Wholesale Price is recommended to address repackaging.
 - pricing source: Redbook, Medispan, or First Databank
 - ratio to benchmark: plus or minus percentage of benchmark plus a dispensing fee
- Other pricing issues
 - Brand v Generic
 - Prepackaging
 - Compounding
 - Use of NDC codes - both original manufacturers and repackaged NDC's
- Don will forward a copy of Coventry's January 2015 newsletter, which contains a survey of state prescription drug fee schedules.

XIII. Other Discussion

- The committee concluded with a general overview of the approval process, with recommendations going to the Commissioner of Labor and Workforce Development, then on to the Workers' Compensation Board.
- The goal is to propose a fee schedule that is overall fee schedule neutral to the existing fee schedule. However, it has been 5 years since the last fee schedule was produced, so significant adjustments in the maximum allowable reimbursement rate should not be unexpected. Because of the amount of time that has passed, the crosswalk from the old fee schedule to the FairHealth data appear to be in the 80th percentile range, which makes workers' compensation rates more in line with general healthcare.
- If it looks like we will not be able to meet the July 1 deadline, the committee may have to seek an extension from the legislative sponsor.

Meeting Adjourned 4:06 pm

January 16, 2015

I. Call to order

The Medical Services Review Committee was called to order at 9:03 am on Friday, January 15, 2015, in Anchorage, Alaska.

II. Roll Call to order

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
Pamla Scott	Kevin Smith	

III. Review of Updated Optum Non-Facility Medical Data

Carla Gee stepped through the changes she made to the data from the previous day.

IV. Fee Schedule Development Discussion - Non Facility

- The calculated conversion factor to take the existing fee schedule to CMS relative values calculates out as follows
 - Evaluation and Management - 77.0383
 - CLAB -260.0467
 - LAB -230.1556
 - DME-POS -88.4549
 - Medicine - 79.734
 - Radiology - 313.809
 - Surgery - 219.6829
 - Combined -126.714
- The consensus of the committee is that a single conversion factor would initially be too significant because of the variances. Service areas like surgery and radiology would be reduced more than 50%, which might lead to a reduction in service, and loss of access to care. Member Foland pointed out that the methodology that produces relative values should ultimately lead to a single conversion factor that works for each category.
- The committee discussed having individual conversion factors adopted by service category, with the goal of migrating to a single conversion factor in 3-4 years. Member Scott recommend having as few differences as necessary.
- The service categories that would have individual conversion factors would exclude CLAB, LAB, HCP, and DME-POS as CMS does not have relative values for these areas.
- Member Pfeifer recommended looking at the high frequency procedures by service category to see what the big winners and losers are, and how those numbers compare to FairHealth data. Ms. Gee pointed out that the spreadsheet can be filtered by category and by frequency to evaluate the data as member Pfeifer suggests. She noted a wide variance in surgery, and noted that Alaska wouldn't be the only state to have adopted multiple conversion factors within a single service category.

- The chair stated that the goal is to make the conversion from UCR to RBRVS fee schedule neutral, and make adjustments from there. However, he also reminded the committee that the whole reason for the adoption of HB316 was to address workers' compensation medical costs which make up \$.75 cents of every dollar spent on comp, compared to \$.57 countrywide. He also noted that while regional costs for evaluation and management and medicine are higher than regional costs, it really is in the specialty areas that there is a very significant difference. The challenge is to adopt a fee schedule that is not so punitive to specialists that it will impact access to care.
- Member Scott opined that conversion factors will impact utilization, and the committee will have to assess after the first year of implementation to see how frequency changes in response to the new fees. There was general consensus that utilization will need to be reviewed as part of medical reform in workers' compensation.
- The committee discussed various conversion factors, analyzing the impact on proposed fee schedules and how those proposals compare to FairHealth data.

Break 10:20am-10:35am

V. Fee Schedule Development Discussion - Non-Facility (Continued)

- As a draft recommendation, the committee chose the following conversion factor values
 - Evaluation and Management - 85.0
 - CLAB -204.0
 - LAB -204.0
 - DME-POS -88.45
 - Medicine - 85.0
 - Radiology - 280.0
 - Surgery - 205.0
- Based on the NCCI data, the proposed conversion factors would result in a new fee schedule total spend of \$107.3 million, compared to the old fee schedule total spend of \$111.3 million. This would be a 10.3% increase in E&M, a 5.4% increase in medicine, a 25.6% decrease in radiology (*the committee stated 11%*), and a 6.7% decrease in surgery. The \$107.3 million crosswalks between the 70th and 75th percentile of the FairHealth data.
- The committee agreed that separate CMS relative values should be used for professional services provided in office and professional services provided in a facility.
- For services without a CPT code or relative value, the committee discussed using the 2010 fee schedule values, adjusted up or down by the service category change recommended by the committee. The committee did not come to consensus on a rule how to address gaps.
- The committee will need to recommend rules for coding and bill payment. HB316 does not specifically address which rules to adopt, so that would have to be done by regulation. The committee may wish to recommend adoption of national coding and

bill payment guides, such as the CMS National Correct Coding Initiative, and recommend state specific exemptions or rules where applicable.

- For service categories LAB, CLAB, and DMEPOS, CMS does not produce relative values. The committee's recommendation is to propose a rule designating a percentage above the CMS allowable fee schedules. Optum will analyze this data and convert the calculated conversion factor to a percent of Medicare for discussion purposes. Like the professional services fee schedule, the committee will need to recommend a rule to deal with gaps.
- The committee will need to identify a conversion factor for anesthesia. Optum will analyze data and report back to the committee.
- Member Lindsey expressed concern over the fee schedule allowance for physical therapy. She states it is one of fastest growing service areas. The issue is both related to the fee schedule and frequency (utilization).

Lunch Break 11:55pm-1:33pm

VI. Fee Schedule Development Discussion - Facility

Doctor Foland participated by phone for the remainder of the meeting.

Outpatient Facility Discussion

- The NCCI data calculates to a conversion factor of \$221.79.
- Optum's calculated base rate of \$101.72 is based on an average Alaskan hospital wage index. The question is whether the committee agrees with that assumption, or should the lower (urban) wage index of \$1.3064 be used or the higher (rural) wage index of \$1.9343? The committee would like to see the data displayed with these pivot values to see what the base rate would calculate to. The committee would also like to see
 - billed charges
 - a calculation of the proposed conversion factor times the weight
 - a comparison of the proposed fee to the existing fee schedule, and
 - how this compares to FairHeath percentiles.
- The committee will need to determine whether to follow CMS rule on payments to ASC's of 68% allowable outpatient charges, or to adopt a state specific rule allowing a higher rate. The current fee schedule does not have separate pricing for outpatient facilities.
 - Member Hall noted that if ASC's are already taking a reduction in professional services, taking another hit on facility pricing would be problematic.
 - Member Griffith agreed that following CMS rules for ASC payments would not be fair in workers' comp.
- The committee will need to propose a rule for outpatient status codes.
- The committee will need to propose a rule dealing with implants, i.e., does the committee want to allow ASC's to be able to bill separately for implants above a certain dollar threshold? In Idaho, the outpatient threshold is \$500, which can be billed at manufacturer's invoice plus 10%, but not exceeding \$1,000 above invoice.
 - Member Griffith noted that is frequently very difficult to obtain the manufacturer's original invoice to submit for payment.

Inpatient Facility Discussion

- The committee discussed whether to use the conversion factor of \$21,449.74 calculated by Optum, or whether individual base rates should be used for each hospital.
 - Member Griffith stated that hospitals are receiving approximately 75-80% of billed charges, which includes private health. The calculated conversion factor is closer to 67%. Payers will be monitoring closely the inpatient fee schedule adopted by the Board. She would prefer that the committee adopt different base rates for each of the 9 acute care hospitals. Optum will revise their analysis so the committee can see what these values would be.
- The committee will also have to address what adjustment, if any, needs to be made for disproportionate share and outlier cases. Optum will take these factors into their revised analysis as well. Conceptually, the committee would looking in the 5-10% range. In Idaho, the threshold is when the charge exceeds the MS DRG allowance by \$30,000. Payment is then at 75% of the charged amount exceeding the MS DRG allowance.
- Similar to the outpatient discussion, the committee will need to propose a rule dealing with implants. In Idaho, the inpatient threshold is \$10,000, which can be billed at manufacturer's invoice plus 10%, but not exceeding \$3,000 above invoice.

VII. Fee Schedule Development Discussion - Other

- The committee will need to decide whether to recommend an air ambulance fee schedule. From the previous meetings with Guardian and LifeMed, the committee heard that fixed wing liftoff fees in Alaska are around \$12,000, and fixed wing air mile rates are around \$80/mile if 800 miles or less and \$55/mile for transports over 800 miles. Rotary wing lift off is around \$16,500, and the mileage rate is \$175/mile. According to data from the National Council on Compensation Insurance, the average regional fixed wing air mile rate charged is \$20/air mile. Countrywide it is \$35. Rotary wing is \$155/air mile regionally, and \$108/air mile countrywide. As previously mentioned, legal counsel for Guardian believes the State lacks jurisdiction to set an air ambulance rate fee schedule. The committee agreed that it would like to address this issue at a later date.

Break 2:59am-3:15am

VIII. Fee Schedule Development Discussion - Other (continued)

- On prescription drugs, the committee reviewed the January 2015 survey of state fee schedules distributed by Coventry. Most states are using AWP plus or minus a markup, plus a dispensing fee. Alaska's current fee schedule is AWP plus 20% for brand, and AWP plus 25% for generic. Alaska regulations require the use of generic drugs. The committee noted there are differing definitions of AWP. It can mean manufacturer's average wholesale price or repackaged average wholesale price. HB316 specifies that the committee use "the manufacture's invoice", which the committee can define as manufacturer's wholesale price. After discussion, the committee recommended manufacturer's wholesale price plus a \$5 dispensing fee for brand, and manufacturer's wholesale price plus a \$10 dispensing fee for generic.

- The committee may also wish to adopt a rule for compounded drugs. Delaware's rule on compounds is manufacturer's wholesale price for each drug in the compound, listed separately by NDC, plus a \$10 dispensing fee.
- On repackaged drugs, HB316 requires prescribers to use the original manufacturer's national drug code as published by the United States Food and Drug Administration.

The committee recommended having a discussion with the Commissioner about moving the effective date to January 1, 2016.

The committee agreed to meet next on January 29th, and February 23rd.

Meeting Adjourned 4:08 pm