

***Workers' Compensation
Medical Services Review Committee
Meeting Minutes***
April 20, 2015

I. Call to order

The Medical Services Review Committee was called to order at 9:00 am on Monday, April 20, 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 adopt the agenda was made by member Pfeifer and seconded by member Foland. The agenda was adopted unanimously.

IV. Approval of Minutes

A motion to adopt the minutes from the March 16, 2015 meeting was made by member Smith and seconded by member Pfeifer.

- Member Pfeifer asked that his document regarding NCCI edits be included with the March 16, minutes. There was no opposition from the committee.
- Member Foland stated there was discussion at the March meeting of the need to have a narrative summary of how the committee arrived at their recommended conversion factors. The chair agreed, and acknowledged he had received reports from Optum and will be incorporating their reports into the committee's final report.
- Member Foland stated the summary report should also acknowledge the committee's goal of working toward a single conversion factor in four years. The chair will clarify in the March minutes that working with Optum, he will draft a summary report with findings and recommendations for review by the committee and submission to the Commissioner and Workers' Compensation Board.

The March 16, 2015 minutes, as amended, were unanimously adopted by the committee.

V. Chair's Report

HB178, extending the fee schedule effective dates from July 1, 2015 to December 1, 2015 has passed the House and is awaiting a hearing on the Senate floor. Although the legislature was scheduled to adjourn yesterday, April 19th, they did not adjourn, so the legislature could still take action on this bill. The Committee discussed possible ramifications if HB178 does not pass.

VI. Fee Schedule Development Discussion

- The committee discussed what they would like to see in the final report.
 - Optum will provide a summary of their analysis and methodology. The chair will incorporate Optum's summary in the final report. Once the summary report has been drafted, it will be circulated to the committee members for review.
 - Member Foland recommended including a price comparison with the final report so stakeholders can see the differences between current fee schedule pricing, Medicare pricing, FairHealth pricing, and the proposed changes. The chair intends to include that analysis in the committee's report.
 - After review and input from the committee, the final report will be sent to the Commissioner, the Workers' Compensation Board, and made available to the public.
 - The projected time table would be to have the report to the Commissioner in early May, allow 2 weeks for public comment, then call for a Board meeting in mid June to promulgate regulations.
- Member Griffith looked at the worksheet produced by the chair and noted that the current fee schedule pricing is based on the inpatient rate of \$19,659 times the CMS geometric mean for length of stay. Member Griffith stated Providence data reflects the average length of stay is significantly greater than the CMS mean, which indicates that the proposed fee schedule impact may be significantly greater than indicated.
- The chair noted that the differential between the old fee schedule and the proposed new fee schedule is skewed by the significant increase that occurred in 2010. NCCI's January 2014 analysis of the 2010 fee schedule change showed that the average change in the maximum allowable reimbursement (MAR) rate for inpatient medical/surgical stays increased 127% over the prior fee schedule. As a result of this significant increase in the MAR, NCCI's analysis indicates that observed billed charges increased 46.2%.
- Eric Anderson noted that Member Griffith brings up a good point. Because Alaska's rural population has limited access to local facilities, CMS' length of stay is probably undervalued for Alaska. It was also noted that the overall Medicare population are retirees, whereas workers' compensation patients would be of a younger working age, which would likely result in shorter lengths of stay.
- Member Griffith opined that, given this analysis, the proposed inpatient conversion factor will likely not be received well by her stakeholder group.
- The chair noted that one of the findings that will be written up in the summary report will be the need for more comprehensive medical data.
- Member Scott reminded the committee that workers' compensation premium rates are a major concern for employers. While workers' compensation may be less than 10% of a provider's revenue, it is a significant business expense for employers.
- Member Foland reminded the committee that they have only dealt with costs. The other cost driver that has yet to be addressed is utilization.

The committee took up discussion of the outpatient conversion factor.

- The committee evaluated conversion factors from \$221.79 to \$245.77 in \$3.0 increments.

Break 10:15am-10:30am

- The committee discussed the difference between CPT codes and APC codes in outpatient settings.
- Member Hall moved that the outpatient conversion factor be \$221.79, and that ambulatory surgical centers (ASC) be paid at the same maximum allowable reimbursement (MAR) rate as outpatient clinics. The committee had previously proposed reimbursing ASC's at 95% of the MAR for outpatient clinics. The motion was seconded by member Smith. After discussion, the motion was unanimously approved by the committee.

The committee took up discussion of recommendations for an air ambulance fee schedule.

- HB 316 mandates that an air ambulance fee schedule be produced by the Workers' Compensation Board. It states, "A fee or other charge for air ambulance services rendered under this chapter shall [underlined for emphasis] be reimbursed at a rate established by the board and adopted in regulation." In its statutory advisory capacity, the committee believes it appropriate to make an air ambulance fee schedule recommendation.
- The committee understands that a proposed regulation may be subject to a legal challenge, but believes a recommendation is necessary to meet the statutory mandate.
- The committee reviewed information provided at earlier presentations by Guardian and LifeMed, and a November 2014 analysis from the National Council on Compensation Insurance.
 - LifeMed's fixed wing liftoff fee is \$12,127. Their rotary wing lift off fee is \$16,631. Their fixed wing air mile rate is \$82.60/mile for transports less than 800 miles, and \$55.13/mile for transports over 800 miles. Their rotary wing air mile rate is \$174.70/mile. Guardian did not provide charge rates.
 - NCCI's analysis indicates a countrywide liftoff rate of \$5,488 and a regional (AZ, MT, NM, OR) liftoff rate of \$4,166. The countrywide air mile rates are \$35/mile for fixed wing and \$108/mile for rotary wing. The regional air mile rates are \$20/mile for fixed wing and \$155/mile for rotary wing.

VII. Public Comment

Misty Steed, PACBLU

- The committee might wish to consider using a percentage of allowable charges authorized by the federal workers' compensation fee schedule.

VIII. Fee Schedule Development Discussion (continued)

The committee continued discussion of an air ambulance fee schedule.

- Member Pfeifer moved that an air ambulance fee schedule be recommended which establishes the following maximum allowable reimbursement (MAR) rates

- For HCPCS Code A0430, Ambulance service, conventional air services, transport one way (fixed wing) a base rate (commonly referred to as a lift-off charge) of \$11,500.
- For HCPCS Code A0431, Ambulance service, conventional air services, transport one way (rotary wing) a base rate (commonly referred to as a lift-off charge) of \$13,500.
- For HCPCS Code A0435, Fixed wing air mileage, per statute mile, a maximum allowable reimbursement of the CMS rate times 400%.
- For HCPCS Code A0436, Rotary wing air mileage, per statute mile, a maximum allowable reimbursement of the CMS rate times 400%.

The motion was seconded by member Smith. After discussion, the motion was unanimously approved by the committee. Member Griffith abstained.

Lunch Break 11:45am-1:30pm

IX. Fee Schedule Development Discussion (continued)

Having voted on conversion factors, the committee next took up proposed fee schedule rules.

Proposed Physician Fee Schedule Payment Rules

1. Separate CMS relative values shall be used for physician services provided in facilities and physician services provided in non-facilities.
2. The maximum allowable reimbursement for medical services that do not have a current CPT code, a currently assigned RVU, or a conversion factor shall be the lower of 85% of billed charges, the charge for the treatment or service when provided to the general public, or the charge for the treatment or service negotiated by the provider and the employer.
3. Providers and payers shall follow the billing and coding rules, as amended, in effect at the time of treatment, as established by the Centers 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:
4. Modifier 50: 100% of the fee schedule amount or the lesser of the billed charge for the procedure with the highest RVU. 50% of the fee schedule amount or the lesser of the billed charge for the procedure for the second and all subsequent procedures.
5. Modifier 51: 100% of the fee schedule amount or the lesser of the billed charge for the procedure with the highest RVU rendered during the same session as the primary procedure. 50% of the fee schedule amount or the lesser of the billed charge for the procedure with the second highest RVU and all subsequent procedures during the same session as the primary procedure.
6. Modifiers 80, 81, and 82: Reimbursement shall be twenty percent (20%) of the surgical procedure.

8. Modifier PE: Reimbursement shall be 85% of the value of the procedure. State specific modifier PE shall be used when services and procedures are provided by physician assistants and an advanced practice registered nurse.
 - Member Foland stated that PA's and APRN's are reimbursed in her clinic at 100%. The chair stated that the long standing practice in workers' compensation is reimbursement at 85%. Member Scott asked Sheila Hansen from Coventry what bill review is paying, and Ms. Hansen responded that they are paid at 85%.
9. Modifier AS: Reimbursement shall be fifteen percent (15%) of the value of the procedure. State specific modifier AS shall be used when a physician assistant or nurse practitioner acts as an assistant surgeon and bills as an assistant surgeon.
10. Modifier QZ: Reimbursement shall be 85% of the value of the anesthesia procedure. State specific modifier QZ shall be used when unsupervised anesthesia services are provided by a certified registered nurse anesthetist.
11. Providers and payers shall follow National Correct Coding Initiative edits established by the Centers Medicare and Medicaid Services and the American Medical Association, as amended, in effect at the time of treatment.

Member Scott moved that the payment rules as presented above be adopted for recommendation to the workers' compensation board. The motion was seconded by member Foland.

- Member Pfeifer moved that a rule be added to the NCCI edits, providing that when there is a billing rule discrepancy between CMS NCCI edits and AMA CPT Assistant, that AMA CPT Assistant guidance governs. His motion was seconded by member Hall. After discussion, the motion was unanimously approved by the committee.
- Carla Gee from Optum reported that of the procedures unvalued by CMS, the NCCI data reflects a high frequency for work hardening codes 97545 and 97546. She recommended the committee value these codes. A relative value of \$3.41 for 97545 and \$1.36 for 97546 would put these at the 80 percentile of the FairHealth Data. Member Smith moved to adopt these relative values for CPT codes 97545 and 97546. The motion was seconded by Dr. Hall. After discussion, the motion was unanimously approved by the committee.

Returning to the main motion, the motion to adopt the physician fee schedule payment rule recommendations, as amended, was unanimously approved by the committee.

Proposed Inpatient Hospital, Outpatient Clinic, And Ambulatory Surgical Center Facility Payment Rules

1. The maximum allowable reimbursement for medical services provided by a critical access hospital, rehabilitation hospital, or long term acute care hospital is the lower of one-hundred (100%) of billed charges, the charge for the treatment or service when provided to the general public, or the charge for the treatment or service negotiated by the provider and the employer.

3. Medical services for which there is no APC weight listed shall be the lower of 85% of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.
4. Status codes C, E, and P, shall be the lower of 85% of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.
 - Carla Gee from Optum stated that some status codes simply state charges are not paid under the outpatient prospective payment system. Some states refer payers to other valued fee schedules, such as the professional fee schedule, for payment. Ms. Gee recommends Alaska do the same where applicable.
5. Two (2) or more medical procedures with a status code T on the same claim shall be reimbursed with the highest weighted code paid at one hundred percent (100%) of the APC calculated amount and all other status code T items paid at fifty percent (50%).
6. Outpatient clinics and ambulatory surgical centers shall subtract implantable hardware from billed charges and bill separately at invoice cost plus ten percent (10%).
 - Member Griffith recommended amending this to read, "Payers shall subtract implantable hardware from billed charges and pay separately at invoice cost plus ten percent (10%). The implant invoice must accompany the billed charges."
7. When total charges for a hospital inpatient MS-DRG coded service exceeds the sum of thirty thousand dollars (\$30,000) of the inpatient payment calculated for that service (deemed an outlier case), then the total payment for that service shall be calculated using the CMS Inpatient PC Pricer tool as follows:
 - Implantable charges, if applicable, are subtracted from the total amount charged.
 - The charged amount from (a) is entered into the most recent version of the CMS PC Pricer tool at the time of treatment.
 - The Medicare price returned by the CMS PC Pricer tool is multiplied by 2.5 (250% Medicare price).
 - The allowable implant reimbursement, if applicable, is the invoice cost of the implant(s) plus ten percent (110% of invoice cost).
 - The amounts calculated in (c) and (d) are added together to determine the final reimbursement.

Member Griffith stated that the outlier threshold should be determined by "total costs" not "total charges". After further discussion, the committee acknowledged that the inpatient fee schedule methodology is intended to be calculated by multiplying the hospital's conversion factor by the MS-DRG weight. The PC Pricer would be used when a case is an outlier case. The challenge is coming up with language to adequately define what an outlier case is. The chair tasked member Griffith and Eric from Optum to work on the rule language & report back to the chair.

Member Scott moved that the proposed facility payment rules be adopted as amended (#6), with conceptual agreement to the inpatient outlier payment rule (#7), which will be clarified by Optum and member Griffith, subject to committee review. The motion was seconded by member Foland. After discussion, the motion was unanimously approved by the committee.

Proposed Payment Rule for Medical Services Provided by Other Providers

The maximum allowable reimbursement for medical services provided by providers other than physicians, hospitals, outpatient clinics, or ambulatory surgical centers, shall be the lower of eighty-five (85%) of billed charges, the fee or charge for the treatment or service when provided to the general public, or the fee or charge for the treatment or service negotiated by the provider and the employer.

Member Smith moved the proposed payment rule for other providers by adopted. The motion was seconded by member Scott. There being no further discussion, the motion was unanimously approved by the committee.

Carla from Optum suggested the committee consider whether they want to define “the fee or charge for the treatment or service when provided to the general public”. She noted that this amount can vary depending on what benchmarking product payers are using and what percentile they use. She suggested disputes can be mitigated by further defining this in rule, i.e. “the 85th percentile of billed charges”. Member Pfeifer stated that he interprets the statute as referring to a specific doctor’s billing, not to what all doctor’s charge for that treatment.

Member Smith thanked Optum, particularly Carla Gee, for their assistance putting together the committee’s recommendations. He also thanked the division and the chair for the support provided to the committee.

The chair noted that the committee’s next meeting will be at the call of the chair. This is not likely to happen until after the Board adopts the committee’s recommendations into regulation.

Meeting Adjourned 3:23 pm