EK HEALTH
Transforming Managed Care℠

Compliance and Regulations Newsletter

Demetria Woodson
Manager of Compliance and Regulations, EK Health Services, Inc.

ARIZONA

Fee Schedule Increase and Switch to RBRVS Before Industrial Commission

The Industrial Commission of Arizona (ICA) heard testimony on April 28th on the proposal to increase rates in its Physicians' and Pharmaceutical Fee Schedule effective October 1, 2016. The Commission's agenda stated it may discuss implementing Medicare's Resource-Based Relative Value Scale reimbursement methodology.

Proposed fee schedule changes would increase reimbursement an average of 3%-7%.

The Commission reviewed workers' compensation fee schedules from Colorado, Nevada, New Mexico, North Carolina, Oregon, Utah, and Washington. Using information gathered through the survey, the Commission used the following methodology to calculate values for codes under review.

- Current Arizona values between the 75th and 100th percentile of the states surveyed are not adjusted.
- Current Arizona values over the 100th percentile of the states surveyed are reduced to the 100th percentile.
- Current Arizona values below the 75th percentile are increased to the 75th percentile subject to the following: increases shall be capped at 25% unless necessary to bring a current value up to the 50th percentile.

Written comments on proposed changes were accepted through May 12th. One comment was received, and it was in support of the retention of Medispan as the data source for determining average wholesale price for prescription medicine.

The agenda for the April 28th meeting stated it may include discussion of an RBRVS fiscal impact study related to adoption of an RBRVS-based fee schedule.

ICA contracted with Public Consulting Group, Inc. (PCG) to study the fiscal impact of transitioning to an RBRVS-based payment methodology and if it is feasible to implement such a fee schedule using Arizona-specific conversion factors. PCG released the report on April 5th finding it would be feasible to institute an RBRVS-based reimbursement methodology which is the basis of workers' compensation reimbursement for 32 other states. The report also stated providers are familiar with this fee schedule structure and that providers and the Commission would benefit by reduced administrative costs involved in updating values on an annual basis.

To date, the Commission has not posted the outcome of the April 28th hearing.

The proposed fee schedule increase would be effective October 1, 2016.

Potential Impact
While fee schedule reimbursement will increase with this update, this is in line with annual updates of the Arizona Physicians' & Pharmaceutical Fee Schedule.

Source 1
Source 2
Source 3

Bill Requiring PMP Verification Waiting Governor's Signature

Senate Bill 1283, by Sen. John Kavanagh (R), will require providers to check the state's prescription monitoring program database before prescribing opioids.

The House approved the bill on March 28th 58-0. SB 1283 was passed by the Senate 28-0 on May 4th and sent to Gov. Doug Ducey who signed on May 12th.

Beginning October 1, 2017, providers will be required to obtain the patient's utilization report for the preceding twelve months at the beginning of each new course of treatment and at least quarterly while the prescription remains part of the treatment when prescribing an opioid analgesic or benzodiazepine controlled substance listed in Schedule II, III, or IV.

Practitioners will not be required to obtain a patient utilization report if the patient is receiving hospice care, cancer treatment, inpatient or residential treatment, or the practitioner will administer the controlled substance. Practitioners may be granted a one-year waiver from the requirement due to technological limitations not within their control.

Potential Impact
This bill which has been signed into law will enable physicians to be informed of injured workers' prescription history to curtail long-term use or drug-seeking efforts by injured workers.

Source

Bill Includes Translation Services as Medical Benefits and Requires Certified Translators

Gov. Doug Ducey signed House Bill 2240 into law on May 11th. The bill states medical benefits include translation services, if needed. A carrier, self-insurance pool, or employer that does not direct care may choose the translator if said translator is certified by an outside agency and is not an employee of the carrier, self-insurance pool, or employer. If the carrier, self-insurance pool, or employer is unable to locate a certified translator for the language needed, the parties may agree on a translator who is not a certified translator.

Potential Impact
HB2240 will ensure non-certified translators do not provide services for injured workers. This law should prevent fraud from translators who may not be qualified.

Source

CALIFORNIA

Conservative Care Bill Delayed by Committee
Assembly Bill 2407, by Assembly Member Rocky Chavez (R), would require a provider to assess the employee's risk for chronic back pain if the employee's injury affects his or her back and determine whether the employee meets the criteria for surgical consultation.

Following the assessment, alternatives to surgery may be appropriate and include acupuncture, chiropractic manipulation, cognitive behavioral therapy, office visits, osteopathic manipulation, physical and occupational therapy, yoga, massage, supervised exercise therapy, or medications including short-term opiate drugs but excluding long-term prescriptions.

Surgery may be recommended for a limited number of conditions and only if there is sufficient evidence to indicate surgery would be more effective than other treatment option.

The Assembly Committee on Insurance voted 13-0 on May 4th and referred AB 2407 to the Committee on Rules to be assigned to the appropriate committee for study.

Potential Impact
Assessing the injured worker's risk for chronic pain allows the provider to determine a course of treatment without ordering surgery when another type of treatment may be more appropriate and effective.

Source

NORTH DAKOTA

WSI Adopts Chronic Opioid Therapy Medical Policy
North Dakota Workforce Safety & Insurance adopted a new policy which explains when WSI will cover chronic opioid therapy for an injured employee when opioid treatment extends beyond 90 days. The new policy is a result of 2015 North Dakota Legislative Assembly amending North Dakota Century Code §65-05-39 to address chronic opioid therapy.

WSI will review medical documentation and claim data to assess the progress of an injured employee's opioid therapy including the employee's compliance with treatment protocol. Such assessments will help WSI to determine whether an injured employee is eligible to receive continued coverage of opioid therapy.

Chronic opioid therapy beyond the initial 90 days is covered if therapy results in an increase in function, enables an injured employee to resume working, or improves pain control without debilitating side effects.

The therapy should be used for injured employees who are nonresponsive to non-opioid treatment, not using illegal substances or abusing alcohol, and compliant with treatment protocol.

At least every 90 days, prescribers of chronic opioid therapy must provide documentation to WSI on the effectiveness of the therapy including documentation of improvements in function or pain control without debilitating side effects. A signed treatment agreement between the injured employee and prescriber that limits prescriptions to a single prescriber must also be submitted to WSI.

Potential Impact
The guideline allows WSI to monitor injured worker's chronic opioid therapy and determine if treatment beyond 90 days is appropriate if improved patient's condition is expected.

Source

PENNSYLVANIA

Trauma Center Should Not be Reimbursed Billed Charges

The Commonwealth Court of Pennsylvania ruled that a trauma center was entitled to 100% of usual and customary charges charged by like providers in the same geographic region for similar treatment not 100% of the billed amount.

Case: ***Geisinger Health System v. Bureau of Workers' Compensation Fee Review Hearing Office, No. 1627 C.D. 2015, published 4/21/16.***

Geisinger submitted a bill to the workers' compensation carrier for the injured worker's employer, State Workers' Insurance Fund, and the carrier did not pay the full amount billed. The carrier used a repricing database to determine the charge billed most often by providers with similar training, experience, and licensure for the treatment provided by Geisinger and paid Geisinger that amount.

The Bureau's Workers' Compensation Medical Fee Review Section determined Geisinger should be paid 100% of billed charges noting the provider's documentation met guidelines in Section 127.128 of the Workers' Compensation Medical Cost Containment (MCC) Regulations. The hearing officer disagreed stating the carriers reimbursed Geisinger correctly at 100% of the usual and customary charges in the geographic region for services provided to the injured worker.

The hearing officer overturned the Medical Fee Review Section's decision, noting Section 127.3 of the MCC Regulations defines "actual charge" as "the provider's usual and customary charge for a specific treatment, accommodation, product or service." The hearing officer determined payment should be based on "100% of the usual and customary charge" as defined in 34 Pa. Code §127.3 which defines "usual and customary charge" as "the charge most often made by providers of similar training, experience and licensure for a specific treatment, accommodation, product or service in the geographic area where the treatment, accommodation, product or service is provided."

The hearing officer went on to state she feels since "usual and customary charge" is mentioned three times as opposed to the single mention of "the provider's usual and customary charge" and the fact that the MCC Regulations include separate definitions for "actual charge" and "usual and customary charge" that the goal of the MCC Regulations and the Act was to reimburse providers 100% of the usual and customary charge for specific treatment rendered in a specific geographic area.

Judge Robert Simpson agreed with the majority but stated there was no evidence in this case that another accredited trauma care facility exists in the provider's geographic area. He also stated there was no evidence in this case of the charge of any accredited trauma care facility in the same geographic area.

Potential Impact

Providers currently reimbursed based on their own usual and customary charge may see a decrease in payment based on the court's ruling which stated providers should be reimbursed based on the usual and customary charge for services provided in the same geographic region and not the provider's usual and customary charge.

Source 1
Source 2

SOUTH DAKOTA

Proposed Fee Schedule Change Would Result in 1.5% Increase for Most Services

The South Dakota Division of Labor and Management held a public hearing on May 10th to discuss the adoption of a proposed workers' compensation fee schedule. If adopted, changes to Chapter 47:03:05 would update references to the most current version of the relative values manual and revise conversion factors for some services.

Proposed conversion factors increases are as follows:

Fee Schedule Section	Procedure Code	Conversion Factor	
Surgery	10000-69999	~~$98.24~~	$99.71
Radiology	70000-79999	~~$18.60~~	$18.88
Pathology/Lab	80000-89999	~~$14.90~~	$15.12
Medicine/Misc.	90000-99071	~~$6.40~~	$6.50
Nerve Conduction	95907-95913	~~$6.40~~	$8.30
E&M	99201-99450	~~$7.80~~	$7.92
Anesthesia	00100-01999	~~$39.65~~	$40.28
Dental	D0120-D9999	~~$53.20~~	$56.48

The outcome of the hearing has not yet been posted on the state's website.

Potential Impact

If adopted, fee schedule reimbursement would increase. However; this is in line with past fee schedule updates of the South Dakota Fee Schedule.

Source

TEXAS

TDI-DWC Finalized Criteria for Compound Medication Plan-Based Audit

The Texas Department of Insurance, Division of Workers' Compensation finalized the revised Compound Medications Plan-Based Audit April 28, 2016 for physicians who prescribe compound drugs.

Selection criteria will include prescribed compounds filled between September 1, 2014 and August 31, 2015. No more than 10 physicians from a ranking of two groups - doctors who prescribed the highest number of compound drugs and doctors that accounted for the highest amount billed for compound drugs. Compound drugs for which the only ingredient was a laxative drug will be excluded. For each physician selected, the top five prescribed compounds with the highest dollar amount will be selected. Only the highest dollar amount billed for a compound prescription per injured employee will be included.

Potential Impact

Compounds are not included in the formulary. This may lead to pricey compound prescriptions with multiple active ingredients being prescribed without authorization. TDI-DWC hopes the audit results will help to promote quality health care and ensure physicians prescribing compound drugs are following ODG Drug Formulary guidelines. Prescribing of expensive compounds may be curbed once audit results are analyzed.

Source 1
Source 2

NATIONAL

NAMSAP Leads Charge on Limiting Opioid Use for Medicare Set-Asides

The National Alliance of Medicare Set-Aside Professionals (NAMSAP) proposed an "evidence-based limit on opioids for Worker's Compensation Medicare Set-Aside (WCMSA) arrangements" to combat what is being called an opioid epidemic in the United States. NAMSAP requested the Centers for Medicare and Medicaid Services (CMS) "cap costs earmarked for future opioid expenditures, thereby seeking to reduce ongoing usage of these dangerous medications," as stated in a March 23rd press release.

NAMSAP reviewed studies that found long-term use of opioids for chronic, non-cancer pain is ineffective and hurtful, if not monitored appropriately. NAMSAP supports a limit of 90 morphine equivalent dosages (MED) based on CDC guidelines for no more than a month when the WCMSA includes a projected surgical procedure(s) and/or a limit of 40 MED for no more than a month, followed by a 10% per week weaning plan recommended by the CDC. A morphine equivalent dose (MED) is the amount of opioid prescription drugs converted to a common unit (milligrams of morphine). Morphine is regarded as the "standard" for the treatment of moderate to severe pain.

CMS's policy suggests Medicare prescription drug plans set flags for patients taking a morphine equivalent dose of 120 milligrams a day for more than 90 days.

Prium President Michael Gavin noted CDC's and CMS' opioid policies and the fact that they are conflicting. In a blog about NAMSAP's press release, Gavin stated, "when the federal government's public health agency says one thing, but that same government's healthcare payment policy agency says another, they ought to be called to account for it."

Gavin believes NAMSAP's proposal is a good idea but doesn't believe it will be implemented.

Potential Impact

Limiting opioid use would reduce costs as well as reduce the chances of possible addition, overdose, and death.

Source 1
Source 2
Source 3