EK HEALTH
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Compliance and Regulations Newsletter

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CALIFORNIA

California's Medical Fee Schedule - Implementing Drug Formulary and MTUS Guidelines Update

The California Division of Workers' Compensation (DWC) posted draft regulations for its drug formulary on August 26, 2016 which included a proposed list of preferred drugs.

The Legislature's intent of the Administrative Director of the DWC is to create an evidence-based drug formulary, consistent with California's Medical Treatment Utilization Schedule (MTUS), to provide quality care, maximize health, and promote return to work in a timely fashion, while reducing administrative burden and cost.

Assembly Bill 1124 requires the administrative director to create a drug formulary as part of the Medical Treatment Utilization Schedule (MTUS) on or before July 1, 2017. DWC intends to concurrently adopt updated MTUS clinical topic guidelines to coordinate with the drug formulary. The proposed guidelines for adoption for MTUS were created by the American College of Occupational and Environmental Medicine (ACOEM), published by Reed Group, Ltd. Instead of using evidence-based drug recommendations in the guidelines, the DWC created a preferred drug list proposed in the draft regulations.

Potential Impact

The comment period for a drug formulary was closed on September 16, 2016. Monitoring of this proposed legislation will continue.

Source

KANSAS

Kansas Proposed Schedule of Medical Fees Released

The Kansas Division of Workers Compensation has released its proposed workers' compensation schedule of medical fees for 2017. The Division will hold a public hearing in November to consider proposed changes to the fee schedule.

Some of the most important revisions are as follows:

- Conversion factors for all CPT codes increased by 3% except dental codes which were increased by 10%.
- The hourly rate for depositions, testimony, and independent medical examinations increased from $300 to $400 for the first hour.
- The review for the first 50 pages of medical records for a deposition or an independent medical examination increased from $75 to $100. Reimbursement for each additional 50 pages increased from $37.50 to $75. Additional charges submitted by/for copying services are prohibited, including charges for searching when no records are found.
- Invoices shall not be required to reimburse implantables if the billed charge is less than $5,000. They will be reimbursed at 50% of the billed charge.
- Outpatient surgeries will be paid at the maximum allowable fee for the respective CPT code. Outpatient hospitals will not be reimbursed for supply codes 270-279.
- Trauma center activation fees increased by 60%.
- Air ambulance services shall be reimbursed at the amount most commonly charges for the same or similar services in a given area. Current reimbursement is billed charge minus 10%.
- Reimbursement for Nursing Homes, Intermediate Care, and Assisted Living Facilities has changed from billed charges less 15% to billed charges less 20%. Radiology, pathology or laboratory charges are carved out and paid at the maximum allowable fees for the respective CPT code.

If approved, the update will be effective January 1, 2017.

Potential Impact

The proposed fee schedule includes significant changes, most notably, the 60% increase to trauma activation fees. Rates for 2015 trauma activation fees only increased 7%. The conversion factor increase impacting physician fees is consistent with the last two increases of 3% in 2015 and 5% in 2014. Reimbursement of facility bills will also see significant changes in the reimbursement of implants under $5,000 and outpatient hospital services.

Source

NEW YORK

Board Proposes New Workers' Compensation Pharmacy Benefit Plan

The New York State Workers' Compensation Board welcomes comments on its proposal of a new Workers' Compensation Pharmacy Benefit Plan.

The current pharmacy benefit describes reimbursement methodologies for brand, generic, and compounded medications, but provides little structure or guidance to prescribers. There is no drug formulary, no prior authorization requirement, and no process to ensure the appropriateness of prescribed medications.
The Board is considering implementing a drug formulary to provide stronger oversight of medications to ensure injured workers receive clinically appropriate, cost-effective medications, as part of their medical care and that they are used for an approved indication and/or via an approved route of administration.

The proposed Pharmacy Benefit Plan requires insurers to provide Pharmacy Benefits Manager services, introduces a prescription drug formulary, imposes limitations on the prescribing of compounded medications, requires compliance with the Medical Treatment Guidelines prescription drug recommendations, and changes the reimbursement methodology.

Potential Impact

Appropriate utilization of pharmaceuticals has been a challenge in New York. The Board hopes an approved pharmacy benefit plan will lead to injured workers receiving more clinically appropriate medications that are more cost-effective. If this can be achieved, everyone wins.

Source

OREGON

Proposed Administrative Rules to Impact Self-Insureds and Claims Administration

Proposed administrative rule changes are before the Oregon Workers' Compensation Division that would impact several areas - Employer/Insurer Coverage Responsibility, Claims Administration, Employer-at-Injury Program, Preferred Worker Program, and Vocational Assistance to Injured Workers. A public hearing was held on October 24th to discuss proposed changes to Oregon Administrative Rules 436-050, 436-060, 436-105, 436-110, and 436-120.

The following are among the numerous proposed rule amendments:

- Describe additional criteria the director will use to determine a self-insured employer's required deposit.
- The director may impose a civil penalty of up to $2,000 if an employer restricts an injured worker from choosing a medical provider.
- The director may award a reasonable fee if an injured worker's attorney is instrumental in obtaining an order that reclassifies the claim from non-disabling to disabling.
- The insurer must reimburse the employer for any employer-paid temporary disability benefits.
- Require a medical release specify the worker's hourly restrictions if the release is for part-time work or fewer hours than worked before the injury.
- Limit the effective period for a medical release to 30 days if the release does not specify an end date or follow-up date.
- Remove the limits on the number of uses for several categories of employment purchases: tuition, books, and fees; tools and equipment; and clothing.
- Requires the insurer provider further training to a worker when the initial plan will not be or was not successful to prepare the worker for suitable employment.
- Require the insurer to approve or disapprove a training plan within 14 days.
- Require the insurer to pay for approved direct worker purchases within 30 days after the insurer receives the worker's request or proof of payment, whichever is less.

The closing date for testimony was October 28th. If approved, rules are expected to be effective January 1, 2017.

Potential Impact

Several of these proposed rules are needed to improve efficiency and effectiveness of programs related to workers' compensation coverage, self-insurance, record-keeping, and claims processing. Clear worker reimbursement requests should expedite payments. Enhanced return-to-work incentives should help workers in overcoming obstacles to employment.

Source

UTAH

Utah Proposes Changes to Conversion Factor and Mileage Rule

The Utah Labor Commission has proposed a change to the rule which addresses the general method for computing medical fees. The purpose of the rule change is to adopt the Optum 2016 Essential Resource-Based Relative Value Schedule (RBRVS), 2016 1st Quarter Emergency Update, and the 2016 American Medical Association Current Procedural Terminology (CPT) coding standards, to increase the anesthesiology conversion factor from $53 to $57, and to specify the rule effective date as December 1, 2016.

According to the October 15th edition of the Utah State Bulletin, the National Council on Compensation Insurance projects overall workers' compensation costs will increase by 0.1% should the new conversion factor is adopted.

Utah uses the Resource-Based Relative Value Scale used by Centers for Medicare & Medicaid Services (CMS) and most other payers. This system assigns relative value units to procedures which are multiplied by a conversion factor to determine how much a provider will be reimbursed.

The commission also proposed an amendment to add a provision back into the rule that would reimburse injured workers for mileage regardless of the distance traveled. The commission stated it inadvertently changed the rule in 2013 to only reimburse other travel expenses when traveling outside of the injured workers' community.
This rule may become effective as soon as November 22nd according to the rule notice.

The Commission accepted written comments on the proposed changes until November 15th.

Potential Impact

If the anesthesia conversion factor increase is approved, overall impact to costs will be minimal. The additional language regarding mileage will allow reimbursement of mileage to the injured worker regardless of the distance traveled.

Source

VIRGINIA

Work Comp Commission Releases Medical Fee Project Timeline

The Virginia Workers' Compensation Commission has released a Medical Fee Schedule Project Update with the timeline to implement fee schedules mandated by House Bill 378. The Virginia Workers' Compensation Commission selected Oliver Wyman Actuarial Consulting a Melville, New York-based firm as the vendor to develop and implement a medical fee schedule.

Meetings are scheduled with the Commission and Oliver Wyman up until implementation of Virginia's first medical fee schedule. The November 10th meeting was expected to review draft fee schedules, impact analysis, and stakeholder testing and feedback. The December 1st meeting will review the updated impact analysis and discuss proposed revisions to the draft fee schedules.

The advisory panel will review final proposed fee schedules and discuss implementation and maintenance requirements during its January 4th meeting.

In 2017, date to be determined, proposed fee schedules are to be reviewed, public hearings conducted, required regulatory processes executed, and fee schedules posted to the Commission website. Medical fee schedules will be implemented January 1, 2018.

Oliver Wyman is tasked with creating seven different fee schedules for six different geographic communities including the Northern region, Northwest region, Central region, Eastern region, Near Southwest region, and Far Southwest region. The seven fee schedules are for surgeons, non-surgeons, Type One teaching hospitals, other hospitals, ambulatory surgical centers, outpatient centers, and providers of miscellaneous services.

Fee schedules will be based on payments doctors and hospitals received on average for each procedure or treatment in 2015.

According to the Workers' Compensation Research Institute, Virginia is one of seven states without a medical fee schedule. With no fee schedule, medical costs tend to be much higher in Virginia than most states. The fee schedules are expected to reduce the number of medical fee disputes submitted each year.

Potential Impact

With a fee schedule, the work comp community will have some certainty to properly set reserves to appropriately impact claims. The number of disputes should also decrease with the implementation of the fee schedule.

Source 1
Source 2