EK HEALTH
Transforming Managed Care℠

Compliance and Regulations Newsletter

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

CALIFORNIA

Formulary Rules Take Effect January 1st

The Division of Workers' Compensation (DWC) has adopted an evidence-based drug formulary for medical providers treating injured workers beginning January 1, 2018. The division incorporated the American College of Occupational and Environmental Medicine's (ACOEM) treatment guidelines, published by ReedGroup, into the Medical Treatment Utilization Schedule which also serve as the foundation for the recommendations in the formulary.

"The adoption of the drug formulary is a step forward for California's injured workers and should help address the overuse of high-risk medications such as opioids," said DWC Administrative Director George Parisotto. "It is expected to improve patient care and ease approval of appropriate treatment."

For all prescriptions written on or after January 1st, physicians will be able to dispense medications designated as "exempt" without going through prospective utilization review, provided the drug is prescribed in accordance with the MTUS Treatment Guidelines.

Physicians may dispense no more than a seven-day supply of one or more drugs designated as "exempt" on the MTUS Drug List without receiving authorization through prospective review. The drug treatment must be in accordance with MTUS Treatment Guidelines and the no more than seven-day supply must be dispensed at the initial visit occurring within seven days of the date of injury.

Drugs identified as non-exempt and drugs not listed in the formulary, will require authorization through prospective review prior to dispensing. Compound drugs will also require prior authorization even if one or more of the ingredients is listed as "exempt" on the MTUS Drug List.

Under the Special Fill policy, a "non-exempt" drug usually requiring prospective review will be allowed without prospective review if certain conditions are met.

Rules also allow "non-exempt" drugs without prospective review if certain conditions are met under the Perioperative Fill policy. The perioperative period is defined as the period of four days before surgery to four days after surgery.

For workers injured prior to January 1, 2018, receiving non-exempt drug treatment, an unlisted drug, or a compound drug, physicians must submit a progress report and a Request for Authorization to address the injured worker's drug treatment plan.

The treatment plan should either address medically appropriate weaning, tapering, or transitioning to a drug pursuant to the MTUS or provide documentation to support the medical necessity of and authorization for the non-exempt drug, unlisted drug, of compound drug pursuant to the MTUS.

The progress report should be submitted by April 1, 2018, and should include the treatment plan and Request for Authorization.

Source 1
Source 2

NEW YORK

New Registration Process for Authorized Health Care Providers

The NYS Workers' Compensation Board launched a registration process to update and maintain a directory of health care providers authorized to treat injured workers. Once authorized, a provider must register with the Board every two to three years which should coincide with their professional license renewal date. Having such a directory will make identifying Board-authorized providers easier for injured workers.

Authorized providers must be registered by January 15, 2018. Providers not completing the registration process that time will be removed from the public directory of authorized providers and will become ineligible for the Board's HP-1 disputed bill process.

The Board is using the existing New York State Health Commerce System (HCS) for the registration process and future updates to registration information.

Providers must have an HCS account or apply for one. They must then complete and submit the WCB registration form using their HCS account. Information collected will include National Provider Identifier (NPI), disciplinary action information, and practice website.

The Board has provided additional resources on its website to assist providers.

Source

VIRGINIA

Virginia Implements Medical Fee Schedule

Virginia is the latest state to implement a new medical fee schedule.

In early March 2016, the House passed HB 378 which mandated regulations implementing fee schedules. The initial fee schedules were to be based on the average of all amounts paid to providers in the same category of providers in the same medical community.

Oliver Wyman Actuarial Consulting, Inc. of New York was hired to assist with the development of the MFS at a cost just under $784,000. Oliver Wyman worked with the Advisory Panel to develop guiding principles such as fee schedule estimates relying on Virginia's experience instead of an outside source and the MFS limiting disruption to Virginia's marketplace.

The Medical Fee Schedule (MFS) includes services for physicians, hospitals, ambulatory surgery centers, and other healthcare providers and suppliers. Fees vary based on provider group and six different geographic regions. Maximum fees were determined using valid and statistically reliable data comprised of approximately 74% of the total Virginia workers' compensation market in 2014 and 2015.

The MFS applies to all healthcare services provided to injured workers on or after January 1, 2018, regardless of the date of injury. Providers may contract for reimbursement lesser than or more than the maximum fee schedule value.

Exclusions from the MFS include inpatient treatment of a traumatic injury or serious burn which should be reimbursed no more than 80% of the provider's billed charge. Pharmaceuticals other than those administered as part of medical care and durable medical equipment dispensed from a retail facility are also excluded.

Providers may submit a dispute over reimbursement to the Virginia Workers' Compensation Commission for determination. The Medical Fee Services Department will make an administrative decision within 30 days of receipt of all requested information.

The Commission will review the MFS in 2019 and every two years thereafter on or after January 15th of the review year. The Commission will make adjustments to the fee schedules as needed to address inflation, deflation, and other specific criteria. Such revisions to the fee schedules will become effective on April 1st of the review year.

Source 1
Source 2