EK HEALTH
Transforming Managed Care

Compliance and Regulations Newsletter

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

CALIFORNIA

Changes to State Reporting Requirements - Effective April 6, 2016

CA DWC has released a new version of the California Electronic Data Interchange (EDI) Implementation Guide for Medical Bill Payment Records, Version 2.0.

The updated guide effective April 6, 2016, is based on International Association of Industrial Accident Boards and Commissions (IAIABC).

Potential Impact

New reporting requirements include Jurisdiction Claim Number (JCN) (DN0005), Claim Administrator Claim Number (DN0015), and Insurer FEIN (DN0006). Workers' Compensation Information System (WCIS) uses a combination of the three to match medical bills to claims previously reported in the First Report of Injury (FROI). If the Jurisdiction Claim Number is not reported with the medical bill data, the bill will be rejected.

Programming and testing are currently underway. Reporting will commence with the new requirements as of April 6, 2016.

Source

Bills Involving Interpreters and Medical Billing Deadlines Among Those to be Discussed in 2016

California lawmakers can expect to debate numerous issues in 2016 including whether injured workers should have the right to choose their own interpreters and whether medical providers should be required to submit bills within 12 months of the date of service.

Assembly Bill 2230, by Assembly Member Kansen Chu (D), would add language to the Labor Code stating the injured worker may select an interpreter who is certified or deemed certified if interpretation services are required. The bill also allows the employer to select the interpreter if interpretation services are required and the employee has not selected an interpreter.

Mike Herald, a lobbyist for the California Applicants' Attorney Association, noted the Labor Code gives injured workers the right to an interpreter and requires employers to pay for these services. However; the Labor Code is silent on who may select the interpreter.

AB 2230 may be heard in Committee on March 20th.

Senate Bill 1175, by Senator Tony Mendoza (D), would require medical providers to submit bills (including medical-legal services) within 12 months of the date of service or within 12 months of the date of discharge for inpatient facility services. The administrative director will define circumstances that constitute good cause for an exception to the 12-month period.

SB 1175 may be acted upon on or after March 20th and would be effective for services provided on or January 1, 2017.

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.

AB 2407 may be heard in Committee on March 22nd.

Potential Impact

AB2230

The intent is to address the issue of the employer choosing an interpreter and the worker having no choice in whether or not to accept the employer's choice.

SB1175

Timely submission of bills would decrease administrative burdens placed on payers who must review records to verify if services were provided, possibly review the claim, and check for duplicate bills.

AB2407

No information has been documented for the need for this bill.

Source 1
Source 2
Source 3

CA DWC Approves Use of Telemedicine by QME

The Division of Workers' Compensation has approved the use of telemedicine by one physician for conducting medical-legal evaluations.

Dr. Behzad Emad, a qualified medical examiner in Monica, informed Elaine Goodman, a reporter with WorkCompCentral, that he received approval from DWC to use telemedicine during medical-legal evaluations as an accommodation for a disability. Dr. Emad did not state the nature of his disability nor why he could not conduct evaluations in person.

DWC spokesman Peter Melton confirmed the agency approved telemedicine for disability evaluations for one QME but did not disclose the physician's name.
If the evaluator is selected for a medical-legal review, the evaluation would occur via live videoconferencing between the worker and the QME. A medical professional under the evaluator's supervision, would be present with the office. The evaluator would talk with the worker in real time.
Full disclosure of the telemedicine process would be provided by the evaluator's office, and parties would decide whether or not to "strike" the evaluator.

Under California law, telemedicine for medical treatment is allowed if the provider is a licensed California physician. Applying it to a QME disability evaluation is a new concept and time will tell if a report from a telemedicine evaluation will constitute substantial evidence.

Potential Impact
If Dr. Emad is indeed the one approved QME, it remains to be seen how many "strikes" he will receive when attorneys find out he will be using telemedicine. Another unknown is if the findings of telemedicine evaluations will be disputed.

Source 1
Source 2

CWCI Report: IMR Decision Letters Increased by 19% in 2015

According to a California Workers' Compensation Institute (CWCI) report published February 18th, the number of independent medical review determination letters issued by Maximus Federal Services increased by 19% in 2015. Maximus issued 163,826 decision letters in 2015, compared to 137,761 in 2014.

CWCI's report found 49.6% of services reviewed in 2015 involved prescription drugs. Pharmaceuticals continue to account for a majority of service requests. The utilization review decision was upheld in 89.7% of pharmaceutical IMR decisions.

Physical therapy services account for the second largest percentage of requests at 8.7%. The UR decision was upheld in 92.5% of physical therapy.

Interestingly, the top 1% of providers, 128 people, generated 46% of the IMR decisions. Ten providers alone accounted for 17,406 IMR letters and 34,710 medical service requests.

Potential Impact
Overall, the report showed Maximus concurred with the UR decision that the requested service was not medically necessary in 88.6% of treatment decision issued in 2015.

Source

CONNECTICUT

CT WCC Implements Medical Protocols for Psychological Pain Assessment and Treatment

The State of Connecticut Workers' Compensation Commission implemented medical protocols for psychological pain assessment and treatment effective February 15, 2016. Practitioners, insurers, and the Medical Advisory Panel were consulted in the implementation process.

The protocols will be used to evaluate whether treatment is reasonable and appropriate based on the diagnosis of an injury or illness. Protocols can be found at http://wcc.state.ct.us/download/acrobat/protocols.pdf.

Potential Impact

The protocols are not absolute and medical providers are urged to contact the insurer if they feel a treatment method other than these protocols is necessary.

Source

2016 WCC Hospital and Ambulatory Surgical Center Fee Schedule

The following will be effective April 1, 2016, for services rendered by hospitals and ambulatory surgical centers.

- The hospital inpatient rate shall be 174% of the Medicare rate payable to that facility.
- The hospital outpatient and hospital-based ambulatory surgical center rate shall be 210% of the Medicare rate payable to that facility.
- The non-hospital based ambulatory surgical center rate shall be 195% of the hospital-based outpatient Medicare rate payable in the same Core Based Statistical Area (CBSA).
- When there is no Medicare rate for services in an outpatient hospital setting, parties shall negotiate reimbursement. If negotiation is unsuccessful, parties may request a hearing with the Commission. Treatment shall proceed pending the Commission's decision.

The Commission is working with a vendor to publish 2016 rates, rules, and guidelines. Optum is believed to be publishing 2016 rates as they published 2015 facility rates. This fee schedule is expected to be available prior to the effective date. Notice of availability will be posted at http://wcc.state.ct.us.

Potential Impact

Connecticut does not have a facility fee schedule and bills are currently paid according to Usual and Customary Rates (UCR). Approval of this bill should reduce medical payments.

Source

FLORIDA

2015 Edition of Health Care Provider Reimbursement Manual Pending Legislative Approval

The Department of Financial Services (DFS) filed amendments to Rule 69L-7.020 for final adoption. The amended rule adopts the 2015 Edition of the Health Care Provider Reimbursement Manual; however, the amended rule is **not** in effect.

Potential Impact

DFS's statement of estimated regulatory costs for the amended rule found it would increase regulatory costs by more than the threshold amount requiring legislative ratification under section 120.541(3) of Florida Statutes. The amended rule and adoption of the 2015 Provider Reimbursement Manual will become effective once ratified by the Legislature. The Department will pursue ratification in the 2016 regular legislative session.

Source

Revision F Medical EDI Reporting - Effective February 18, 2016

Changes to the Florida Medical EDI Implementation Guide (MEIG) include the following:

- Data Element (DN) names changed to be more consistent with national standard names.
- New Explanation of Bill Review (EOBR) Codes have been added.
- Data Elements now required: Claim Administrator Code number, FEIN, and Physical Postal Code
- New field added for additional NDC number for repackaged drug scenarios.

Revision F will be phased in and testing time will be determined by the sender's FL ID number. The Division will allow senders to complete testing transmission processes earlier than the scheduled time on a volunteer basis.

Senders must accurately complete the testing requirements in accordance with the MEIG Revision F before reporting production data.

Potential Impact

Testing not completed and approved by the scheduled times will delay reporting of production files based on Revision F guidelines.

Source

MARYLAND

Bills would enact bill submission deadline effective October 1, 2016

Senate bill 258, sponsored by Senator Katherine Klausmeier (D), would require medical providers to submit bills and documentation to the employer or insurer within 45 days after the medical service or treatment is provided to a covered employee. The employer or insurer may not be required to pay a bill not submitted within the 45-day period. The provider must file an application with the Workers' Compensation Commission within three years from the date service or treatment is provided and the Commission may excuse the untimely submission for good cause.

SB 258 is pending with the Senate Finance Committee after a hearing held on February 9th.

HB 710 by Delegates Cheryl Glenn (D) and Warren Miller (R) is identical to SB258 and pending with the House Economic Matters Committee after a hearing held on February 23rd.

Potential Impact

Bills not submitted within the 45-day period may be disallowed. Payment would only be required if the Commission reviews the provider's application and allows the untimely submission.

Source 1
Source 2

NEW HAMPSHIRE

Pending Legislation to Establish Fee Schedule

After failing to pass in 2015, House Bill 477 was reintroduced on January 6, 2016. This bill requires the labor commissioner to establish medical payment schedules. New Hampshire is one a few remaining states without a fee schedule.

HB 477 states the commissioner shall adopt rules to establish a medical payment schedule which shall require medical payments at the rate of 150% of the Medicare reimbursement rate.

The original effective date was January 1, 2016. A new effective date has not been established.

Potential Impact
With the absence of a fee schedule, bills are currently paid according to Usual and Customary Rates (UCR). Approval of this bill would significantly reduce medical payments.

Source

OREGON

Final Medical Fee Rules Published - Effective April 1, 2016
The most significant updates are:

- Maximum allowable rates increased 3% for physician services except physical therapy services.
- Platelet rich plasma injections are not compensable.
- Maximum amount payable for hearing aids without insurer approval increased from $5,000 to $7,000 for a pair and from $2,500 to $3,500 for a single hearing aid.
- Injured worker is allowed to upgrade a hearing aid from the prescribed device by paying the price difference.
- Compound drugs must be billed at the ingredient level with each NDC listed. Ingredients listed without an NDC will not be reimbursed.
- Maximum allowable rate for compound drug is 83.5% of the average wholesale price for each ingredient plus a $10.00 compounding fee.
- Current mileage reimbursement rate for interpreters of $0.50 per mile is replaced by the private vehicle mileage rate listed in Bulletin 112 ($0.54 per mile effective January 1, 2016).

Potential Impact
Rule update results in increased payments for a major portion of the fee schedule. Compound drugs will have a payment methodology in place whereas they are currently reimbursed at a usual and customary rate.

Source

Bill Seeks to Inform Injured Workers of Right to Choose Medical Provider
The Management-Labor Advisory Committee, which advises the Oregon legislature on workers' compensation issues, opposes a bill that would require injured workers to be notified of their right to choose a medical provider.

Under the current statutes, the worker may seek treatment with a medical provider of his/her choice.

HB 4052 proposes the following:

- Employers would be required to provide the worker with written notice explaining medical treatment rights.
- The notice of medical treatment rights must be signed by the injured worker and the employer.
- The employer would be required to provide a copy (electronic form if requested) of the signed notice to the injured worker and insurer, if any. The insurer or self-insured employer would be required to make a copy of the notice upon request by a third party.
- The worker may seek treatment with a provider of the worker's choice.
- The employer may not direct injured workers to a specific physician, nurse practitioner, occupational medical center, emergency care clinic, or other medical group for non-emergency medical treatment in most cases.
- Self-insured employers and insurers who contracts with a managed care organization (MCO) may still direct care. Workers subject to the contract shall receive medical services in the manner prescribed in the contract.
- Employers may direct injured workers to a facility of the employer's choice for post-injury drug testing. After the testing, the worker may continue treatment with a medical provider of the worker's choice.

Vern Saboe, a chiropractor in Albany, said an ongoing problem exists in Oregon with some employers intentionally directing workers to treatment providers of their choosing. He believes the bill attempts to ensure injured workers know their rights to select a physician.

The City of Portland submitted written testimony to the MLAC that many employers utilize MCO's and would be exempt and that the bill would create an unnecessary burden for injured workers and employers.

Associated Oregon Industries also submitted written testimony stating the bill is "unnecessarily duplicative" and that increased paperwork will increase costs for employers and "assures no improvement in the medical treatment workers receive."

HB 4052 was referred to the Business and Labor Committee on February 1st with no action taken since that time.

Potential Impact
Passage of HB 4052 would mandate the injured workers be informed of their medical treatment rights and require they sign a notice of such. This may result in increased paperwork for workers and employers.

Source 1
Source 2

PENNSYLVANIA

House Committee Schedules Hearing on Treatment Guideline Bill
The House Labor and Industry Committee has scheduled a hearing for March 17th that would mandate the adoption of nationally recognized treatment guidelines for the state workers' compensation system.

The Committee will discuss House Bill 1800 by Rep. Ryan E. MacKenzie (R) which would require the Department of Labor & Industry to adopt nationally recognized evidence-based treatment guidelines after consulting with a panel of medical providers for the purpose of proposing modifications to the guidelines.

The panel of providers shall be appointed for a six-year term without remuneration and include one medical provider from each of the following specialties:

- Occupational medicine
- Orthopedic medicine
- Neurosurgical medicine
- Pain management
- Physical therapy
- Chiropractic medicine
- Any of the above may include an osteopathic equivalent.

The panel shall review the guidelines, consider public comments, and recommend modifications at least once each calendar year.

Potential Impact
"Studies have also demonstrated that medical practitioners who utilize evidence-based treatment guidelines experience lower costs, have fewer patients who require continued care after a certain number of months, and their patients show improved physical functioning 12 months after injury" said Rep MacKenzie.

Source

TENNESSEE

Supporters Hope to Revive Opt-Out Bill

Supporters of House Bill 997, which would allow Tennessee employers to opt out of the workers' compensation system, hope to find another lawmaker to take the lead after the original author took the bill off the calendar.

Before taking an approved leave of absence, Rep. Jeremy Durham (R) took HB 997 "off notice" which means it won't be heard by the Consumer and Human Resources Subcommittee.

"As long as the bill has not been formally withdrawn, the sponsor may put the bill back 'on notice' for a future meeting of the committee," said Nathan Whitt, legislative assistant to Republican Rep. Jimmy Eldridge, who chairs the full House Consumer and Human Resources Committee. "We haven't received any indication whether or not the bill will be brought up again during this session of the (Tennessee) General Assembly."

The "Tennessee Employee Injury Benefit Alternative," proposed in February 2015, would allow employers to provide injury benefit plans that are less comprehensive than state-mandated workers' compensation insurance. The bill borrows language from Oklahoma and Texas that have traditionally allowed employers to opt out of the state workers comp system.

SB 721, the Tennessee Senate's companion bill, was also introduced in February 2015. No action has been taken since the bill was assigned to the General Committee of Senate Finance, Ways & Means Committee on October 26, 2015.

Potential Impact

If passed, this would bill would add Tennessee to the short list of opt-out states. Limited details have been provided on this bill.

Source 1
Source 2

VIRGINIA

House Bill 2384 - Electronic Billing and Payment

Pursuant to Va. Code Sec. 65.2-605.1(H), the Commission has established the following schedule which employers, workers' compensation insurance carriers, and providers of workers' compensation medical services shall be required to adopt and implement infrastructure under which providers of workers' compensation medical services shall submit their billing and supporting documents to payers for such services electronically and payers shall return payments and remittance information electronically. Providers and payers may voluntarily begin submitting electronic submissions and payments beginning July 1, 2016. Providers and payers must make all submissions and remittances electronically in accordance with the final adopted regulations beginning December 31, 2018.

Potential Impact

The schedule provides for electronic processing no earlier than July 1, 2016 and no later than December 31, 2018.

Source

Senate Bill 631 - Workers' Compensation Fee Schedule

The Virginia Senate passed SB 631 which would establish a workers' compensation fee schedule effective January 1, 2018. The initial fee schedule will be based on reimbursement which is the average of all amounts paid to providers

in the same category of providers for the medical service in the same medical community. Six geographic areas will be determined by zip codes. The Commission is required to review and revise the fee schedules in the year after they become effective and every two years thereafter.

SB 631 was sent to Governor McAuliffe on February 29th and he has until midnight March 7th to take action.

Potential Impact

The Commission is required to retain a firm to assist in establishing the initial fee schedules. The firm will recommend a methodology that will provide statistically valid estimates of the reimbursement within the medical communities for services listed in fee schedule.

Reimbursements for medical services provided to treat traumatic injuries and serious burns are excluded from the fee schedule and will be reimbursed 80% of the provider's charges absent a contract. However, treatment of such injuries and burn will be 100% of the provider's charges if the employer unsuccessfully contests the compensability of the claim. Hospitals may receive payments exceeding the fee schedule amount for certain claims when the total charges exceed a charge outlier threshold, which initially is 150% of the maximum fee for the service in the applicable fee schedule. The regulatory advisory panel is directed to make recommendations to the Commission prior to July 1, 2017, on workers' compensation issues relating to pharmaceutical and durable medical equipment costs not previously included in the fee schedules, certain awards of attorney fees, peer review of medical costs, prior authorization for medical services, and other issues assigned by the Commission.

Source