EK HEALTH
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Compliance and Regulations Newsletter

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

CALIFORNIA

DWC Adopts Geographic Practice Cost Index

The Division of Workers' Compensation (DWC) has adopted amendments to implement local specific geographic adjustment factors into Official Medical Fee Schedule (OMFS) for Physician and Non-Physician Practitioner Services as of January 1, 2019. The local geographic adjustment factors will replace the average statewide geographic adjustment factor which makes no adjustments for differences in costs of providing medical care across geographic areas.

The local geographic adjustment factors, known as the Geographic Practice Cost Index (GPCI), were implemented by Medicare in January 2017 as part of its Metropolitan Statistical Area (MSA) program. "Adoption of the Medicare MSA-based locality GPCIs will improve payment allowance accuracy by reflecting the resources required to provide a service according to specific regions" stated DWC.

Locality-specific geographic zones, preferred to a single statewide adjustment factor adopted in 2014, would ensure reimbursement rates are consistent with the cost of providing care.

A new section added to the rules indicates payment locality is determined by the zip code where service "is actually performed and not necessarily the physical location of the provider's office" in most cases.

For physicians providing professional interpretation for radiology services, pathology services, and other diagnostic procedures in "an unusual and infrequent location, for example, a hotel, the locality of the professional interpretation is determined based on where the interpreting physician most commonly practices."

The GPCI rules establish 32 different regions in California. An analysis by Rand Corp. found that payments will increase in 12 counties, have no impact in Sonoma County, and decrease payments in all other counties.

The largest increase, 9.8%, will be seen in San Benito County. The largest decrease, 5.3%, will be in Shasta County.

Source

CALIFORNIA

DWC Proposed Amendments to Pharmaceutical Fee Schedule

The Division of Workers' Compensation (DWC) has posted proposed amendments to the Pharmaceutical Fee Schedule.

The current pharmaceutical fee schedule is based primarily upon the Medi-Cal payment system. Medi-Cal is implementing a revised payment methodology approved by the Centers for Medicare and Medicaid Services (CMS). Due to requirements of the federal law, the Department of Health Care Services (DHCS) will implement Medi-Cal pharmacy fee schedule changes retroactively to April 1, 2017. For workers' compensation, fee schedule changes will not be retroactive. Draft regulations propose a January 1, 2019 effective date for the new payment methodology.

The following regulation changes have been proposed to align the fee schedule with the new Medi-Cal system:

- Elimination of the Average Wholesale Price (AWP) minus 17 percent as a benchmark;
- Revised methodology for maximum payment for the lower of:
  - National Average Drug Acquisition Cost (NADAC) or Wholesale Acquisition Cost (WAC) when no NADAC is available;
  - Federal Upper Limit (FUL);
  - Maximum Allowable Ingredient Cost (MAIC); or
  - Provider's usual and customary charge;
- Revised two-tier Medi-Cal dispensing fee structure from current dispensing fee of $7.25
  - $10.25 for pharmacies other than those below; or
  - $13.20 for pharmacies identified by National Provider Identifier (NPI) in the Medi-Cal dispensing fee file
- Rules addressing fees for compounded drugs and repackaged drugs.

Source

VIRGINIA

E-Billing Rules Postponed to July 1

The Virginia Workers' Compensation Commission has delayed the effective date for proposed electronic billing regulations after taking into consideration comments received during the public comment period. The mandatory effective date was changed from December 31, 2018 to July 1, 2019. Providers and payers may voluntarily comply with the rules starting December 31st.

The final version of the regulations broaden the small provider exemption, add an exemption for small payers, clarify requirements for electronic payment, and make the regulation consistent with the provisions of the prompt-pay statute (Va. Code. 65.2-605.1).

Providers and payers must be able exchange electronic data by July 1, 2019, unless exempted from the process.

Health care providers are exempt from the requirement to submit medical bills electronically to a payer if they employ 10 or fewer full-time employees or if they submitted fewer than 250 medical bills for workers' compensation treatment, services or products in the previous calendar year.

Payers are exempt from the requirements to receive and pay medical bills electronically if the payer processed fewer than 250 medical bills for workers' compensation treatment, services or products in the previous calendar year.

Payments for services that have been billed electronically are required to be paid via electronic funds transfer unless an alternate method is agreed upon by the payer and health care provider.

A payer should not reject medical bills that are complete, unless the bill is a duplicate bill. A payer may subsequently reject a complete medical bill or any portion thereof that is contested or denied in accordance with the requirements of subsection B of § 65.2-605.1 of the Code of Virginia.

Within 45 calendar days of receipt of an incomplete medical bill, a payer should either complete the bill by adding missing health care provider identification or demographic information already known to the payer or reject the incomplete bill, in accordance with this subsection and the requirements of subsection B of § 65.2-605.1 of the Code of Virginia.

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