VIRGINIA WORKERS' COMPENSATION COMMISSION REPORT ON SPECIFIC MEDICAL ISSUES

Requested by The Honorable Richard L. Saslaw, Chairman
Commerce and Labor Committee
Senate of Virginia
Virginia General Assembly

December 2010

FOREWORD

This report was prepared in response to SB367 and HB1326 considered during the 2010 Session of the Virginia General Assembly. On March 12, 2010, Hon. Richard L. Saslaw, Chairman of the Senate Commerce and Labor Committee, requested that the Virginia Workers' Compensation Commission (the Commission) review and report recommendations for the following issues: (1) the extent to which reductions and discounts are allowed for multiple surgical procedures performed during a single operative session; (2) the extent to which an employer is liable for the costs of assistants at surgery; (3) the extent to which prompt payment to medical providers should be required; and (4) how charges for medical services provided for treatment to Virginia claimants in foreign jurisdictions are determined to be appropriate under Virginia law.[1]

The Commission extends its appreciation to the agencies and organizations that cooperated and assisted with the investigation, specifically, Virginia Chamber of Commerce's Business Coalition on Workers' Compensation, FairPay Solutions, Inc., Medical Society of Virginia, Property Casualty Insurers Association of America, Virginia Association of Defense Attorneys, Virginia Coal Association, Inc., Virginia Hospital & Healthcare Association, Virginia Self-Insurers Association, Inc., Virginia Trial Lawyers Association, and Virginia AFL-CIO.

[1] This letter and the bills are attached at Appendix A.

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A. March 12, 2010 letter from Hon. Richard L. Saslaw, Chairman of the Senate Commerce and Labor Committee.

House Bill No. 1326

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B. Table – Number of Applications Filed with the Virginia Workers' Compensation Commission by Medical Providers 2000-2010

Graph – Number of Medical Provider Applications Filed with the Virginia Workers' Compensation Commission

C. Nicole M. Coomer & Te-Chun Liu, *Benchmarks for Designing Workers' Compensation Medical Fee Schedules: 2009* (Workers Compensation Research Institute, Boston, Mass.) (June 2010).

D. Medicare Claims Processing Manual, Chapter 12: Physicians/Nonphysician Practitioners, § 40 – Surgeons and Global Surgery (2010), http://www.cms.gov/manuals/downloads/clm104c12.pdf

INTRODUCTION

According to data compiled by the Commission, in 2000, medical providers filed only 236 applications requesting that the Commission adjudicate reimbursement issues between the providers and insurance carriers. By 2009, the number of medical provider applications increased to 1298, and through May 2010, the Commission has received 656 applications, increasing the Commission resources required to adjudicate these disputes.[1] Medical costs represent approximately two-thirds of the total cost of workers' compensation benefits in Virginia. While the Commission takes no position on the issue of whether medical costs are too high or low, issues related to medical costs are significant both to the Commission and to other stakeholders.

In **Section One** of this report, we review the four issues assigned by the Senate Commerce and Labor Committee. We summarize Medicare's response to the issue, and survey Virginia case law. Finally, we provide summaries and tables demonstrating how other states manage each of these four issues. We concentrate on the states and region bordering Virginia – including Washington, D.C., Kentucky, Maryland, North Carolina, Tennessee, and West Virginia.

Forty-three states currently use a medical fee schedule system to reimburse health care providers in workers' compensation cases. **Section Two** of this report contains a summary of the methods of reimbursement used in other states, with particular emphasis on the states that border Virginia. All of the states that border Virginia have some form of fee schedule. Our research indicates that most states base their fee schedules at least in

[1] See table and graph in Appendix B.

part on the rules set out by the Centers for Medicare and Medicaid Services (CMS) for Medicare claims.

Several of Virginia's border states, including Kentucky, North Carolina, Tennessee, and West Virginia, have legislation providing guidelines for the creation of state-approved managed care organizations (MCO). The MCOs must meet certain criteria and are not subject to the state's medical fee schedule because the MCOs contract with healthcare providers for payment of services.

In **Section Three** of this report, we include a summary of comments we have received from organizations interested in the issues raised in Senator Saslaw's letter.

Finally, in **Section Four**, we provide a summary of our findings with recommendations for further consideration by the General Assembly.

The Commission has contracted with the Workers' Compensation Research Institute (WCRI) to provide research services to benchmark the performance of Virginia's workers' compensation system in comparison to 12-20 large states. WCRI will provide benchmarks of the following aspects of system performance, both interstate comparisons and trends:

a. Time from injury to notice of injury and first payment
b. Average total cost per claim and benefit payments (medical/indemnity benefits)
c. Medical costs per claim
    i. costs by provider type
    ii. costs by service type
    iii. prices per service
    iv. utilization of services
d. Vocational rehabilitation use and costs
e. Benefit delivery expenses (litigation and medical cost containment)
f. Defense attorney involvement
g. Duration of disability and indemnity payments
h. Claim closure patterns

WCRI anticipates delivery of the benchmark report and medical benchmark report in January and August 2012.

BACKGROUND

Workers' Compensation in Virginia and Medical Charges

Workers' compensation laws are legislatively enacted, not a development of the common law. In fact, in many instances, they are contrary to the common law. See Low Splint Coal Co. v. Bolling, 224 Va. 400, 406, 297 S.E.2d 665, 668 (1982). In Fauver v. Bell, 192 Va. 518, 65 S.E.2d 575 (1951), our Supreme Court discussed "the objects and purposes of workmen's compensatory legislation and the changes which it has wrought in the rules of the common law." Id. at 521, 65 S.E.2d at 577. The Court stated:

> The legislation was for the beneficent purpose of providing compensation, in the nature of insurance, to a workman or his dependents, in the event of his injury or death, for the loss of his opportunity to engage in gainful employment when disability or death was occasioned by an accidental injury or occupational disease, to the hazard or risk of which he was exposed as an employee in the particular business, without regard to fault as to the cause of such injury or death. The pecuniary loss incident to the payment of the compensation is cast upon the employer as a part of the expenses of his business.
>
> Under the Act both employer and employee surrender former rights and gain certain advantages. The employee surrenders his right to bring an action at law against his employer for full damages and agrees to accept a sum fixed by statute, based on the extent of his injuries and the amount of his wages. He gains a wider security in line with the more inclusive recovery afforded. The employer surrenders his right of defense on the grounds of contributory negligence, assumption of risk and the fellow servant rule. He is relieved from liability for damages to the employee for which in an ordinary negligence case he might otherwise be liable to a much greater extent. Negligence is of no concern in a compensation case unless the injury is caused by the employee's wilful negligence or misconduct. Rules of evidence are relaxed and procedures simplified. Rights granted and obligations imposed are limited as granted or imposed by the Act and are in their nature contractual. Enacted for the purpose of attaining a humanitarian end, the legislation, although in derogation of the

> common law, is highly remedial and is to be liberally construed. 192 Va. at 521-22, 65 S.E.2d at 577.

Currently, Va. Code § 65.2-605 states:

> The pecuniary liability of the employer for medical, surgical, and hospital service herein required when ordered by the Commission shall be limited to such charges ***as prevail in the same community for similar treatment when such treatment is paid for by the injured person*** and the employer shall not be liable in damages for malpractice by a physician or surgeon furnished by him pursuant to the provisions of § 65.2-603, but the consequences of any such malpractice shall be deemed part of the injury resulting from the accident and shall be compensated for as such. (emphasis added)

The predecessor of Code § 65.2-605 was Code § 65-86 (1950). That section read as follows:

> The pecuniary liability of the employer for medical, surgical and hospital service herein required when ordered by the Commission shall be limited to such charges ***as prevail in the same community for similar treatment of injured persons of a like standard of living when such treatment is paid for by the injured person*** and the employer shall not be liable in damages for malpractice by a physician or surgeon furnished by him pursuant to the provisions of the preceding section, but the consequences of any such malpractice shall be deemed part of the injury resulting from the accident and shall be compensated for as such. (emphasis added)

Pre-1994, North Carolina's statute contained similar language. N.C. Gen. Stat. § 92-76 provided:

> The pecuniary liability of the employer for medical, surgical, hospital service, nursing services, medicines, sick travel or other treatment required when ordered by the Commission, shall be limited to such charges ***as prevail in the same community for similar treatment of injured persons of a like standard of living when such treatment is paid for by the injured person.*** (emphasis added)

In a North Carolina case decided under that version of the statute, Charlotte-Mecklenburg Hosp. Auth. v. North Carolina Indus. Comm'n, 443 S.E.2d 716 (N.C. 1994), the North Carolina Supreme Court concluded that the legislature intended "that the employer not be charged more than his employee would have been had the employee paid for the services." Id. at 727. The

court found that the legislature intended that the Commission's authority under the statute "be limited to review and approval of hospital charges to ensure, first, that the employer is charged only for those reasonably required services, and, second, that the employer is not charged more for such services than the prevailing charge for the same or similar hospital service in the same community." Id.

The court discussed the climate that existed before workers' compensation statutes were enacted:

> Before the 1930s, most people did not have private health insurance; the only extensive private health plans offered direct services, usually to employees in an industry. Paul Starr, *The Social Transformation of American Medicine* 294 (1982) [hereinafter "Starr"]. Hospitals generally provided three classes of service: wards for the poor and working-class, semi-private rooms for the middle-class, and private rooms for the wealthy. [Footnote 1: Few class distinctions could be more sharply delineated. While ward patients were attended by the hospital staff, private patients were attended by doctors of their choice. Ward and private patients usually received two different kinds of food, and ward patients were often not permitted to see friends and relatives as frequently as were private patients. Starr at 159.] In some communities, hospitals were segregated by race. Anne M. Dellinger, "A History of Hospitals in North Carolina," in *Hospital Law in North Carolina* 1-History, 7-History to 8-History (Anne M. Dellinger ed., 1985) [hereinafter "Dellinger"] (In Greensboro, L. Richardson Hospital, established in 1927, "remained the only facility open to blacks on a non-discriminatory basis until 1963, when Wesley Long and Cone Memorial hospitals were integrated by court order."). Physicians and hospitals could increase profits both by providing additional services and by charging according to the patient's ability to pay. *See* Starr at 291.

Thus, when the Virginia Workers' Compensation Act developed, most people did not have private health insurance. Hospitals provided different levels of service based on a person's class or race, and hospitals charged according to a patient's ability to pay. It was in this climate

that the General Assembly enacted the provision regarding charges for services limiting the fees to those that prevailed in the same community for similar treatment of injured workers "of a like standard of living when such treatment is paid by the injured worker." Va. Code § 65-86 (1950). The statute was designed to prohibit medical providers from charging more when an injured worker was covered by workers' compensation insurance. The statute was later amended to delete the language "of injured persons of a like standard of living" but still provides that rates be based on the payment an injured worker would pay.

Today, many people have private health insurance, federal coverage through Medicare, and/or workers' compensation insurance coverage through their employers. Many health insurance and workers' compensation carriers contract with medical providers to set limits on fees that can be charged or will be paid by the carriers. Medicare likewise contracts with providers and sets fee limits on medical providers and suppliers. The current Virginia statute uses the prevailing community rate but bases that rate on what an injured worker would pay rather than on what an insurance carrier or even Medicare would pay. Therefore, while the statute was enacted ostensibly to protect the employer from paying excessive costs, application of the statutory language today may render an opposite result.

SECTION ONE

REVIEW OF ISSUES PROPOUNDED BY SENATE COMMERCE AND LABOR COMMITTEE

(1) the extent to which reductions and discounts are allowed for multiple surgical procedures performed during a single operative session

Summary - Multiple Surgery Rules

The federal government has implemented a multiple surgery rule for all claims paid by Medicare. In general, the primary surgical procedure is paid at one hundred percent (100%) of the fee schedule amount. The second through fifth procedures are paid at fifty percent (50%) of the fee schedule amount. Any procedures beyond the fifth procedure are considered on an individual basis.

The majority of states have similar multiple surgery rules. See Table 2 at the end of this section. Most states utilizing fee schedules generally follow the coding guidelines published by CMS and by the American Medical Association (AMA), including the use of modifiers for secondary procedures. States use Modifier 51 for multiple procedures. Generally, the primary procedure, or that procedure with the highest value, will be paid at 100% of the fee schedule amount. Additional procedures will be paid at 50% of the fee schedule amount. Some states provide additional discounting, i.e. 25% and 10% for each additional procedure. Some states distinguish between procedures using the same incision or same body part.

We have concentrated on the five states that border Virginia – Kentucky, Maryland, North Carolina, Tennessee, and West Virginia – and the District of Columbia. A summary of each state or region's rules regarding reimbursement for multiple surgical procedures appears below. Kentucky, North Carolina, and Tennessee use Medicare coding for multiple procedures. Each of these states reimburses medical providers 100% of the listed value for the primary procedure and 50% for each secondary procedure. Washington, D.C. does not have specific rules

governing multiple procedures but generally follows Medicare guidelines. Maryland and West Virginia follow CMS's Medicare claims processing rules.

In Virginia, the Commission has held that in general, charges should not be reduced because multiple procedures were performed at the same time. See Hargrave v. Williamsburg/James City County School Board, VWC No. 195-12-65 (March 20, 2002). However, if there is a contract between the parties that governs this issue, and the evidence shows that the contract provided for a multiple procedure discount, the Commission has found that proper payments to the provider were made based on the contract.

Below we have summarized Medicare's provisions governing multiple surgery discounts, Virginia case law on the subject, and the laws in our bordering states as well as Washington, D.C. We have also included a table surveying other state laws on this issue.

Medicare

The federal government has authorized CMS to establish uniform national definitions of services, codes, and payment modifiers for Medicare claims.[1] Medicare's rules for billing for multiple surgical procedures are found in Medicare Claims Processing Manual, Chapter 12, Physicians/Non-Physician Practitioners, Section 40.6. Medicare also utilizes a Global Surgical Package which groups certain procedures together for billing purposes. See Section 40 – Surgeons and Global Surgery. This section is contained in Appendix E.

In summary, for dates of service after January 1, 1995, multiple surgical procedures are to be ranked subject to multiple surgery rules. Payment is to be made at one hundred percent (100%) of the fee schedule amount for the highest valued procedure, and fifty percent (50%) for the second through fifth highest valued procedures. If there are more than five procedures billed, the sixth and subsequent procedures are to be suspended and reviewed. If payment is appropriate,

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[1] 42 C.F.R. § 414.40 Coding and ancillary policies provides:

> (a) *General rule.* CMS establishes uniform national definitions of services, codes to represent services, and payment modifiers to the codes.
>
> (b) *Specific types of policies.* CMS establishes uniform national ancillary policies necessary to implement the fee schedule for physician services. These include, but are not limited to, the following policies:
>
> (1) Global surgery policy (for example, post- and pre-operative periods and services, and intra-operative services).
>
> (2) Professional and technical components (for example, payment for services, such as an EEG, which typically comprise a technical component (the taking of the test) and a professional component (the interpretation)).
>
> (3) Payment modifiers (for example, assistant-at-surgery, multiple surgery, bilateral surgery, split surgical global services, team surgery, and unusual services).
>
> Global surgery policy (for example, post- and pre-operative periods and services, and intra-operative services).

it is paid "by report," and should never be lower than 50% of the full payment amount. For billing, Modifier -51 is used. See § 40.6 of the Manual.

Virginia Workers' Compensation Commission Opinions

Since 2004, the Commission has adjudicated approximately 65 cases dealing with the issue of multiple procedure discounts. This includes 44 cases at the deputy commissioner level and 21 review opinions by the full Commission.

In general, the Commission has rejected the argument that charges should be reduced because multiple procedures were performed at the same time. However, where a contractual agreement governs the parties, and the agreement provides for reimbursement to the medical provider based on multiple procedure discount provisions of the contract, the Commission has held that these discounts govern the parties.

The General Rule – charges should not be reduced because multiple procedures were performed at the same time. The Commission often cites the decision in Hargrave v. Williamsburg/James City County School Board, VWC No. 195-12-65 (March 20, 2002), where the insurance carrier argued that charges should have been reduced for four medial branch blocks performed on the same day.

> [T]he employer suggests that Dr. Newman's February 8, 2001, charges of $400 each for multiple medial branch blocks of the L3, L4, L5 and L1 levels of the left side were "in obvious excess of what is usual and customary for the community." However, the employer provides absolutely no support for this statement. Ingenix indicates that relative values are assigned to procedures based on "difficulty, time, work, risk and material costs," but provides no evidence to suggest that any of the branch blocks performed on February 8, 2001, were less difficult, time-consuming, labor intensive, risky, or expensive than any of the

> others. Thus, it is unclear why Dr. Newman would earn $400 for the first procedure and less for the others, simply because they were performed in conjunction with others, instead of on separate dates.
>
> The employer has failed to provide sufficient credible evidence to determine whether the fee charges by Dr. Newman fall within the prevailing community rate.

In Edwards v. Potomac Hosp. Corp., VWC File No. 221-29-54 (Feb. 6, 2006), the carrier reduced certain charges by various percentages because of "multiple surgical procedures." The Commission noted that "this methodology has been rejected by the Commission, at least in the absence of specific evidence justifying such a methodology." The Commission ordered the carrier to pay the medical provider's remaining charge balance.

Relying on Hargrave in Williams v. Encompass Srv. Corp., VWC File No. 201-37-68 (Oct. 21, 2008), the Commission considered a carrier's argument using a database and system developed by Ingenix which included the use of Medicare "relative value" rules related to multiple surgical procedures and assistants at surgery. The Commission held: "Absent evidence of actual charge data from other medical [providers] in the relevant community supporting such 'relative value' reductions, we have rejected the use of such rules in past opinions. See, e.g., Hargrave,..."

Where there is a contract between the parties

The Commission is often called upon to interpret contractual agreements between health care providers and insurance carriers. In the absence of fraud, mutual mistake, or violation of law or public policy, the Commission will uphold these contractual agreements. In those cases, the Commission determines whether there exists a valid preferred provider organization (PPO)

contract between the parties and whether the medical provider was reimbursed in accordance with the terms of the PPO agreement.

Where there is a valid PPO contract between the parties, and the evidence shows that the PPO contract provided for a multiple procedure discount, the Commission has found that proper payments to the provider were made based on the contract.

For example, in McIntosh v. Mary Washington Hosp., VWC File No. 222-62-86 (Dec. 15, 2009), the deputy commissioner determined that there was a valid applicable PPO contract between the parties and that the medical provider failed to prove that it was not reimbursed in accordance with the terms of the PPO agreement. In that case, the PPO contract provided for reimbursement equal to "85% of usual charges, 85% of usual and customary reimbursement. . . [whichever] is less." The medical provider argued that "usual and customary reimbursement" was equivalent to the prevailing community rate and also asserted that the carrier improperly applied "multiple procedure" and "assistant surgeon" reductions. According to the carrier's evidence, the PPO contract provided that multiple procedures by the same surgeon were subject to a 50% reduction with respect to the secondary procedure, and that assistant surgeons' reimbursement was approximately 20% of that of the primary surgeon. In finding the medical provider was paid in accordance with the contract, the deputy commissioner reasoned:

> While such discounts may not be encompassed in the statutory standard of the prevailing community rate, the carrier has presented some evidence that the discounts are appropriate in computing usual and customary reimbursements. The medical provider has presented no contrary evidence. Moreover, as the carrier points out, the medical provider has accepted such discounts for many years with no complaints. Thus, custom and usage, and the parties' course of dealing, support the carrier's interpretation of the contract. See, e.g. 1M.J. Contracts, § 51.

In Smith v. Richmond (City of) Fire & Emergency, VWC File No. 230-93-96 (Feb. 26, 2009), the parties agreed that a PPO contract governed the case. They disagreed regarding the interpretation of the contract. This contract provided for reimbursement rates "at a level of 140% of the current Medicare fee schedule for covered charges . . . ." The parties disagreed regarding whether, under this contractual provision, multiple surgical procedure discounts were allowed. The Commission examined the statutes and regulations surrounding the Medicare fee schedule and noted that the fee schedule is modified to take into account the reduction of payments for assistant surgeons as well as multiple surgical procedures. The Commission held that the Medicare fee schedule encompasses the multiple surgical procedure adjustments and therefore these adjustments were part of the PPO contract between the parties.

We have revisited this issue and made the same finding in over two dozen cases. See, e.g., Zinn v. Magic Special Events, VWC File No. 221-13-08 (March 31, 2009); Pacheco v. Slurry Pavers, Inc., VWC File No. 219-01-37 (May 12, 2009); Covington v. Taylor Constr. Svs., Inc., VWC File No. 224-43-99 (March 5, 2009); Davis v. Central Virginia Locate & Recovery, Inc., VWC File No. 226-36-00 (March 5, 2009); Wallace v. Ellis Capital Awning, VWC File No. 226-94-91 (March 5, 2009) 219-69-21(March 3, 2009); Pedersen v. Handyman Matters, VWC File No. 225-19-44 (Feb. 26, 2009); and Robinson v. Richmond (City of) Fire, VWC File No. 221-36-28 (Feb. 24, 2009).

In a recent opinion, the Commission held that a contract between the parties included reductions for multiple procedures where the parties had accepted payment pursuant to that construction for years without objection. Parr v. Haynesville Correctional Ctr., VWC File No. 225-05-76 (Feb. 3, 2010). Under the PPO contract in Parr, the carrier applied numerous and various reductions, including multiple procedure reductions and assistant surgeon reductions

between 1993 and 2007, and the medical provider accepted payment without objection. In 2006, the carrier reduced payment to the provider based on the contract's provisions for multiple procedure reductions, and the medical provider accepted this payment. The medical provider later filed an application with the Commission seeking additional reimbursement of the balance billed for the multiple procedures.

The Commission denied the medical provider's application, holding that the "the parties' actions established" that the medical provider accepted the carrier's "methods of reimbursement – including multiple procedure reductions – for over ten years." The Commission cited its reasoning in Curtis v. Ace Electric Co., VWC 226-63-03 (May 14, 2008), where the Commission agreed that a medical provider was reimbursed in accordance with terms of the contract. The Commission explained:

> [T]here is no mention of multiple procedure discounts in the contract. However, if a contractual term is ambiguous, the court may accept the construction adopted by the parties. Dart Drug Corp. v. Nicholakos, 221 Va. 989, 995, 277 S.E.2d 155, 158 (1981). The evidence demonstrates that 'usual and customary reimbursement' under the PPO contract has been consistently subject to a discount for multiple procedures, and that this is not an uncommon practice in the industry. [The medical provider] has accepted payment to Corvel's method of determining reimbursement for years and has discussed and negotiated the terms of the contract.

Based on this reasoning, the Commission held that under the terms of the contract in Parr, the provider was not entitled to additional reimbursement.

States and Regions that Border Virginia

Summary

We have concentrated on the five states that border Virginia – Kentucky, Maryland, North Carolina, Tennessee, and West Virginia – and the District of Columbia. Table 1 provides a summary of each state/region's multiple surgery rules. A summary of each state/region's rules regarding reimbursement for multiple surgical procedures appears below. Kentucky, North Carolina, and Tennessee use Medicare coding for multiple procedures. Each of these states reimburses medical providers 100% of the listed value for the primary procedure and 50% for each secondary procedure. Washington, D.C. does not have specific rules governing multiple procedures but generally follows Medicare guidelines. Maryland and West Virginia follow CMS's Medicare claims processing rules.

Kentucky

Under Kentucky's medical fee schedule, multiple surgical procedures use Modifier 51. Providers are reimbursed one hundred percent (100%) of the listed value for the primary procedure and fifty percent (50%) for each secondary procedure.

Maryland

Maryland, with few exceptions, follows the Centers for Medicare and Medicaid (CMS) guidelines for reimbursement methodologies, models, and values or weights, including applicable payment policies relating to coding, billing, and reporting. Med. Code Regs. 14.09.03.01 (Guide of Medical and Surgical Fees) (2004). In December 2009, the Maryland Workers' Compensation Commission adopted the CMS Multiple Procedure Rule 100%-50%-50%.

North Carolina

North Carolina's Medical Fee Schedule includes rules governing multiple surgical procedures. For multiple arthroscopic procedures, the providers are reimbursed 100% of the listed value for the primary procedure and 50% for each secondary procedure as long as the secondary procedure or procedures are not considered integral to the primary procedure.

Multiple surgical procedures performed through the same incision will have the unit value of the major procedure. Any secondary or lesser procedure is identified by adding modifier -51 to the secondary procedure. Secondary procedures are reimbursed at 50% of the listed value based on the Medical Fee Schedule allowance.

Multiple operative procedures performed at the same session in separate operative fields and through separate incisions are allowed total Medical Fee Schedule value for each procedure. *See* N.C. Medical Fee Schedule, Surgery Section 5, and Addendum.

Tennessee

Under Tennessee's Medical Fee Schedule, providers are reimbursed 100% of the physician's usual charge for the major procedure and 50% of the physician's usual charge for each secondary procedure. The Tennessee Compensation Rules and Regulations, Rule 0800-2-18.04, Surgery Guidelines, provides:

> **0800-2-18-.04 SURGERY GUIDELINES.**
>
> (1) Multiple Procedures: Reimbursement shall be based on 100% of the physician's usual charge for the major procedure (not to exceed 100% of the TDWC Medical Fee Schedule amount allowable) plus 50% of the physician's usual charge for the lesser or secondary procedure (s) (not to exceed 50% of the TDWC Medical Fee Schedule allowable).
>
> ...

(3) When a surgical fee is chargeable, no office visit charge shall be allowed for the day on which this surgical fee is earned, except if surgery is performed on the same day as the physician's first examination. All exceptions require use of the appropriate modifiers.

(4) Certain of the listed procedures in the Medical Fee Schedule are commonly carried out as an integral part of a total service and, as such, do not warrant a separate charge, commonly known as a global fee.

(5) Lacerations ordinarily require no aftercare except removal of sutures. The removal is considered a routine part of an office or hospital visit and shall not be billed separately unless such sutures are removed by a provider different from the provider administering the sutures.

Washington, D.C.

In Washington D.C., the Department of Employee Services, Workers' Compensation Program (Department), processes claims and monitors the payment of benefits to injured private-sector employees in the District of Columbia. The office mediates disputes between claimants and employers (or their insurance carriers), and monitors employers to ensure compliance with insurance coverage requirements. The Department does not publish its own fee schedule but is guided by the CMS rules and schedule. The District of Columbia allows reimbursement at 113% of the CMS listed value of each procedure.

West Virginia

West Virginia follows the CMS's Physician Fee Schedule with its modifiers for multiple procedures. West Virginia pays 35% above CMS listed values. See "Detail Reference Guide to Determining CMS Medicare + 35% for Offices of the Insurance Commissioner (OIC) Workers' Compensation Maximum Medical Reimbursement Fee Schedules" (effective July 1, 2009).

TABLE 1

REIMBURSEMENT FOR MULTIPLE SURGICAL PROCEDURES
MEDICARE AND STATES THAT BORDER VIRGINIA

State/Region	**Fee Schedule**	**Reimbursement for Multiple Procedures**	**Source**
Medicare	Yes	100% of the fee schedule amount for the highest valued procedure 50% of the fee schedule amount for the second through fifth highest valued procedure If more than five procedures are billed, the sixth and subsequent procedures undergo manual review and payment, if appropriate, "by report" never lower than 50% of full payment amount.	http://www.cms.gov/manuals/Downloads/clm104c12.pdf
Kentucky	Yes	100% of the listed value for the primary procedure 50% for each secondary procedure Uses Modifer -51	http://www.labor.ky.gov/workersclaims/ http://www.labor.ky.gov/NR/rdonlyres/59FCE011-9EDF-4672-B2FF-3363D990F4DD/0/803KAR24089E.pdf
Maryland	Yes	The Maryland Workers' Compensation Commission adopted the CMS Multiple Procedure Rule: 100%- 50%- 50%.	http://www.wcc.state.md.us/PDF/MFG/MFG_Misc_info.pdf http://www.wcc.state.md.us/MFG/Medical_Fee_Schedule.html

TABLE 1

REIMBURSEMENT FOR MULTIPLE SURGICAL PROCEDURES
MEDICARE AND STATES THAT BORDER VIRGINIA

State/Region	**Fee Schedule**	**Reimbursement for Multiple Procedures**	**Source**
North Carolina	Yes	100% of the listed value for the primary procedure 50% for each secondary procedure	http://www.ic.nc.gov/ncic/pages/feesched.asp#intro http://www.ic.nc.gov/ncic/pages/feesec05.htm
Tennessee	Yes	100% of the physician's usual charge for the major procedure 50% of the physician's usual charge for each secondary procedure	http://www.state.tn.us/sos/rules/0800/0800-02/0800-02-18.pdf
West Virginia	Yes	Uses CMS modifiers.	http://www.wvinsurance.gov/Default.aspx?tabid=372
Washington, D.C.	Yes	Follows CMS guidelines at 113% - no specific multiple surgery rule	http://www.does.dc.gov/does/cwp/view.asp?a=1232&q=537428

TABLE 2

REIMBURSEMENT FOR MULTIPLE SURGICAL PROCEDURES
SURVEY OF VARIOUS STATES

State	**Reimbursement for Multiple Procedures**	**Source**
Alabama	Operations performed by same physician during same operative session: 100% for procedure with highest fee schedule allowance 50% for all additional procedures	http://dir.alabama.gov/docs/law/wc_480-5-5-.15.pdf
Arizona	100% (full value) for the first or major procedure 50% for the second procedure 25% for the third procedure 10% for the fourth procedure 5% for the fifth procedure Over five procedures – by report	http://www.ica.state.az.us/Director/DIR_FSList2009.aspx
Arkansas	100% of physician's usual charge for the major procedure (not to exceed 100% of the Medical Fee Schedule allowable) 50% of physician's usual charge for the lesser or secondary procedure(s) (not to exceed 50% of the Medical Fee Schedule allowable)	http://www.awcc.state.ar.us/rule30misc/newmedfeesch.html
Colorado	100% of listed value for primary procedure 50% for additional procedures	http://www.coworkforce.com/dwc/rules/rapidnavrules13-18.asp
Connecticut	100% (full value) for the first or major procedure 50% for the second procedure 25% for the third procedure 25% for the fourth procedure 25% for the fifth procedure Over five procedures – by report	http://wcc.state.ct.us/law/menus/wc-regs.htm

TABLE 2

REIMBURSEMENT FOR MULTIPLE SURGICAL PROCEDURES
SURVEY OF VARIOUS STATES

State	**Reimbursement for Multiple Procedures**	**Source**
Delaware	Multiple procedures performed during same operative session at same operative site: use Modifier 51 and reimbursed as follows: 100% of the allowable fee for primary procedure 100% of the allowable fee for second & subsequent procedures	http://dowc.ingenix.com/info.asp?page=rules
Florida	Single operative session Primary surgical procedure MRA in Part B, Section XI of manual or agreed upon contract price Additional procedures 50% of the listed MRA in Part B, Section XI in manual or agreed upon contract price. The additional procedure shall be identified when modifier 51 is added to the code to indicate the performance of multiple procedures.	http://www.myfloridacfo.com/wc/pdf/2007HCPRM.pd
Idaho	Modifier 51 50% secondary procedure	http://adm.idaho.gov/adminrules/rules/idapa17/0208.pdf
Illinois	100% first procedure 50% subsequent procedures	http://www.state.il.us/agency/IIC/FScomments100208.pdf
Kansas	Full value for major procedure 50% for the lesser procedure, up to four (4) additional/secondary procedures paid at 50% of the maximum allowable payment	http://www.dol.ks.gov/wc/html/doc/med_fees_2010.pdf
Louisiana	100 percent for the primary procedure 60 percent for the second procedure 40 percent for the third procedure 25 percent for fourth and fifth procedures Others by special report	http://doa.louisiana.gov/osr/lac/40v01/40v01.pdf

TABLE 2

REIMBURSEMENT FOR MULTIPLE SURGICAL PROCEDURES
SURVEY OF VARIOUS STATES

State	**Reimbursement for Multiple Procedures**	**Source**
Maine	Modifer 51 Multiple Procedures: pay at 50% of the Maximum Allowable Fee	http://www.maine.gov/wcb/departments/omrs/2005_MFS/RCh5MFS.doc
Massachusetts	Modifier 51 Second and subsequent procedures paid at 50% of the allowable fee	http://www.mass.gov/Eeohhs2/docs/dhcfp/g/regs/114_3_16.doc
Michigan	100% of the maximum allowable payment or the facility's usual and customary charge, whichever is less, for the procedure classified in the highest payment group. Other surgical procedures performed during the same session – reimbursed at 50% of maximum allowable payment or 50% of the facility's usual and customary charge, whichever is less.	http://www.state.mi.us/orr/emi/admincode.asp?AdminCode=Single&Admin_Num=41810101&Dpt=LG&RngHigh
Mississippi	Multiple procedures performed during the same operative session at the same operative site: 100% of the allowable fee for the primary procedure 50% of the allowable fee for the second and subsequent procedures	http://www.mwcc.state.ms.us/services/2010finaldraft.pdf
Nebraska	Same operative session and through the same incision: total fee = highest fee plus 50 percent of the fee for each additional procedure Same operative session through separate incisions and/or involving different parts of the body: total fee = highest fee plus 75 percent of the fee for each additional procedure	https://www.wcc.ne.gov/apps/IPUBA0008Gfrm.aspx

TABLE 2

REIMBURSEMENT FOR MULTIPLE SURGICAL PROCEDURES
SURVEY OF VARIOUS STATES

State	Reimbursement for Multiple Procedures	Source
New Mexico	Modifier 51 Primary procedure: paid at the lesser of the billed charges or the APC base payment rate times 1.3 Second and third procedure: use 51 Modifier and paid at 50% of the APC base payment rate times 1.3 Fourth and subsequent procedures paid by report	http://www.workerscompensation.com/regulations/stateitem.php?ID=78671&state=new_mexico&Parent=78671
New York	Modifier 51 100% for primary procedure 50% for secondary procedure	http://www.wcb.state.ny.us/content/main/hcpp/MedFeeSchedules/2010medfee.jsp
North Dakota	Incorporates the same multiple procedure discounting methodology as Medicare	http://www.workforcesafety.com/medical-providers/feeschedule/displayFeeSchedule.asp?name=ASC2010April.pdf
Oklahoma	Major procedure - full value 50% for the lesser procedure(s)	http://www.owcc.state.ok.us/PDF/2010%20Fee%20Schedule%20updated%203-3-10.pdf
Oregon	Highest payment group paid at the ASC's usual fee or the maximum allowable amount, whichever is less; Each additional procedure paid at 50%	http://arcweb.sos.state.or.us/rules/OARS_400/OAR_436/436_009.html
Rhode Island	Same incision and/or anatomical site: 100% of the practitioner payment amount for primary procedure 50% for the secondary procedure 30% for the third, fourth, or fifth procedures. Different incision and/or anatomical site: 100% of the practitioner payment amount for primary procedure 50% for the second, third, fourth, or fifth procedures	http://www.risingms.com/RIFee/Pages/FeeSchedule2008.aspx http://www.risingms.com/RIFee/2008%20Fee%20Schedules/Surgical%20Guidelines.pdf

TABLE 2

REIMBURSEMENT FOR MULTIPLE SURGICAL PROCEDURES
SURVEY OF VARIOUS STATES

State	**Reimbursement for Multiple Procedures**	**Source**
Utah	Primary procedure: billed at 100% of the profile fee Lesser procedures (performed through the same operative incision or performed in the same general operative area): billed at 50% of the relative value	http://www.laborcommission.utah.gov/IndustrialAccidents/pdfs/Med_Fee_Guidelines__2008-9_3-26-08.6-08doc.pdf
Vermont	Modifier 51 Same operative session: Maximum reimbursement allowance of the major procedure 50% for the secondary procedure 25% for the tertiary procedure 10% for each lesser procedure thereafter.	http://www.labor.vermont.gov/Portals/0/WP%20Safety/Rule%2040.pdf
Washington	Modifier 51 100% of first procedure 50% of subsequent procedures	http://www.lni.wa.gov/ClaimsIns/Files/ProviderPay/FeeSchedules/2010FS/fsSurg.pdf
Wyoming	Two or more incisions at the same operative setting: 100% of fee schedule allowance for primary procedure 80% of fee schedule allowance for procedures performed through secondary incision(s) Multiple procedures in the same anatomical surgical site: 100% of fee schedule allowance for primary procedure 50% of fee schedule allowance for each additional procedure	http://www.workerscompensation.com/regulations/stateitem.php?ID=84141&state=wyoming&Parent=8307 http://soswy.state.wy.us/Rules/RULES/7072.pdf

(2) the extent to which an employer is liable for the costs of assistants at surgery

Summary – Assistants at Surgery Rules

The federal government has implemented an assistant surgeon rule for all claims paid by Medicare. If the assistant is a physician, the assistant is paid sixteen percent (16%) of the amount of the primary surgeon. If the assistant is not a physician, the assistant is paid 85% of the above amount or 13.6% of the fee schedule amount of the primary surgeon. There are also some circumstances where no fee will be paid to the assistant.

The majority of states have rules governing reimbursement of assistants at surgery. Some states, like CMS, distinguish between physician and non-physician assistants at surgery. Most states provide a reduced fee for assistants at surgery. See Table 4 at the end of this section. Most states utilizing fee schedules generally follow the coding guidelines published by CMS and by the American Medical Association (AMA), including the use of modifiers for assistants at surgery. The percentage of the fee schedule amount reimbursed to the health care provider varies from state to state. Generally, if another physician (MD) assists at surgery, reimbursement ranges from 15 to 25% of the fee schedule amount for the primary surgeon. For a registered nurse surgical assistant, nurse practitioner, or physician's assistant assisting at surgery, reimbursement ranges from 10 to 15% of the primary surgeon's fee schedule amount.

We have concentrated on the five states that border Virginia - Kentucky, Maryland, North Carolina, Tennessee, and West Virginia - and the District of Columbia. Kentucky reimburses assistants at surgery at 20% of the listed value. North Carolina reimburses medical doctors who assist at surgery at 20% of the fee listed for the surgical procedure, and 17% for physician assistants who assist at surgery. In Tennessee, a physician who assists at surgery may

be reimbursed up to 20% of the maximum allowable medical fee schedule amount. Maryland, West Virginia, and the District of Columbia follow the CMS guidelines.

In Virginia, the Commission considers whether the assistant surgeon's services were medically necessary and whether the insurance carrier proved that the charges for the assistant exceeded the prevailing community rate. The Commission also considers the terms of the contract between the provider and the carrier to determine whether a reduced rate is appropriate for a surgical assistant.

Below, we have summarized Medicare's provisions governing assistants at surgery, Virginia case law on the subject, and the laws in our border states as well as Washington, D.C. We have also included a table surveying other state laws on this issue.

Medicare

In the Medicare system, the fee schedule is modified to take into account services of assistants at surgery. 42 USCS § 1395w-4(i) provides, *inter alia*, that "for the services of a physician serving as an assistant-at-surgery, the fee schedule amount shall not exceed 16 percent of the fee schedule amount..."[1] Non-physicians assisting in surgery, including physician assistants, nurse practitioners, or clinical nurse specialists, are paid 85% of the amount that would otherwise be recognized if a physician had

[1] 42 USCS 1395w-4(i)(2)(A) provides:

> (2) Assistants-at-surgery.
>
> (A) In general. Subject to subparagraph (B), in the case of a surgical service furnished by a physician, if payment is made separately under this part [42 USCS §§ 1395j et seq.] for the services of a physician serving as an assistant-at-surgery, the fee schedule amount shall not exceed 16 percent of the fee schedule amount otherwise determined under this section for the global surgical service involved.

served as the assistant at surgery, or 13.6% of the fee schedule amount of the primary surgeon's fee for the surgery.

The Medicare rules generally deny payment for an assistant surgeon, "in surgical procedures for which CMS has determined that assistants-at-surgery on average are used in less than 5 percent of such procedures nationally." 42 CFR 405.502 (a) (9) (2010).[2] See 42 USCS 1395w-4(i)(2)(B) (2010).[3]

Medicare's rules for billing for an assistant at surgery are found in the Medicare Claims Processing Manual, Chapter 12, section 20.4.3. This section provides:

> For assistant at surgery services performed by physicians, the fee schedule amount equals 16 percent of the amount otherwise applicable for the global surgery.
>
> Carriers may not pay assistants at surgery for surgical procedures in which a physician is used as an assistant at surgery in fewer than five percent of the cases for that procedure nationally. This is determined through manual reviews.
>
> In addition to the assistant at surgery modifiers "-80," "-81," or "-82," any procedures submitted with modifier AS are subject to the assistant surgeon's policy enunciated in the Medicare physician fee schedule database (MPFSDB). Accordingly, pay claims for procedures with these modifiers only if the services of an assistant surgeon are authorized.

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[2] 42 CFR 405.502(a)(9) provides:

> Except as provided in paragraph (a)(10) of this section, in the case of services of assistants-at-surgery as defined in § 405.580 in teaching and non-teaching settings, charges that are not more than 16 percent of the prevailing charge in the locality, adjusted by the economic index, for the surgical procedure performed by the primary surgeon. Payment is prohibited for the services of an assistant-at-surgery in surgical procedures for which CMS has determined that assistants-at-surgery on average are used in less than 5 percent of such procedures nationally.

[3] 42 USCS 1395w-4(i)(2)(B) provides:

> (B) Denial of payment in certain cases. If the Secretary determines, based on the most recent data available, that for a surgical procedure (or class of surgical procedures) the national average percentage of such procedure performed under this part [42 USCS §§ 1395j et seq.] which involve the use of a physician as an assistant at surgery is less than 5 percent, no payment may be made under this part [42 USCS §§ 1395j et seq.] for services of an assistant at surgery involved in the procedure.

> Physicians are prohibited from billing a Medicare beneficiary for assistant at surgery services for procedure codes subject to the assistant at surgery limit. Physicians who knowingly and willfully violate this prohibition and bill a beneficiary for an assistant at surgery service for these procedures codes may be subject to the penalties contained under §1842(j)(2) of the Social Security Act (the Act.) Penalties vary based on the frequency and seriousness of the violation.

Virginia Workers' Compensation Commission Opinions

Since 2002, the Commission has adjudicated approximately 26 cases dealing with the issue of payment for assistants at surgery. This includes twenty cases at the deputy commissioner level and six review opinions by the full Commission.

The Commission generally looks at two issues when considering the extent to which an employer is liable for the costs of an assistant at surgery: (1) whether the assistant's services were medically necessary and (2) whether the insurance carrier proved that the charges for such assistant exceeded the prevailing community rate.

The standard: The Commission considers the medical provider's statement of charges *prima facie* evidence of the reasonableness and necessity of the charges and services. To refute this *prima facie* evidence of the reasonableness of the charges, the insurance carrier must submit evidence pursuant to Va. Code § 65.2-605 and pursuant to the Commission's Rule 14 to the effect that the charges exceed those that "prevail in the same community for similar treatment when such treatment is paid for by the injured person."

The fact that the treating surgeon requested an assistant at surgery raises a presumption that the assistance was medically necessary. Jones v. Artic Slope Regional Corp., VWC File No. 213-32-43 (May 14, 2007). In Jones, the carried denied payment for an assistant at surgery on the grounds that the procedure typically did not require an assistant surgeon. However, the

treating surgeon requested an assistant, and the Commission held that the carrier failed to rebut this presumption because it presented no medical evidence to the effect that the medical provider's services were not necessary.

Similarly, the Commission has held that reference to the CPT code book is insufficient to rebut the presumption that an assistant was necessary when the treating surgeon requested the assistant. Ott v. Reconstruction Consultants, Inc., VWC File No. 163-17-66 (Dec. 20, 2002). In Ott, a physician's assistant assisted the claimant's treating surgeon in performing complex surgical procedures on the employee's back. The carrier argued that the medical provider improperly "unbundled" one of his services, and that the charges for a particular CPT Code should be disallowed. The deputy commissioner found the carrier's reference to the CPT book "insufficient to refute the necessity of these medical services, particularly in light of the fact that the attending surgeon found assistance by the physician's assistant to be required."

Likewise, in Nichols v. Cracker Barrel Old Country Store, Inc. #281, VWC File No. 206-19-05 (Dec. 10, 2001), a physician's assistant assisted the treating surgeon in performing surgical procedures on the claimant. The insurance carrier provided evidence from Corvel which analyzed the CPT book and opined that the CPT codes relating to the procedures performed did not justify the utilization of an assistant. The deputy commissioner found this evidence unpersuasive and "insufficient to refute the necessity of these medical services, particularly in light of the fact that the attending surgeon found assistance by the physician's assistant to be required." See also Gibson v. A&T Painting, VWC File No. 228-49-02 (July 6, 2007).

On the other hand, where the carrier presents expert evidence that an assistant surgeon was not medically necessary for a particular procedure, and the medical provider offers no rebuttal, the Commission has held that the medical provider was not entitled to additional

payments for charges for an assistant surgeon. For example, in Eggleston v. Colonial Heritage, VWC File No. 228-14-77 (Dec. 22, 2009), the Commission relied on the carrier's experts' opinions that the medical provider improperly billed for various CPT codes, and that an assistant surgeon was not medically necessary for one procedure. The Commission noted that the medical provider offered no rebuttal, and the Commission found the expert analysis persuasive.

Similarly, in Cradle v. Home Recovery of Virginia, Inc., VWC File No. 231-55-77 (March 24, 2009), the medical provider filed an application seeking payment of its outstanding balance for services rendered by an assistant at surgery. The employer submitted evidence from its expert who reviewed the CPT codes and documentation from the medical provider for the procedures performed and compared it to the National Physician Fee Schedule Relative Value File, as established by the Centers for Medicare and Medicaid Services (CMS). The expert relied on the Medicare Claims Manual and opined that for the particular CPT codes used, CMS does not pay for an assistant at surgery relative to this procedure. Therefore, the expert concluded that the medical provider had improperly upcoded its services and should not have billed for an assistant surgeon because an assistant surgeon was not medically necessary.

The Commission found the expert's opinion reasonable. The Commission noted that based on Medicare criteria, assistants at surgery are not often used in this type of surgical procedure. The Commission also reviewed the medical records and found no indication that the disputed surgical procedure was complicated by any unusual circumstances surrounding this particular patient. Therefore, the Commission concluded that the medical provider was not entitled to additional payments for charges for an assistant surgeon. See Schmitt v. Whitlow Chevrolet Corp., VWC File No. 232-75-95 (Dec. 19, 2008) (similar holding and reasoning).

Where there is a contract between the parties

The Commission is often called upon to interpret contractual agreements between health care providers and insurance carriers. In the absence of fraud, mutual mistake, or violation of law or public policy, the Commission will uphold these contractual agreements. In those cases, the Commission determines whether there exists a valid PPO contract between the parties and whether the medical provider was reimbursed in accordance with the terms of the PPO agreement.

Where there is a valid PPO contract between the parties, and the evidence shows that the PPO contract provided that assistant surgeons' reimbursement was at a percentage of that of the primary surgeon, and the provider had accepted such discounts for many years without dispute, the Commission has found that proper payments to the provider were made based on the contract.

For example, in McIntosh v. Mary Washington Hosp., VWC File No. 222-62-86 (Dec. 15, 2009), the deputy commissioner determined that there was a valid applicable PPO contract between the parties and that the medical provider failed to prove that it was not reimbursed in accordance with the terms of the PPO agreement. In that case, the PPO contract provided for reimbursement equal to "85% of usual charges, 85% of usual and customary reimbursement. . . [whichever] is less." The medical provider argued that "usual and customary reimbursement" was equivalent to the prevailing community rate and also asserted that the carrier improperly applied "multiple procedure" and "assistant surgeon" reductions. According to the carrier's evidence, the PPO contract provided that multiple procedures by the same surgeon were subject to a 50% reduction with respect to the secondary procedure, and that assistant surgeons'

reimbursement was approximately 20% of that of the primary surgeon. In finding the medical provider was paid in accordance with the contract, the deputy commissioner reasoned:

> While such discounts may not be encompassed in the statutory standard of the prevailing community rate, the carrier has presented some evidence that the discounts are appropriate in computing usual and customary reimbursements. The medical provider has presented no contrary evidence. Moreover, as the carrier points out, the medical provider has accepted such discounts for many years with no complaints. Thus, custom and usage, and the parties' course of dealing, support the carrier's interpretation of the contract. See, e.g. 1 M.J. Contracts, § 51.

States and Regions that Border Virginia

Summary

We have concentrated on the five states that border Virginia - Kentucky, Maryland, North Carolina, Tennessee, and West Virginia - and the District of Columbia. Table 3 provides a summary of each state/region's assistant at surgery rules. A summary of each state/region's rules regarding reimbursement of assistants at surgery appears below. Kentucky reimburses assistants at surgery at 20% of the listed value. North Carolina reimburses medical doctors who assist at surgery at 20% of the fee listed for the surgical procedure, and 17% for physician assistants who assist at surgery. In Tennessee, a physician who assists at surgery may be reimbursed up to 20% of the maximum allowable medical fee schedule amount. Licensed physician assistants may serve as surgical assistants, but their fees are limited to the fee due from the procedure as calculated pursuant to Medicare guidelines. Maryland, West Virginia, and the District of Columbia follow the CMS guidelines.

Kentucky

Kentucky's fee schedule provides reimbursement to assistants at surgery including physician's assistants and registered nurse first assistants. The fee schedule calls for use of Modifier 80 and reimburses surgical assistants at twenty percent 20% of the listed value. Registered nurse first assistants (RNFA) are reimbursed at ten percent 10% of the listed value. In 2007, Kentucky amended its law to provide reimbursement to RNFAs who were not employed by the hospital or the surgeon performing the service and only if reimbursement for an assisting physician would be covered, and an RNFA who performed the services would be used as a substitute. Ky. Rev. Stat. Ann. § 342.035.

Maryland

Maryland, with few exceptions, follows the CMS guidelines for reimbursement methodologies, models, and value or weights, including applicable payment policies relating to coding, billing, and reporting. Md. Code Regs. 14.09.03.01 (Guide of Medical and Surgical Fees) (2004). Therefore, it follows the Medicare manual for assistants at surgery.

North Carolina

In North Carolina, when another physician assists at surgery, the assistant is reimbursed up to 20% of the fee listed for the surgical procedure if the services of a hospital staff member or resident are not available and CPT codes indicate that an assistant surgeon is medically necessary. If the surgery assistant is a physician assistant, the assistant is reimbursed 17% of the fee schedule allowance. This is based on 85% of the assistant surgeon's fee of 20%.

The Medical Fee Schedule, Introduction, provides:

> The North Carolina Industrial Commission will allow reimbursement of physician assistant services, when assisting in surgery, as a minimal surgical assistant at the rate of seventeen percent (17%) of the fee schedule allowance.
>
> The seventeen percent (17%) is based on eighty-five percent (85%) of the assistant surgeon's fee of 20 percent (20%). This rate would equal the same as that applied by the Health Care Finance Administration (HCFA).
>
> The surgical procedure code should include modifier 81 (used to identify a minimum assistant surgeon). The name of the physician assistant should appear in Field 31 of the HCFA Form 1500.

Rule 9 of the Rules Governing the Application of the Fee Schedule provides:

> **Where patient is attended by more than one physician or surgeon.** Fees will not be approved for the services of more than one physician or surgeon during the same period of time unless the necessity for more than one shall be shown or such shall be ordered by the insurance carrier, the self-insuring employer, or the Commission, provided, however, that a fee not to exceed twenty per cent (20%) of the fee listed for the surgical procedure may be paid to a medical doctor who assists the surgeon in a major operation where the services of a hospital resident or staff member are not available[.] **CPT codes indicate whether an assistant surgeon is medically necessary.** Please refer to the Assistant Surgeon Guide include[ed] in the surgery section of this schedule for a listing of procedures normally appropriate for assistant surgeons.

Rule 26 provides:

> **Assistant Surgeon Fee.** Surgical Assistant services rendered by a licensed physician who assists the treating physician in a surgical procedure, where the services of a hospital resident or staff member are not available, may not exceed twenty per cent (20%) of the fee listed for the surgical procedure. If the treating physician feels that the use of a[n] assistant is warranted, the request for assistant's fee must be accompanied by a notation on the Form 25M and/or HCFA 1500 and a memorandum from the physician detailing the need. Physician Assistants (PA's) [are] entitled to 17 percent of the fee schedule. Nurse assistants are not billable for assisting in surgery in Workers' Compensation Cases. CPT codes indicate whether an assistant surgeon is medically necessary.

Tennessee

According to Tennessee's Workers' Compensation Medical Fee Schedule, a physician who assists at surgery may be reimbursed up to the lesser of the surgical assistant's usual charge or 20% of the maximum allowable Medical Fee Schedule amount. Licensed physician assistants may serve as surgical assistants but are limited in reimbursement to the fee as calculated pursuant to Medicare guidelines.

Tennessee's Workers' Compensation Medical Fee Schedule provides:

> Q. Surgery, Surgical Assistants and Modifiers
> Physicians performing surgery may generally receive up to 200% of the allowable Tennessee Adjusted Medicare amount. Board-certified, and physicians eligible for board-certification, in either neurological surgery or orthopedic surgery may receive up to 275% of the Tennessee Medicare amount for surgical services only.
>
> A physician who assists at surgery may be reimbursed up to the lesser of the surgical assistant's usual charge or twenty percent (20%) of the maximum allowable Medical Fee Schedule amount. Licensed physician assistants may serve as surgical assistants but shall be limited in reimbursement to the fee due from the procedure as calculated pursuant to Medicare guidelines, not the conversion factors contained in the Workers' Compensation Medical Fee Schedule.

Rule 0800-2-18-.04 (2)(b) of the Rules of Tennessee Department of Labor and Workforce Development, Division of Workers' Compensation, Ch. 0800-2-18 Medical Fee Schedule, provides:

> (2) Services Rendered by More Than One Physician:
> ...
> (b) Surgical Assistant: A physician who assists at surgery may be reimbursed as a surgical assistant. To identify surgical assistant services provided by physicians, Modifier 80 or 81 shall be added to the surgical procedure code which is billed. A physician serving as a surgical assistant must submit a copy of the operative report to substantiate the services rendered. Reimbursement is limited to the lesser of the surgical assistant's usual charge or 20% of the maximum allowable Medical Fee Schedule amount. Duly licensed physician assistants may serve as surgical assistants as deemed appropriate by the physician, and if so, that assistants'

> reimbursement shall not exceed 100% of the physician assistant fee that would be due under Medicare guidelines, without regard for conversion factors contained in the workers' compensation Medical Fee Schedule.

Washington, D.C.

In Washington D.C., the Department of Employee Services, Workers' Compensation Program (Department), processes claims and monitors the payment of benefits to injured private-sector employees in the District of Columbia. The Department does not publish its own fee schedule but is guided by the CMS rules and schedule. The District of Columbia allows reimbursement at 113% of the CMS listed value of each procedure.

There are no specific guidelines for assistants at surgery, but given the District's reliance on CMS rules, the Department likely would provide discounted reimbursement for assistants at surgery.

West Virginia

West Virginia follows the CMS's Physician Fee Schedule with its modifiers for assistants at surgery. See "Detail Reference Guide to Determining CMS Medicare + 35% for Offices of the Insurance Commissioner (OIC) Workers' Compensation Maximum Medical Reimbursement Fee Schedules" (effective July 1, 2009). Section 85-20-6, The Role of the Treating Physician, provides:

> 6.10. Except in cases where a consultant, anesthetist or surgical assistant is required, or the necessity for treatment by a specialist is clearly shown, fees not pre-authorized by the Commission, Insurance Commissioner, private carrier or self-insured employer, whichever is applicable, will not be approved for treatment by more than one medical vendor for the same condition over the same period of time.

TABLE 3 REIMBURSEMENT OF ASSISTANTS AT SURGERY
MEDICARE AND STATES THAT BORDER VIRGINIA

State/Region	Fee Schedule	Reimbursement of Assistants at Surgery	Source
Medicare	Yes	For assistant surgeon (MD) - 16% of schedule amount for procedure For PA, NP, CNP – 85% of amount listed above	http://www.cms.gov/manuals/Downloads/clm104c12.pdf
Washington, D.C.	Yes	Follows CMS guidelines at 113%	http://www.does.dc.gov/does/cwp/view.asp?a=1232&q=537428
Kentucky	Yes	20% of listed value RNFA – 10% of listed value	http://www.labor.ky.gov/workersclaims/
Maryland	Yes	Follows CMS	http://www.dsd.state.md.us/comar/comarhtml/14/14.09.03.01.htm http://www.wcc.state.md.us/PDF/MFG/MFG_suppregs_06.pdf
North Carolina	Yes	20% for assistant surgeon (MD) 17% for physician assistant	http://www.ic.nc.gov/ncic/pages/feesched.asp#intro http://www.ic.nc.gov/ncic/pages/feesec05.htm
Tennessee	Yes	20% for assistant surgeon (MD) 100% of physician assistant fee due under CMS guidelines	http://www.state.tn.us/labor-wfd/wc_medfeebook.pdf http://www.state.tn.us/sos/rules/0800/0800-02/0800-02-18.pdf
West Virginia	Yes	Follows CMS guidelines + 35%	http://www.wvinsurance.gov/LinkClick.aspx?fileticket=IoXHcc-ihrc%3D&tabid=210

TABLE 4 REIMBURSEMENT OF ASSISTANTS AT SURGERY
SURVEY OF VARIOUS STATES

State	Reimbursement for Assistants at Surgery	Source
Arizona	Modifier 80 Assistant Surgeons: valued at 20% of listed value of surgical procedure(s) Modifier 81 Minimum Assistant Surgeons: valued at 10% of the listed value of the surgical procedure(s)	http://www.ica.state.az.us/Director/DIR_FSList2009.aspx
Arkansas	Only a physician who assists at surgery may be reimbursed as a surgical assistant. Reimbursement is limited to the lesser of the surgical assistant's usual charge or 20% of the maximum allowable Fee Schedule amount.	http://www.awcc.state.ar.us/rule30misc/newmedfeesch.html
Florida	Reimbursement for an assistant surgeon: 25% - identified by the Modifier 80 added to the specific code. Reimbursement for a non-physician surgical assistant for surgical services: not to exceed 75% of the 25% listed above	http://www.myfloridacfo.com/wc/pdf/2007HCPRM.pdf
Idaho	Modifier 80: 15% of code procedure Modifier 81: 15% of coded procedure – applies to MD and non-MD assistants	http://adm.idaho.gov/adminrules/rules/idapa17/0208.pdf
Illinois	Reimbursed lesser of the actual charge or 15% of the surgeon's fee for modifier 81 (minimum assistant surgeon) and 20% for modifier 80 (assistant surgeon) or 82 (assistant surgeon when qualified resident surgeon not available)	http://www.iwcc.il.gov/IG020109.pdf

State	Reimbursement for Assistants at Surgery	Source
Kansas	Assistant surgeon: Identify the surgery performed by using the respective code number along with the appropriate modifier (-80, -81, or -82) and bill at 25% of the code fee. Assistant surgeon fees are not payable when the hospital provides an intern or resident staff to assist at surgery.	http://www.dol.ks.gov/wc/html/doc/med_fees_2010.pdf
Louisiana	Physician who assists at surgery - reimbursed as a surgical assistant using Modifier 80. Reimbursement at 20 percent of the allowable reimbursement amount for the procedure(s). Payment for physician assistant, nurse practitioner or surgical technicians - reimbursement is limited to 65 percent of the allowable amount for M.D. assistant surgeons. Must be medically necessary.	http://doa.louisiana.gov/osr/lac/40v01/40v01.pdf
Maine	Modifier 80 Assistant Surgeon: pay at 25% of the Maximum Allowable Fee. Modifier 81 Minimum Assistant Surgeon: Pay at 10% of the Maximum Allowable Fee. Modifier 82 Assistant Surgeon: Pay at 25% of the Maximum Allowable Fee.	http://www.maine.gov/wcb/departments/omrs/2005_MFS/RCh5MFS.doc
Michigan	Procedure must be designated by CMS as allowing additional reimbursement for surgical assistant. Modifier 80 if an MD. Modifier 81 if a physician's assistant or an advanced practice nurse with a specialty licensure certification issued by the state.	http://www.state.mi.us/orr/emi/admincode.asp?AdminCode=Single&Admin_Num=41810101&Dpt=LG&RngHigh

State	Reimbursement for Assistants at Surgery	Source
Massachusetts	Modifier 80: Pertains to assistant surgeons: Surgical assistant services may be identified by adding the modifier '-80' to the usual procedure code. This allows 15% of the allowable fee to be paid to the eligible assistant surgeon. Modifier 82: Pertains to assistant surgeons when qualified resident surgeon not available. Surgical assistant services may be identified by adding modifier '-82'to the usual procedure code when a qualified resident surgeon is not available. This allows 15% of the allowable fee contained to be paid to the eligible assistant surgeon.	http://www.mass.gov/Eeohhs2/docs/dhcfp/g/regs/114_3_16.doc
Mississippi	Physician surgical assistant – use Modifier 80 – allowed 20% of maximum reimbursement allowance (MRA) for procedure(s). Registered Nurse Surgical Assistant or Physician Assistant – allowed 10% of surgeon's fee for procedure(s) performed.	http://www.mwcc.state.ms.us/services/2010finaldraft.pdf
Nebraska	Modifier 80 (Assistant Surgeon) – 20% of fee for procedure Modifier 81 (Minimum Assistant Surgeon) – 10% of fee for procedure Modifier 82 (Assistant Surgeon when qualified resident surgeon not available) – 20% of fee for procedure	https://www.wcc.ne.gov/apps/IPUBA0008Gfrm.aspx
Nevada	Licensed registered nurse, certified physician's assistant, or operating room technician -- reimbursed at 14% of maximum allowable fee for surgeon's services	http://dirweb.state.nv.us/WCS/2008medfee.pdf
New York	Uses Modifiers 80,81,82	http://www.wcb.state.ny.us/content/main/hcpp/MedFeeSchedules/2010medfee.jsp

State	Reimbursement for Assistants at Surgery	Source
Ohio	Modifier 80 (Assistant Surgeon) - 20% of fee schedule amount Modifier 81 (Minimum Assistant Surgeon) - 10% of fee schedule amount Modifier 82 (Assistant Surgeon when qualified resident surgeon is not available) - 20% of fee schedule amount	http://www.ohiobwc.com/downloads/blankpdf/ProfProvFeeSchedule1010.pdf
Oklahoma	Physician – 20% of code allowable charge Physician's Assistant/RNFA – use Modifier 81 – 10% of code allowable charge	http://www.owcc.state.ok.us/PDF/2010%20Fee%20Schedule%20updated%203-3-10.pdf
Oregon	Modifier 81 - Physician assistant, authorized nurse practitioner – 85% of physician's allowable fee	http://arcweb.sos.state.or.us/rules/OARS_400/OAR_436/436_009.html
Texas	Uses Medicare coding and billing	http://www.tdi.state.tx.us/wc/hcprovider/index.html#billing http://www.workerscompensation.com/regulations/stateitem.php?ID=103365&state=texas&Parent=103365
Utah	Modifier 80 for Assistant Surgeon: MD's, DO's, and Podiatrists Modifier 81 for Minimum Assistant Surgeon Schedule has list of procedures for which assistant is payable.	http://www.laborcommission.utah.gov/IndustrialAccidents/pdfs/Med_Fee_Guidelines__2008-9_3-26-08.6-08doc.pdf
Vermont	Modifier 80 - reimbursement for surgical assistants must not exceed 25% of the total surgical procedure	
Washington	Uses Medicare modifiers 80, 81, 82	http://www.lni.wa.gov/ClaimsIns/Files/ProviderPay/FeeSchedules/2010FS/fsSurg.pdf
Wyoming	MD assistants paid 20% of the surgical allowance Non-MD assistants paid 15% of the surgical allowance	http://soswy.state.wy.us/Rules/RULES/7072.pdf

(3) the extent to which prompt payment to medical providers should be required

Summary – Prompt Payment Rules

The federal government provides standards for prompt payment of medical bills for Medicare claims. The majority of states have enacted prompt payment rules governing payment of workers' compensation health care providers. The Workers' Compensation Research Institute (WCRI) completed a study entitled "Workers' Compensation Medical Cost Containment: A National Inventory As of January 1, 2008" (Aug. 31, 2009), which we cite with permission from WCRI. Table 20 of the WCRI report appears at the end of this section. This table provides state-by-state information for medical bill filing, payment, and medical dispute resolution.

We have concentrated on the five states that border Virginia - Kentucky, Maryland, North Carolina, Tennessee, and West Virginia - and the District of Columbia. Table 5 summarizes these states' prompt payment provisions. Kentucky, North Carolina, and West Virginia provide timeframes in which a medical provider must submit a bill or face potential forfeiture of any payment owed. Kentucky, Maryland, North Carolina, and Tennessee establish specific timeframes in which the employer, insurer, or other payer must either pay the bill or dispute the bill. A payer will face wavier of any objection to the bill and potential fines, penalties, and/or interest if it does not meet these deadlines.

The Virginia Workers' Compensation Act does not contain a timeframe specific provision regarding the prompt payment of medical bills to medical providers. Virginia's Fair Business Practice Act, Va. Code § 38.2-3407.15 (2010), does not apply to workers' compensation. In certain circumstances, the Commission has ordered workers' compensation carriers to make prompt payment to medical providers. The Commission also has the power to

issue penalties when a carrier delays payment of medical expenses. Va. Code § 65.2-713. If the Commission has ordered a defendant to pay a sum certain for medical treatment, the Commission might also use its contempt powers to enforce prompt payment. *See* Va. Code §65.2-202. In determining whether a penalty is due, the Commission considers whether the carrier's delay in payment was unreasonable.

Medicare

Timeframe for Providers to Submit Claims

The time period for filing Medicare fee-for-service (FFS) claims is specified in Sections 1814(a), 1835(a)(1), and 1842(b)(3) of the Social Security Act and in the Code of Federal Regulations (CFR), 42 CFR Section 424.44.[1]

Under the Medicare program, providers in the Original Medicare Plan (e.g.: hospitals, skilled nursing facilities, home health agencies, and physicians) and suppliers are required by law to file Medicare claims for covered services and supplies. For claims for services furnished before January 1, 2010, claims must be filed on or before December 31 of the following year for services furnished during the first nine months of a calendar year, and by December 31 of the second following year for services that were furnished during the last three months of the calendar year. For example, if a patient saw his physician on March 22, 2009, the Medicare claim form for that visit must be filed by December 31, 2010. If a patient saw his physician on November 12, 2009, the claim for must be filed by December 31, 2011.

[1] The full text of this regulation is set out at the end of this section.

Claims must be submitted complete and free of errors. Any claim filed with invalid or incomplete information, and returned to the provider (RTP) for correction, is not protected from the timely filing guidelines. Medicare determines whether a claim has been filed timely by comparing the date the services were furnished (line item date or claim statement "from" date) to the receipt date applied to the claim when it is received. If the span between these two dates exceeds the time limitation, the claim is considered to have been not timely filed.

The Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010, amended the time period for filing Medicare fee-for-service (FFS) claims. Under the new law, claims for services furnished on or after January 1, 2010, must be filed within one calendar year after the date of service. For example, if a patient saw his physician on March 22, 2010, the Medicare claim form for that visit must be filed by March 22, 2011.

Timeframe for Insurance Carriers to Pay Medicare Claims

Federal regulations require plans to make timely payment to, or on behalf of, plan enrollees for services obtained from non-contracted providers. See 42 CFR § 422.[2] The Medicare Advantage Program imposes certain prompt payment requirements on managed care organizations (MCO) contracting with CMS to participate in the Medicare Advantage program.

Specifically, CMS requires that no less than 95% of clean claims from non-contracting providers or suppliers be paid within 30 days. Under the program, "clean claim" means a claim that has no defect or impropriety (including lack of any required substantiating documentation), or involves no particular circumstance requiring special treatment that prevents timely payments from being made on the claim. If payment is not made on a clean claim within 30 days, interest shall be paid by the MCO at a rate established by the federal government.

[2] The full text of this regulation is set out at the end of this section.

Part D Pharmacy Requirements – Starting with the 2010 benefit year, contracts between Part D Plan Sponsors and CMS must include a provision that requires Part D Plan Sponsors to make payment on all electronically submitted "clean claims" within 14 days (30 days for clean claims submitted through other mediums).

Medicare regulations require Medicare+Choice organizations to include a prompt payment provision in their contracts with providers. In addition, most contracts between health plans and the CMS require that the health plans include in its contracts with providers a prompt payment provision.

TITLE 42 - PUBLIC HEALTH
CHAPTER IV - CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBCHAPTER B - MEDICARE PROGRAM
PART 422 - MEDICARE ADVANTAGE PROGRAM
subpart k - CONTRACTS WITH MEDICARE ADVANTAGE ORGANIZATIONS

42 CFR § 422.520

§ 422.520 - Prompt payment by MA organization.

(a) Contract between CMS and the MA organization. (1) The contract between CMS and the MA organization must provide that the MA organization will pay 95 percent of the clean claims within 30 days of receipt if they are submitted by, or on behalf of, an enrollee of an MA private fee-for-service plan or are claims for services that are not furnished under a written agreement between the organization and the provider.

(2) The MA organization must pay interest on clean claims that are not paid within 30 days in accordance with sections 1816(c)(2)(B) and 1842(c)(2)(B).

(3) All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request.

(b)(1) Contracts between MA organizations and providers and suppliers.

Contracts or other written agreements between MA organizations and providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the MA organization and the relevant provider.

(2) The MA organization is obligated to pay contracted providers under the terms of the contract between the MA organization and the provider.

(c) Failure to comply. If CMS determines, after giving notice and opportunity for hearing, that an MA organization has failed to make payments in accordance with paragraph (a) of this section, CMS may provide (1) For direct payment of the sums owed to providers, or MA private fee-for-service plan enrollees; and (2) For appropriate reduction in the amounts that would otherwise be paid to the organization, to reflect the amounts of the direct payments and the cost of making those payments.

(d) A CMS decision to not conduct a hearing under paragraph (c) of this section does not disturb any potential remedy under State law for 1866(a)(1)(O) of the Act.

TITLE 42 - PUBLIC HEALTH
CHAPTER IV - CENTERS FOR MEDICARE & MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES
SUBCHAPTER B - MEDICARE PROGRAM
PART 424 -- CONDITIONS FOR MEDICARE PAYMENT
SUBPART C -- CLAIMS FOR PAYMENT

42 CFR § 424.44

§ 424.44 Time limits for filing claims.

(a) Basic Limits. Except as provided in paragraph (b) and (e) of this section, the claim must be delivered to the intermediary or carrier as appropriate:

(1) On or before December 31 of the following year for services that were furnished during the first 9 months of a calendar year; and

(2) On or before December 31 of the second following year for services that were furnished during the last 3 months of the calendar year.

(b) Extension of filing time because of error or misrepresentation. (1) The time for filing a claim will be extended if failure to meet the deadline in paragraph (a) of this section was caused by error or misrepresentation of an employee, intermediary, carrier, or agent of the Department that was performing Medicare functions and acting within the scope of its authority.

(2) The time will be extended through the last day of the 6th calendar month following the month in which the error or misrepresentation is corrected.

(c) Extension of period ending on a nonworkday. If the last day of the period allowed under paragraph (a) or (b) of this section falls on a Federal nonworkday (a Saturday, Sunday, legal holiday, or a day which by statute or Executive Order is declared to be a nonworkday for Federal employees), the time is extended to the next succeeding workday.

(d) Outpatient diabetes self-management training. CMS makes payment in half-hour increments to an entity for the furnishing of outpatient diabetes self-management training on or after the approval date CMS approves the entity to furnish the services under part 410, subpart H of this chapter.

(e) Exceptions. Any claims filed by the following suppliers with Medicare billing privileges whose time limits for filing claims are linked to their enrollment status and are governed under § 424.516, § 424.520, and § 424.521 of this subpart:
(1) Physician or nonphysician organizations.
(2) Physicians.
(3) Nonphysician practitioners.
(4) Independent diagnostic testing facilities.

Virginia

Virginia's Prompt Payment Statute

The Virginia Workers' Compensation Act does not contain a timeframe specific provision regarding the prompt payment of medical bills to medical providers. Virginia's prompt-payment statute, Va. Code § 38.2-3407.15 (2010), does not apply to workers' compensation. The statute also does not apply to many Federal health plans; liability, disability, and long-term care plans; the Civilian Health and Medicine Program of the Uniformed Services (CHAMPUS); and Medicare supplemental coverage.[3]

How the Virginia Workers' Compensation Commission Handles Prompt Payment to Medical Providers

The Virginia Workers' Compensation Commission has ordered insurance carriers to make prompt payment of medical bills to medical providers. See, e.g., Jones v. Jamesway Corp., VWC File No. 26-88-53 (Sept. 13, 1991). The Commission has also stated that it has the authority to order the insurance carrier to make prompt payment to a designated pharmacy. Riggleman v. Donald L. Riggleman Contractor, VWC File No. 138-66-10 (May 9, 2005), citing Woody's Auto Parts v. Rock, 4 Va. App. 8, 353 S.E.2d 792 (1987).

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[3] Va. Code Ann. § 38.2-3407.15(A) provides:

> "Health plan"... does not mean (i) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. or Title XX of the Social Security Act, 42 U.S.C. § 1397 et seq. (Medicaid), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (CHAMPUS); or (ii) accident only, credit or disability insurance, long-term care insurance, CHAMPUS supplement, Medicare supplement, or workers' compensation coverages.

When a carrier delays payment of medical expenses, the Commission considers under Va. Code § 65.2-713, whether a penalty is owed. This provision allows the Commission to assess costs, including a reasonable attorney's fee, against an employer or carrier which brings, prosecutes, or defends proceedings without reasonable grounds or which delays payment without reasonable grounds. In determining whether a penalty is due, the Commission considers whether the carrier's delay in payment was unreasonable.

The Commission has held, at least at the deputy commissioner level, that a medical provider may be entitled to an award of attorney's fees and costs pursuant to Code § 65.2-713. In Wilson v. Bob's Electric Co., VWC File No. 234-91-86 (Feb. 22, 2010), the medical provider filed an application seeking attorney's fees for the carrier's unreasonable delay in paying the balance of its charges as awarded in a deputy commissioner's opinion. The Commission entered a show cause order. The issue before the deputy commissioner was whether a health care provider may be entitled to an award of attorney's fees and costs pursuant to Code § 65.2-713. The deputy commissioner concluded that "the Commission has implicitly recognized that such an award would be proper if it found that the carrier had delayed payment without reasonable grounds."

> We are aware of no case that specifically addresses the Commission's authority to award such fees and costs in favor of a medical provider, as opposed to an injured employee claimant. In numerous cases, the Commission has denied such an award to a medical provider on the grounds that the delay in payment was not unreasonable. See, e.g., Warner v. Davis& Green, Inc., VWC File 230-20-79 (July 2, 2009). Thus, the Commission has implicitly recognized that such an award would be proper if it found that the carrier had delayed payment without reasonable grounds. The statute itself is broadly worded, and does not limit its application to an award in favor of an injured employee. We therefore conclude that the medical provider might be entitled to such an award.

The Commission has stated in a number of cases that it is proper to award attorney's fees and costs in cases where it is found that the employer or insurer unreasonably delayed payment of medical expenses, including mileage reimbursement and prescription costs. Rusky v. Atlas Marketing Co., Inc., VWC No. 193-36-27 (June 25, 2001). See, e.g. Stoneberger v. Addison Contractors, Inc., VWC File No. 189-14-77 (January 30, 2001); Parks v. Virginia Division APAC, VWC File No. 119-25-56 (May 21, 1998); and Morris v. City of Manassas School Board, VWC File No. 179-49-15 (January 31, 1997).

An inspection of the case law reveals some guidance regarding what delays are "unreasonable." The Commission generally allows a reasonable time to evaluate the billing. Therefore, in Rusky, the Commission found that a request for a show cause proceeding with respect to the non-payment of medical bills was premature when requested approximately one month after the detailed bill was submitted to the carrier. On the other hand, Rusky also considered a scenario where the defendants had obtained, sometime in the past, detailed information regarding a disputed medical bill, but failed to pay the bill for over two months after the entry of an order approving a compromise settlement, despite having received two reminders from the claimant's counsel. Noting that the carrier had apparently "ignored" claimant's counsel's letters, prompting the filing of a claim, the Commission found the delay in payment to be unreasonable.

In Daye v. Atria Hilltop, VWC No. 192-81-40 (April 16, 2002), the Commission awarded sanctions where a bill went unpaid for some five months from the date of the medical services, even though there appeared to be no evidence of when the carrier had received the bill. On the other hand, no sanctions were assessed where a bill was "placed in line for payment within two months of the bill date," even where there was no evidence that this bill had been paid. In

Hutzenbiles v. Koons of Tysons Corner, Inc., VWC No. 202-49-70 (January 3, 2005), a delay in payment of over a year was found to be unreasonable even though the carrier had not received supporting medical records, where a prior opinion had determined that the medical services were authorized.

A delay resulting from the carrier's negligence, while perhaps unintentional, may be unreasonable. See, e.g., Byrd v. G D C, Inc., VWC No. 194-86-54 (Feb. 26, 2001). In Stoneberger v. Addison Contractors, Inc., VWC File No. 189-14-77 (January 30, 2001), the Commission imposed sanctions for a seven-month delay in payment even though the carrier complained that it lacked sufficient medical reports. The Commission indicated that because the carrier had been furnished with a detailed, as opposed to a summary bill, it had the burden to request additional information, and could not simply refuse to process the bill. In Morris v. City of Manassas School Board, VWC File No. 179-49-15 (January 31, 1997), the Commission found that a payment delay of five months was not justified by the fact that the carrier "shipped [its file] from Pittsburgh to Charlotte," stating that the "carrier is responsible for its obligations to claimant, regardless of the location of its files." Similarly, where there is a pattern of neglect and/or oversight in prompt payment of the claimant's benefits, the Commission has awarded attorney's fees. See Hancock v. Wal Mart, VWC File No. 223-35-62 (Sept. 12, 2008).

States and Regions that Border Virginia

Summary

We have concentrated on the five states that border Virginia - Kentucky, Maryland, North Carolina, Tennessee, and West Virginia - and the District of Columbia. A summary of each state/region's rules regarding prompt payment of medical bills appears below. *See* Table 5. Kentucky, North Carolina, and West Virginia provide timeframes in which a medical provider must submit a bill or face potential forfeiture of any payment owed. Kentucky, Maryland, North Carolina, and Tennessee establish specific timeframes in which the employer, insurer, or other payer must either pay the bill or dispute the bill. A payer will face wavier of any objection to the bill and potential fines, penalties, and/or interest if it does not meet these deadlines.

Kentucky

Kentucky gives medical providers 45 days after treatment is initiated to submit their bills to payers.[4] If a bill is not submitted in a timely manner, the provider may not get paid. Medical providers must submit their bills every 45 days thereafter as long as medical services are rendered. The payer must pay the provider within 30 days of receipt of a statement for services or face fines and may waive the opportunity to challenge the bill. If there is a dispute, the provider must file an administrative request with the agency, and the payer must either pay the penalty or deny the penalty is due. Ky. Rev. Stat. Ann. § 342.020(1).[5] The Kentucky Supreme Court has held that this 30-day requirement applies to medical statements received by an employer *after* an administrative law judge has determined that the bills are owed by the employer.

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[4] In Kentucky, a "payer" includes the employer, insurer, or payment obligor acting on behalf of the employer.

[5] Ky. Rev. Stat. Ann. § 342.020(1) provides, in part:

> The employer, insurer, or payment obligor acting on behalf of the employer, shall make all payments for services rendered to an employee directly to the provider of the services within thirty (30) days of receipt of a statement for services. The executive director shall promulgate administrative regulations establishing conditions under which the thirty (30) day period for payment may be tolled. The provider of medical services shall submit the statement for services within forty-five (45) days of the day treatment is initiated and every forty-five (45) days thereafter, if appropriate, as long as medical services are rendered....

Maryland

Under Maryland's Guide of Medical and Surgical Fees, Md. Code Regs. 14.09.03.01 et seq., to obtain reimbursement, a provider must complete a Form CMS-1500, Claim for Medical Services, and submit this form to the payer (employer or insurer). Reimbursement by the employer or insurer must be made within 45 days of receipt of Form CMS-1500. If a payer denies, in full or in part, a claim for treatment or services, then the payer must notify the provider of the reasons for the denial in writing within the 45 days. If a payer does not pay the fee or file a notice of denial of reimbursement within 45 days, it waives its right to deny reimbursement, and the Maryland Workers' Compensation Commission may assess a fine against the payer, and award interest to the provider. Md. Code Regs. 14.09.03.06.[6] The Commission uses a formal hearing to resolve these issues.

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[6] Md. Code Regs. 14.09.03.06 provides:

> D. Untimely reimbursement.
> If an employer or insurer does not pay the fee calculated under this Chapter or file a notice of denial of reimbursement, within 45 days of receipt of the CMS-1500, the Commission may assess a fine against the employer or its insurer, and award interest to the provider in accordance with Labor and Employment Article, §§ 9-663 and 9-664, Annotated Code of Maryland and COMAR 14.09.01.22.
>
> E. Denial of reimbursement.
> (1) If an employer or insurer denies, in full or in part, a claim for treatment or services, the employer or insurer shall:
> (a) Notify the provider of the reasons for the denial in writing; and
> (b) Mail the notice of denial of reimbursement to the provider within 45 days of the date on which Form CMS-1500 was received.
> (2) An employer or insurer who fails to file a notice of denial of reimbursement within 45 days of receipt of the CMS-1500 waives the right to deny reimbursement and is subject to the provisions of Labor and Employment Article, §§ 9-663 and 9-664, Annotated Code of Maryland and COMAR 14.09.01.22.

North Carolina

In North Carolina, medical providers must submit their statement for services within 75 days of the rendition of the service or, if treatment is longer, within 30 days after the end of the month during which multiple treatments were provided. NCIC Workers' Compensation Rule 407(2).[7] Within 30 days of receipt of the statement, the payer[8] must pay or submit the statement

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[7] Rule 407(2) provides:

> A provider of medical compensation shall submit its statement for services within 75 days of the rendition of the service or if treatment is longer, within 30 days after the end of the month during which multiple treatments were provided, or within such other reasonable period of time as allowed by the Industrial Commission. However, in cases where liability is initially denied but subsequently admitted or determined by the Industrial Commission, the time for submission of medical bills shall run from the time the health care provider received notice of the admission or determination of liability. Within 30 days of receipt of the statement, the employer, or carrier, or managed care organization, or administrator on its behalf, shall pay or submit the statement to the Industrial Commission for approval or send the provider written objections to the statement. If an employer, carrier/ administrator or managed care organization disputes a portion of the provider's bill, it shall pay the uncontested portion of the bill and shall resolve disputes regarding the balance of the charges through its contractual arrangement or through the Industrial Commission. If any bill for medical compensation services is not paid within 60 days after it has been approved by the Industrial Commission and returned to the responsible party, or, when the employee is receiving treatment through a managed care organization, within 60 days after the bill has been properly submitted to an insurer or managed care organization, there shall be added to such unpaid bill an amount equal to 10%, which shall be paid at the same time as, but in addition to, such bill, unless late payment is excused by the Industrial Commission. When the 10% addition to the bill is uncontested, payment shall be made to the provider without notifying or seeking approval from the Industrial Commission. When the 10% addition to the bill is contested, any party may request a hearing by the Industrial Commission pursuant to N.C. Gen. Stat. §97-83, and N.C. Gen. Stat. §97-84

to the Industrial Commission for approval or send the provider written objections to the statement. If a payer disputes a portion of the provider's bill, it must pay the uncontested portion of the bill and resolve disputes regarding the balance of the charges through its contractual arrangement or through the Industrial Commission. Id.

If any bill for services is not paid within 60 days after it has been approved by the Commission and returned to the responsible party, or within 60 days after it was properly submitted to a payer, an additional 10% is added to the bill, unless late payment is excused by the Commission. N.C. Gen Stat. § 97-18(i)[9]. Any unresolved disputes regarding medical reimbursement are submitted to the Industrial Commission Medical Fees Section for resolution. If this is unworkable, the parties use the normal adjudication process. Processes used for resolution of medical fee dispute include administrative review, informal conference, mediation, informal administrative hearing, and formal hearing.

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[8] In North Carolina, the "payer" is an employer, carrier, managed care organization, or administrator on its behalf.

[9]N.C. Gen. Stat. § 97-18(i) provides:

> If any bill for services rendered under G.S. §97-25 by any provider of health care is not paid within 60 days after it has been approved by the Commission and returned to the responsible party, or within 60 days after it was properly submitted, in accordance with the provisions of this Article, to an insurer or managed care organization responsible for direct reimbursement pursuant to G.S. §97-26(g), there shall be added to such unpaid bill an amount equal to ten per centum (10%) thereof, which shall be paid at the same time as, but in addition to, such medical bill, unless such late payment is excused by the Commission.

Tennessee

In Tennessee, carriers must provide an explanation of medical benefits to the health care provider whenever the carrier's reimbursement differs from the amount billed. The carrier must date stamp medical bills and reports upon receipt. Tennessee law provides penalties for violations under the medical fee schedule. Civil penalties may be assessed up to $10,000.00. Tenn. Comp. R. & Regs. 0800-2-17-.01(1)' 0800-2-17-.13.[10] A payer has 31 days to pay the provider or faces a penalty of 2.08% monthly (25% annual percentage rate) up to $10,000.00.[11]

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[10] 0800-2-17-.13(1) is the provision setting penalties for violations of fee schedule rules. This provision provides:

> ...Any other violation of the Medical Cost Containment Program Rules, Medical Fee Schedule Rules, or the In-patient Hospital Fee Schedule Rules shall subject the violator(s) to a civil penalty of not less than one hundred dollars ($100.00) nor more than ten thousand dollars ($10,000.00) per violation, at the discretion of the Commissioner, Commissioner's Designee, or an agency member appointed by the Commissioner.

[11] Tennessee's Workers' Compensation Medical Fee Schedule Section K p. 10 provides:

> **K. <u>Payment</u>**
>
> Carriers must provide an explanation of medical benefits to the health care provider whenever the carrier's reimbursement differs from the amount billed. A carrier must date-stamp medical bills and reports upon receipt.
>
> Any carrier that fails to pay an undisputed and properly submitted bill or the portion of that bill which is undisputed within thirty-one (31) calendar days of receipt shall be assessed a civil penalty of 2.08% monthly (25% annual percentage rate) which is paid to the provider.
>
> If a provider submits a bill on an improper form, the carrier has 20 calendar days of receipt of the bill to return it. The days between the date the carrier returns the bill and the date the carrier receives

Tennessee has a separate process for medical billing and treatment disputes prior to hearing. Medical disputes may be resolved through administrative review of information, informal conference, mediation, arbitration, or through informal or formal hearings.

Washington, D.C.

In Washington D.C., there is no timeframe in which a medical provider must send its bill to the payer and no repercussion for the provider if billing is not sent in a timely manner. District of Columbia regulations provide that the payer must pay the provider in a "timely" manner, and if the payer is late or unresponsive, the provider may file a complaint with the Office of Workers' Compensation (Office). D.C. Mun. Regs. tit. 7, ch. 2 § 212.6 Upon receiving a complaint regarding payment delinquencies, the Office investigates the complaint and attempts to resolve it informally. § 212.7. Generally, the dispute is handled with the same process used to adjudicate other workers' compensation disputes.

The regulations provide that to the extent feasible, any hearing regarding a disputed medical service or fee charged should be consolidated with the hearing regarding other issues in dispute on a specific claim. § 212.10[12]

> the corrected bill shall not apply towards the thirty-one calendar days the carrier has to pay the bill....
> *See* Rule 0800-2-17-10.

[12] The District of Columbia Municipal Regulations Title 7, Ch 2 Private Sector Workers' Compensation Program 212 Medical Services and Supplies provide, in part:

> 212.4 The physician shall file an initial medical report with the Office and the employer containing a diagnosis and prognosis within twenty (20) working days of treatment in accordance with §8(d) of the Act (§36-307(d), D.C. Code, 1981 ed.]
>
> ...
>
> 212.6 Any medical care provider who has properly submitted a bill who is not paid in a timely fashion can make a complaint to the Office.

West Virginia

West Virginia allows the medical provider 180 days from the date of service to submit its bills to the payer or it forfeits its right to reimbursement. W.Va. Code §§ 85-20-9.20 and -9.24[13]

There is no statutory or regulatory timeframe for the payer to pay the bill and no penalty if the payment is late or the payer is unresponsive. West Virginia has a separate process for medical disputes prior to hearings and uses formal hearings to resolve medical disputes.

> 212.7 Upon receiving a complaint regarding payment delinquencies, the Office shall investigate the complaint and attempt to resolve it informally.
>
> ...
>
> 212.10 To the maximum extent feasible, any hearing regarding a disputed medical service or care or fee charged shall be consolidated with the hearing regarding other issues in dispute on a specific claim.

[13] WV § 85-20-9.20 and -9.24 provide:

> 9.20. Bills must be received within six (6) months of the date of service to be considered for payment. Injured workers cannot be billed for any invoice denied under this provision.
>
> 9.24. Failure on the part of the health care provider or other person, firm or corporation to submit fee bills to the Commission, Insurance Commissioner, private carrier or self-insured employer, whichever is applicable, for services rendered within the statutory period prohibits collection thereof from the injured employee, the employer, private carrier, self-insured employer, Insurance Commissioner or the Commission, whichever is applicable.

TABLE 5

PROMPT PAYMENT STANDARDS
MEDICARE AND STATES THAT BORDER VIRGINIA

State/ Region	**Reference**	**Timeframe for provider to submit bill to payer**	**Result if not submitted within timeframe**	**Timeframe in which payer must pay provider**	**Penalty if payer late/ unresponsive**
Medicare	http://cfr.vlex.com/vid/422-520-prompt-payment-organization-19803182 www.medicare.gov/Basics/FAC.asp	2010 claims - One year from date of service Pre-2010 claims – one full calendar year following year services were provided	Waiver	30 days -clean claims 60 days – other claims	Interest
Washington, D.C.	http://www.workerscompensation.com/regulations/stateitem.php?ID=90220&state=dc&Parent=90220	None	None	"timely" manner	None
Kentucky	http://www.labor.ky.gov/workersclaims/	45 days	Waiver	30 days	Fine and/or waiver
Maryland	http://www.wcc.state.md.us/MFG/Medical_Providers.html	None	None	45 days	Fine, waiver and/or interest
North Carolina	http://www.ic.nc.gov/ http://www.ic.nc.gov/faqs.html#medfeefaq	75 days/30 days	Waiver	30 or 60 days	Penalty
Tennessee	http://www.state.tn.us/labor-wfd/wcomp.html	None	None	31 days	Penalty up to $10,000
West Virginia	http://www.wvinsurance.gov/	180 days	Waiver	None	None

Table 20 Medical Bill Filing, Payment and Medical Dispute Resolution Regulations as of January 1, 2008

This table provides state requirements on when providers must bill payors; when the payors must pay the provider; what repercussions exist for violations; and finally, how medical disputes are resolved in each of the states.

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						Separate Process For Medical Disputes Prior to Hearing	Use Same Process For All Litigation	Other		
Alabama	1 year	Claim is dead	25 days	10% of the amount due	Payer is expected to include in payment; if not, provider can bill		Yes		Commissioners	Administrative review, informal conference and mediation
Alaska	No regulatory language on point, however provider is required to send a physician's report to employer and workers' comp board within 14 days of treatment or service	If payment is disputed, the Board may deny payment for failure to bill in a timely manner	30 days	25% of amount due, plus interest	Payer is expected to include in payment; if not, provider can file a claim with the workers' compensation board	No	Yes		Alaska Workers' Compensation Board	Informal conference, and if unresolved, hearing before the workers' compensation board
Arizona	2 years	No payment	30 days	Interest is due	Provider must file request	(1)			Commissioners	Formal Hearing
Arkansas	None	None	30 days	18% penalty can be assessed	The provider has to file an administrative request with the agency and the payor must either pay the penalty or deny the penalty is due	Yes			Administrative review and formal hearing	WC agency using the Director's designated authority to specifically trained staff
California	None	None	45 working days, 60 working days for governmental entities	15% penalty and 10% interest calculated per annum based on length of delay	The provider can send an additional billing to the payer for the penalty. It should be automatic, but if it isn't, the provider can request penalty from the formal adjudication process		Yes		Only the designated fact finders have the authority	A formal hearing
Colorado	120 days	The payer may deny the claim for payment	30 days	No penalty unless issue goes to a hearing and prove the payer was "willfully" delaying payment. The Administrative Law Judge can order a penalty of 8% of the delayed payment	The provider has to file a request for payment of the penalty within the formal adjudication system and a fact finder must issue an order for the payor to pay	Parties may request assistance in resolution from the Division's Medical Policy Unit or Carrier Practice Unit	Yes		Director; Medical Utilization Review Program - a retrospective paper review by three independent peer reviewers that can generate an order from the Division Director Administrative Law Judges	Administrative review or a prehearing, or a formal hearing
Connecticut	Chose not to participate in the study this year									
Delaware	None	None	30 days	A flat amount based on the length of the delay	The provider has to file an administrative request with the agency and the payor must either pay the penalty or deny the penalty is due		Yes	(2)	Only the designated fact finders have the authority	A formal hearing
District of Columbia	None	None	In a "timely" manner	Provider may file a complaint with the Office	Not applicable		Yes		Office of Workers' Compensation	Same as other disputes
Florida	None	None	45 days	(3)	Carrier shall calculate monthly for bills received during the prior period		Yes		Only the designated fact finders have the authority	Employee assistance office may attempt to facilitate a resolution or a formal hearing is required
Georgia	1 year	They waive their right to reimbursement for that treatment	30 days	10% of unpaid balance	Provider can send an additional billing to the payor			Same with peer review added	Peer Review; mediation or hearing	Mediation or formal hearing
Hawaii	2 years	Carrier does not have to pay the bill	60 days	1% per month of outstanding bill	Provider can send an additional billing to the payor		Yes		Only the designated fact finders have the authority	Administrative review; informal administrative hearing
Idaho	120 days	Provider will be ineligible to participate in dispute resolution program	30 days	Payor is precluded from disputing charges	If Provider files an administrative request for approval of disputed charge and prevails, an additional 30% of the owed amount will be ordered	Yes			WC Agency using trained administrative staff	Administrative review of submitted information
Illinois	None	None	60 days	1% interest is due per month	Provider can send an additional billing to the payor		Yes		Only the designated fact finders have the authority	Informal administrative conference or a formal hearing
Indiana	None	None	None	No penalty	None		Yes		Only the designated fact finders have the authority	A formal hearing
Iowa	None	None	None	No penalty	None	Yes			Only the designated fact finders have the authority	Arbitration; a formal hearing
Kansas	None	None	60 days	No penalty	None	Yes			ALJ can hold a hearing	Informal hearing or formal hearing
Kentucky	30 days	May not get paid	45 days	Fines and may waive right to challenge bill	The provider has to file an administrative request with the agency and the payor must either pay the penalty or deny the penalty is due		Yes		ALJ can either make a determination on pleadings or hold a hearing	Administrative review; informal conference; mediation; or hearing
Louisiana	1 year	None payment	60 days	12% of unpaid balance or $50/day for every day the amt. is outstanding up to a max. of $2000	The provider has to file an administrative request with the agency and the payor must either pay the penalty or deny the penalty is due		Yes		Only the designated fact finders have the authority	Mediation; informal or formal hearing
Maine	None	None	30 days	Flat amount based on the length of delay	The provider has to file an administrative request with the agency and the payor must either pay the penalty or deny the penalty is due		Yes		Only the designated fact finders have the authority	Mediation, informal or formal hearing
Maryland	None	None	None	None	None		Yes		Only the designated fact finders have the authority	A formal hearing
Massachusetts	None	None	None	None	None	No	Yes		M.G.L. c.152 Sec. 10	Conciliation, Conference & Hearing per M.G.L. c.152 sec. 10
Michigan	1 year	R 418.10102 Claim filing limitations. Rule 102. (1) A provider shall bill a carrier within one year of the date of service for consideration of payment. (Bill does not have to be paid)	30 days	3%	Self assessed by carrier or provider request			Usually file a 104b for medical billing issues; can also file a petition 104e; or have a small claims court hearing	(a) A magistrate. (b) The appellate commission. (c) The court of appeals. (d) The supreme court. Or they have the option of filing under small claims court	(4)

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						Separate Process For Medical Disputes Prior to Hearing	Use Same Process For All Litigation	Other		
Minnesota	60 days	Provider may be penalized by Medical Review Board; if not paid by 9 months, payment is denied	30 days	Interest and penalties	Provider files an administrative request with the agency which the carrier can pay or deny	Yes			Administrative review; informal conference; mediation; administrative conference; or formal hearing	Disputes of $7,500 or less are handled by administrative conference
Mississippi	20 days after initial treatment and then every 30 days	Reimbursement can be reduced by 1.5% for each 30 days of late billing	30 days	1.5% interest is due for every 30 days bill not paid within 30 days	Provider files an administrative request with the agency which the carrier can pay or deny	Yes			The Director -Workers' Compensation Agency using trained administrative staff	Appeal from Director's decision is to a panel of 3 commissioners - their decision is final
Missouri	None	None	None	None	None	Yes			The Director -Workers' Compensation Agency using trained administrative staff	Administrative review; informal conference; or informal hearing
Montana	None	None	30 days for hospital	None	None	Yes			Mediation	Mediation, nonbinding arbitration
Nebraska	None	None	30 days	No fee schedule or contract reductions fees must be paid as billed			Yes	If dispute is over reasonable and necessary there must be a court appointed IME)	Only the designated fact finders have the authority	Mediation or a formal hearing
Nevada	90 days	Payment may be denied.	60 days	(5)	Provider files an administrative request with the agency which the carrier can pay or deny	Yes		If an MCO is in place, it should involve a resolution process, but any party can request a hearing	Only the designated fact finders have the authority	Informal conference or formal hearing
New Hampshire	30 days (6)	(7)	30 days	A flat amount based on the length of the delay (8)	Provider files an administrative request with the agency which the carrier can pay or deny (9)		Yes		Administrative Hearing	Administrative Hearing
New Jersey	None	None	None	None	None		Yes		Workers Compensation Judge	Administrative conference; a formal hearing
New Mexico	30 days	Provider may send a notice of reconsideration to the payor; if payor refuses to pay, then a complaint maybe filed with WCA	30 days	Provider can send complaint to Agency	Provider has to file a request for payment of the penalty within the formal adjudication system and a fact finder must issue an order for the payor to pay		Yes		Division Director or he designated fact finder	Informal conference, mediation or a formal hearing
New York	90 days	The provider may not be able to collect on the bill	45 days	May be subject to interest and penalty	Provider must request an administrative award	Yes			WC Agency using delegated authority to administrative staff trained for this purpose or a special medical peer review program	Administrative review; information conference; arbitration; or a formal hearing
North Carolina	75 days	They could lose their right to payment	60 days	Interest is due on the unpaid balance after the time frame (specify the interest percentage to be paid - 10%)	The provider has to file an administrative request with the agency and the payor must either pay the penalty or deny the penalty is due	For medical billing, the medical fee section attempts an informal resolution and if unsuccessful, it goes through the usual adjudication process. For treatment issues, file a medical motion with executive secretary's office or request a hearing		We also have a specific process for regular and emergency medical motions	Only the designated fact finders have this authority (may be called Commissioners, Judges, Hearing Officers, or Magistrates	Administrative review; informal conference; mediation; informal administrative hearing; formal hearing
North Dakota	1 year	Not billable; no payment	None	None	None	Yes			WC Agency using trained administrative staff	Administrative review; informal conference; mediation; informal or formal hearing
Ohio	2 years	Bill is forever barred (10)	30 days	Interest is due if $10.00 or more (11)	Provider does not have to do anything. BWC must calculate the amount due and add to payment	Yes			Ohio Industrial Commission	MCO must try to resolve; BWC then tries to resolve; then must go to a formal hearing at Industrial Commission
Oklahoma	None	None	None	None	None		Yes		Oklahoma Workers Compensation Court	Same as other disputes
Oregon	90 days	(12)	45 days	(13)	Provider can send additional billing to payor for penalty or file an administrative request with the agency or adjudicate.	Yes			Only the WC Division Director	Administrative Review; Mediation; or formal hearing
Pennsylvania	None	None	30 days	10% interest on all past due payments and a potential of a penalty of 50% of the unpaid bill	Interest is assessed through fee review and penalty is assessed through the adjudication process			x	Hearing Officer or Workers Compensation Judge	Administrative fee review; penalty process and adjudication
Rhode Island	90 days from conclusion of tx	Payment may not be required	21 days	12% per annum	Provider can simply send a bill to the payor for the penalty		Yes		Only the designated fact finders have the authority	Informal conference or formal hearing
South Carolina	30 days	None		No penalty	None	Yes			Statutory medical review board	Administrative review of submitted information
South Dakota	None		30 days	A flat amount based on the length of the delay	Provider files an administrative request with the agency which the carrier can pay or deny		Yes		Only the designated fact finders have the authority	Administrative review of info; mediation; arbitration; or formal hearing
Tennessee	(14)	(15)	31 days	2.08% monthly (25% annual) up to $10,000	By the Commissioner	Yes			WC Director; peer reviewers; and designated fact finders	Administrative review of info; informal conference; mediation; arbitration; informal and formal hearings
Texas	95 days from date of service	Forfeiture of payment	45 days from receipt of a clean bill	Interest is due (16)	Provider files an administrative request with the agency (17)	Yes			Independent Review Organization are used (IRO)	Administrative review of submitted information with appeal to Division and OAH

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US Federal Programs - FECA	1 year beyond the end of the calendar year in which the expense was incurred or the claim was first accepted, whichever is later	No payment	None	Only billings which fall under the Prompt Pay Act (PPA), 31 U.S.C. Chapter 39	Based on requirements of the Prompt Pay Act	Yes (hold no hearings for any disputes)	No	Employee or provider can request review by District Office and appeal to Regional office	District Director with appeal to Regional Director	Employee or provider can request review by District Office and appeal to Regional office
US Federal Programs - Longshore	10 days for initial treatment only	Employer is not liable for cost of treatment. The failure to submit report within 10 days may be excused by the OWCP District Director in the interest of justice	30 days	Flat amount based on the length of delay	Provider files an administrative request with the agency which the carrier can pay or deny		Yes		Only the designated fact finders have the authority	Administrative review of info; informal conference; mediation; or formal hearing
Utah	1 year	No payment	Within 45 days of being billed	8% per annum interest may be awarded by the Commission	Upon award by the Commission		Yes		Only the designated fact finders have the authority	Mediation or formal hearing
Vermont	None	None	30 days	12% interest	Provider must file a request for review and provide documentation to both the department and the insurer		Yes		Director's designated authority to specially trained administrative staff	Mediation
Virginia	None	None	None	None	If payer unreasonably withholds payment, provider may seek attorney fees		Yes	Parties can voluntarily participate in mediation	Only the designated fact finders have the authority or peer review	Administrative review of submitted information, mediation or a formal hearing
Washington	1 year	No payment for the service	60 days	Interest would be due (in unusual cases it may be up to 1% a month)	Provider must file a request with the fact finder and an award must be ordered		Yes		The agency Medical Director and Associate Medical Directors resolve some disputes. Those not resolved by the department go to the Board of Industrial Appeals	Administrative review of submitted information, an informal administrative hearing or a formal hearing
West Virginia	180 days	Reimbursement denied	None	None	None	Yes			WC Agency using trained administrative staff or the Judges	Formal hearing
Wisconsin	None	None	60 days	No penalty	None	Yes			Only the designated fact finders have the authority	Administrative review of submitted information
Wyoming	60 days	Payment may be denied.	60 days	None	Provider to request a hearing	Yes			Director's designated authority to specially trained administrative staff or Medical Commission	Informal hearing or formal hearing

Notes:

1 Arizona - We have ombudsman and an expedited hearing process. Director or claims manager can attempt resolution.

2 Delaware - Effective 5/23/08, Delaware adopted a Health Care Payment System (HCPS), which can be accessed at www.delawareworks.com.

3 Florida - The Department of Financial Services shall impose penalties for late payments or disallowances for denials of medical, hospital,, pharmacy or dental bills that are below a minimum 95% timely performance standard. The carrier shall pay to the workers compensation Administration Trust Fund a penalty of 1) Twenty-five dollars for each bill below the 95% timely performance standard, but meeting a 90% timely standard; or 2) Fifty dollar for each bill below a 90% timely performance standard.

4 Michigan - R 418.10130 - If the provider sends a properly submitted bill to a carrier and the carrier does not respond within 30 days, and if a provider sends a second properly submitted bill and does not receive a response within 60 days from the date the provider supplied the first properly submitted bill, then the provider may file an application with the agency for mediation or hearing. The provider shall send a completed form entitled "Application for Mediation and Hearing" to the agency and shall send a copy of this form to the carrier. If a carrier adjusts or rejects a bill or a portion of the bill, then the carrier shall notify the provider within 30 days of the receipt of the bill of the reasons for adjusting or rejecting the bill or a portion of the bill and shall notify the provider of its right to provide additional information and to request reconsideration of the carrier's action. The carrier shall set forth the specific reasons for adjusting or rejecting a bill or a portion of the bill and request specific information on a form, "Carrier's Explanation of Benefits," prepared by the agency pursuant to the reimbursement section of these rules.

5 Nevada - Interest is due at a rate equal to the prime rate at the largest bank in Nevada, immediately preceding the date on which the payment was due plus 6% (NRS 616.136). There is also the possibility of an administrative fine

6 New Hampshire - 30 days No mention in law of when bill must be submitted but medical report form must be sent within 10 days of first treatment

7 New Hampshire - No reimbursement for services unless medical report sent within 10 days of first treatment Hearing officer may waive this requirement

8 New Hampshire - Up to $2500 if not paid within 30 days of receipt of bill

9 New Hampshire - Department assess fine

10 Ohio - The bill is forever barred per Ohio Administrative Code rule 4123-3-23, which states: "Fee bills requesting payment for medical or other services rendered in a claim shall be filed with the bureau or commission within two years of the date on which the service was rendered or shall be forever barred. In cases where the claim was disallowed and by later action is allowed, such fee bills shall be filed within six months from the date of the mailing of the final order allowing the claim or be forever barred. Thus, a fee bill to be timely filed, must be filed either within two years from the date services were rendered or within six months from the date of the mailing of the final order of allowance of claim, whichever period of time is longer, or be forever barred."

11 Ohio - Administrative code 4123-6-42(A) requires the "Payment will be made either thirty days after BWC, or its agent receives a proper invoice for the amount of payment due, or thirty days after the final adjudication allowing payment of an award to the claimant, whichever is later". 4123-6-42(B) requires BWC to pay the provider interest if payment is not timely made and the interest accrued is $10.00 or more. Ohio revised statute 126.30(E) specifies that " The interest charge shall be at the rate per calendar month that equals on-twelfth of the rate per annum prescribed by section 5703.47 of the)Ohio) revised code for the calendar year that includes the month for which the interest charge accrues

12 Oregon - OAR 436-009-0010(5)(b) and (c): If the billing Provider can show good cause for submission, they may submit the bill. A bill rendered over twelve months after treatment is not payable without mitigating circumstances, covered under OAR 438-009-007

13 Oregon - OAR 436-009-0030(5): Failure to pay for medical services timely may render the insurer to pay a reasonable monthly service charge for the period payment was delayed, if the provider generally levies such a service charge to the general public.

14 Tennessee - Carriers must provide an explanation of medical benefits to the health care provider whenever the carrier's reimbursement differs from the amount billed. A carrier must date-stamp medical bills and reports upon receipt.

15 Tennessee - L. Penalties for Violations Under the Medical Fee Schedule, civil penalties may be assessed by the Commissioner, at his discretion, up to $10,000.00. Although the Fee Schedule became effective July 1, 2005, these penalty provisions did not become effective until January 1, 2006, and will not be retroactive, that is, they are not applicable to violations pre-January 1, 2006. See Rules 0800-2-17-.01(1), 0800-2-17-.13, 0800-2-.92(b)4, & 5. and 0800-2-18-.15.

16 Texas - Interest is calculated as the treasury constant maturity rate for 1 year treasury bills published by the Federal Reserve Board plus 3.5% if payment is made after the 60th day

17 Texas - Division monitors and audits to detect non-compliance.

(4) how charges for medical services provided for treatment to Virginia claimants in foreign jurisdictions are determined to be appropriate under Virginia law

In Virginia, absent an applicable PPO contract, the usual prevailing community rate analysis is employed, even if the foreign jurisdiction has adopted a fee schedule for workers' compensation cases. In the case of Mullins v. Kyn Coal Corp., VWC File No. 236-10-44 (Sept. 2, 2009), the Commission stated:

> We next examine the defendants' argument that the prevailing community rate should be defined by the Tennessee Workers' Compensation fee schedule. We find no error in the Deputy Commissioner's analysis below.
>
> Rule 14 of the Virginia Workers' Compensation Act provides that, "[w]henever an employee receives treatment outside of the Commonwealth, the Commission will determine the appropriate community in the state or territory where the treatment is rendered upon application of either the employee, employer (or its representative), or medical provider." In this case, the Deputy Commissioner designated Community Area 2 combined with GEOZIP 376 as the appropriate community.
>
> Upon the finding of the appropriate community in this case, the Deputy Commissioner further determined that "the charge data must relate to the rate that would be paid by a self-paying injured person in the community." (Op. at 5). As noted above, according to Section 65.2-605, the determination of prevailing community rate shall be limited to such charges as prevail in the same community for similar treatment when such treatment is paid for by the injured person. Therefore, the prevailing community rates in this area are not necessarily equivalent to the rates that are set forth in the Tennessee fee schedule. The Tennessee fee schedule only applies to individuals seeking benefits under the Tennessee Workers' Compensation Act, not individuals who are seeking benefits under the Virginia Workers' Compensation Act. We agree with the Deputy Commissioner that the Tennessee fee schedule is simply not applicable in this case.

States and Regions that Border Virginia

Summary

We have concentrated on the five states that border Virginia - Kentucky, Maryland, North Carolina, Tennessee, and West Virginia - and the District of Columbia. A summary of each state/region's rules regarding reimbursement of out-of-state providers appears below followed by an informational table.

North Carolina, Kentucky, Tennessee, and West Virginia all have provisions governing the method of reimbursement for out-of-state providers. The District of Columbia has no written rule on this issue but reimburses out-of-District providers in the same manner as in-District providers. Maryland has no provision governing out-of-state providers.

Kentucky

Kentucky has specific regulations governing reimbursement of medical providers located outside of Kentucky. Kentucky's medical fee schedule governs all medical services provided to injured Kentucky workers by physicians. 803 KAR 25:089. A physician or healthcare provider located outside the boundaries of Kentucky who accepts a Kentucky workers' compensation patient "shall be deemed to have agreed to be subject to" Kentucky administrative regulation. Id. Medical fees due an out-of-state physician or medical services provider are calculated under the fee schedule in the same manner as for an in-state physician. Id. Likewise, a hospital or ambulatory surgery center located outside Kentucky is deemed to have agreed to be subject to the Kentucky regulations governing payment of workers' compensation providers if it accepts a Kentucky workers' compensation patient. 803 KAR 25:091.

803 KAR 25:089 provides:

> Section 4. (1) A physician or healthcare or medical services provider located outside the boundaries of Kentucky shall be deemed to have agreed to be subject to this administrative regulation if it accepts a patient for treatment who is covered under KRS Chapter 342.
>
> (2) Pursuant to KRS 342.035, medical fees due an out-of-state physician or healthcare or medical services provider shall be calculated under the fee schedule in the same manner as for an in-state physician.

803 KAR 25:091 provides:

> Section 6. Calculation for Hospitals and Ambulatory Surgery Centers Located Outside the Commonwealth of Kentucky.
>
> (1) A hospital or ambulatory surgery center located outside the boundaries of Kentucky shall be deemed to have agreed to be subject to this administrative regulation if it accepts a patient for treatment who is covered under KRS Chapter 342.

(2) The base cost-to-charge ratio for an out-of-state hospital shall be calculated in the same manner as for an in-state hospital, using Worksheets A and G-2 of the HCFA 2552.

(3) An out-of-state ambulatory surgery center having no contiguous Kentucky counties shall be assigned a cost-to-charge ratio equal to seventy (70) percent of the average adjusted cost-to-charge ratio of all existing in-state acute care hospitals.

(4) An out-of-state ambulatory surgery center having one (1) or more contiguous Kentucky counties shall be assigned a cost-to-charge ratio in accordance with Section 5(1)(c)2.b. of this administrative regulation.

Maryland

Maryland does not have specific statutory or regulatory guidelines for out-of-state medical providers. The statutes define a medical provider as someone licensed under the Maryland statute. The Maryland Workers' Compensation Commission has the authority to regulate the Maryland Fee Guide, Md. Code Ann. Lab. & Empl. § 9-663; however, the code does not contain provisions for out-of-state providers. Guidelines for medical providers and all other fee provisions are outlined in the regulations.

Washington, D.C.

The District of Columbia does not have a fee schedule. Health care providers are paid at 113% of Medicare. Injured workers are permitted to seek treatment from a health care provider of their choice. There is no provision governing out-of-District providers. According to a representative of the Office of Workers' Compensation, out-of-District providers are reimbursed in the same manner as in-District providers. All providers will be reimbursed at 113% of the Medicare fee for those services. D.C. Mun. Regs. tit. 7, ch. 2 (2010).

The District of Columbia municipal regulations governing private section workers' compensation program provide:

> **212 MEDICAL SERVICES AND SUPPLIES**
>
> 212.1 Under §8(a) of the Act [§36-307(a), D.C. Code 1981], the employer of an injured employee shall furnish medical services and supplies for that period of time as the nature of the injury or the process of recovery may require.
>
> 212.2 Under §8(b)(3) of the Act [§36-307(b)(3),D.C. Code, 1991 Supplement], an injured employee has the right to choose any attending or treating physician on or after March 6, 1991 subject to the provisions of §212.13 of this Chapter.
>
> 212.3 If there is need for immediate treatment and, due to the nature of an injury, the injured employee is unable to select a physician, the employer may select a physician to provide initial treatment to the employee. Provided, however, that for purposes of §212.12 of this section, a physician selected by the employer shall not be considered to have been selected by the employee.
>
> ....
>
> 212.14 Medical care, services, and supplies provided on or after April 16, 1999 shall be billed by the provider at 113% of Medicare's reimbursement amounts.

North Carolina

According to North Carolina policy, contained on the North Carolina Industrial Commission's website, out-of-state providers are generally paid in full or according to their own state guidelines. http://www.ic.nc.gov/faqs.html#medfeefaq

The website states as follows:

> **I am an out-of-state medical provider. Am I required to accept medical rates as established by the N.C. Medical Fee Schedule when I treat patients for a N.C. claim?**
>
> No. You are allowed to bill charges in full or based on a prior agreement if one has been established. If one has not been established, expect reimbursement pursuant to your state's fee schedule.
>
> **Do insurers and self-insurers have to send *all* bills to the Industrial Commission?**
> No, they do not. Insurers and self-insurers may pay the following bills without submitting them to the Industrial Commission for approval:
>
> ...
>
> - **Out-of-state claims or providers—pay in full or per agreement or by your state's fee schedule.**
>
> ...

Tennessee

Under Tennessee regulations, out-of-state medical providers who render medical services to Tennessee claimants must agree to abide by Tennessee's fee schedule rules. Tenn. Comp. R. & Regs. 0800-02-17-.18. This section provides:

> **0800-02-17-.18 OUT-OF-STATE PROVIDERS.**
>
> All medical services provided by out-of-state providers must be made by providers who agree to abide by the Division's Medical Fee Schedule Rules, In-patient Hospital Fee Schedule Rules and Medical Cost Containment Program Rules.

West Virginia

In West Virginia, out-of-state medical providers are reimbursed pursuant to West Virginia reimbursement guidelines subject to exceptions for emergency care or if care is unavailable in the claimant's area. A claimant may be personally liable for the difference between the scheduled fee amount and the amount demanded by the out-of-state provider.

West Virginia's fee schedule provides:

> WORKERS' COMPENSATION
> OUT-OF-STATE HEALTH CARE SERVICES
>
> Effective: July 1, 2009
>
> The WV Offices of the Insurance Commissioner (OIC) fee schedule methodology serves as a "maximum allowable" and is applied to all workers' compensation medical care except for care provided under an OIC approved Managed Health Care Plan (exempt from the fee schedule). If out-of-state care is utilized WV fee reimbursement guidelines would apply subject to the exceptions noted in WV Code §23-4-3 (including §23-4-3.(a)(4)) and every effort should be made by all parties to agree on reimbursement prior to rendering service.
>
> See WV Code at:
> http://www.legis.state.wv.us/WVCODE/code.cfm?chap=23&art=1
>
> Additional issues may be carrier/payor specific.

W Va. Code § 23-4-3 provides:

> (4) In the event that a claimant elects to receive health care services from a health care provider from outside of the state of West Virginia and if that health care provider refuses to abide by and accept as full payment the reimbursement made by the Workers' Compensation Commission, and effective upon termination of the commission, all private carriers and self-insured employers or their agents, pursuant to the schedule of maximum reasonable amounts of fees authorized by this subsection, with the exceptions noted below, the claimant is personally liable for the difference between the scheduled fee and the amount demanded by the out-of-state health care provider.

(A) In the event of an emergency where there is an urgent need for immediate medical attention in order to prevent the death of a claimant or to prevent serious and permanent harm to the claimant, if the claimant receives the emergency care from an out-of-state health care provider who refuses to accept as full payment the scheduled amount, the claimant is not personally liable for the difference between the amount scheduled and the amount demanded by the health care provider. Upon the claimant's attaining a stable medical condition and being able to be transferred to either a West Virginia health care provider or an out-of-state health care provider who has agreed to accept the scheduled amount of fees as payment in full, if the claimant refuses to seek the specified alternative health care providers, he or she is personally liable for the difference in costs between the scheduled amount and the amount demanded by the health care provider for services provided after attaining stability and being able to be transferred.

(B) In the event that there is no health care provider reasonably near to the claimant's home who is qualified to provide the claimant's needed medical services who is either located in the state of West Virginia or who has agreed to accept as payment in full the scheduled amounts of fees, the commission, upon application by the claimant, may authorize the claimant to receive medical services from another health care provider. The claimant is not personally liable for the difference in costs between the scheduled amount and the amount demanded by the health care provider.

W. Va. Code of State Rules §85-20-5.10 provides:

5.10. Out-of-State Providers. If an injured worker elects or is directed to receive health care services from an out-of-state provider, and that provider does not accept the Commission's insurance commissioner's, private carrier's or self-insured employer's, whichever is applicable, fee as payment in full, then the injured worker may be liable for the difference between the payment and the amount charged by the out-of-state health care provider.

TABLE 6 PAYMENT OF OUT-OF-STATE PROVIDERS – BORDER STATES

State/ Region	Reference	How Out-of-State Healthcare Providers are Paid
Washington, D.C.	http://www.workerscompensation.com/regulations/stateitem.php?ID=90220&state=dc&Parent=90220 http://does.dc.gov/does/cwp/view.asp?a=1232&Q=537428	Out-of-District providers are reimbursed in the same manner as any provider – 113% of Medicare.
Kentucky	http://www.labor.ky.gov/workersclaims/	Governed by Kentucky fee schedule
Maryland	http://www.wcc.state.md.us/MFG/Medical_Providers.html http://www.wcc.state.md.us/PDF/MFG/COMAR_MFG_Reg_2008.pdf.	No provisions governing out-of-state providers
North Carolina	http://www.ic.nc.gov/ http://www.ic.nc.gov/faqs.html#medfeefaq	By agreement or according to provider's state fee schedule
Tennessee	http://www.tennessee.gov/sos/rules/0800/0800-02/0800-02-17.20090826.pdf	Governed by Tennessee fee schedule
West Virginia	http://www.wvinsurance.gov/ http://www.legis.state.wv.us/WVCODE/code.cfm?chap=23&art=1 http://beta.wvinsurance.gov/LinkClick.aspx?fileticket=cytkVIQ-RsM%3d&tabid=372&mid=994	West Virginia fee reimbursement guidelines apply subject to exceptions.

SECTION TWO

METHODS OF REIMBURSEMENT – OTHER STATE APPROACHES

Methods of Reimbursement

In 2009, 43 states had workers' compensation non-hospital medical fee schedules. *See* Nicole M. Coomer & Te-Chun Liu, *Benchmarks for Designing Workers' Compensation Medical Fee Schedules: 2009* (Workers Compensation Research Institute, Boston, Mass.) (June 2010) [hereinafter *Benchmarks*], reprinted with permission at Appendix D.

Only a handful of states do not utilize some form of fee schedule for reimbursement of workers' compensation medical costs. These non-fee schedule states use statutory language such as "reasonable value," "usual and customary," or charges that "prevail in the same community." These states use their workers' compensation administrative agencies to resolve fee disputes between health care providers and payers.

All of the states that border Virginia have some form of fee schedule. Several of these states also authorize the formation of managed care organizations that are exempt from the fee schedule and contract separately with healthcare providers.

Fee Schedules

"Over the past three decades, medical benefits have grown faster than indemnity, and [workers' compensation] physician fee schedules have become a standard way to control [workers' compensation] medical costs." Barry Lipton, Dan Corro, Natasha Moore, & John Robertson, *Technical Paper: Effectiveness of WC Fee Schedules A Closer Look* (NCCI Feb. 2009) [hereinafter *Technical Paper*] at 3. Currently, 43 states have fee schedules, and many states model or base their fee schedules on Medicare's physician reimbursement schedule.

Medicare's fee schedule dictates amounts (fixed prices) it reimburses participating physicians for specific procedures based on CPT codes. These codes, assigned by the American Medical Association, provide very detailed itemization of medical procedures. CPT codes are the industry standard in group health and Medicare. Barry Lipton, John Robertson, & Dan Corro, *Medicare and Workers Compensation Medical Cost Containment* (NCCI Jan. 2010) [hereinafter *Cost Containment*] at 7. Most state workers' compensation medical fee schedules use CPT coding.

Medicare reimbursements are designed from three components: the Conversion Factor (CF), the Relative Value Unit (RVU), and the geographic variation in rates. *Benchmarks* at 6. "Essentially, the CF is a number that converts value units into current dollar amounts." *Cost Containment* at 7. Medicare uses a single conversion factor for all CPT codes and updates that factor annually. RVUs measure three kinds of resources: (1) work – the physician's time and skills; (2) practice - office staff salaries, rent, supplies, equipment, etc.; and (3) malpractice insurance. The geographic variation in rates is adjusted for each state (or part of a state) using geographic practice cost indices for each of the RVU resources in each state (or part of a state). *Benchmarks* at 6-7.

Medicare's system for determining RVUs is the Medicare Resource-Based Relative Value Scale (RBRVS). *Id.* States may use the Medicare RBRVS[1] or their own Relative Value Scale (RVS).[2]

Unlike Medicare, state fee schedules do not set specific fixed reimbursement amounts. Rather, state fee schedules set maximum allowable reimbursement amounts (MARs) for medical procedures covered by workers' compensation insurance. *Technical*

[1] In 2009, 25 states based their fee schedules on the Medicare RBRVS system. *Benchmarks* at 7.
[2] In 2009, seven states used some other form of RVU system. *Id.*

Paper at 2; *Cost Containment* at 7. State fee schedules generally allow a higher maximum fee than the Medicare reimbursement amount for most procedure codes. John Robertson & Dan Corro, *Making Workers Compensation Medical Fee Schedules More Effective* (NCCI Dec. 2007) at 2 [hereinafter Robertson 2007].

The Medicare RBRVS is used by many states as the starting point for their workers' compensation fee schedules. States use the Medicare RBRVS in various ways. Some states (such as West Virginia) specify the MAR as a percentage of the Medicare rate. Other states (such as Maryland) use the Medicare RVUs but apply their own conversion factors, often varying the CF by service area.[3]

States that do not use the Medicare RBRVS base their MARs on usual and customary charges gleaned from medical fee databases created specifically for this purpose.[4] *Cost Containment* at 8. This approach "relates the scheduled amounts with usual and customary charges" and "entails periodic data collection and analysis." *Technical Paper* at 2.

There is considerable variation in the approaches states take to promulgate workers' compensation fee schedule. "Promulgation of a WC medical fee schedule represents a major commitment for the administrative body of a state WC system." *Technical Paper* at 2. Determining the basis for a fee schedule is very important. Setting a price for a procedure too low causes providers to make up the difference in volume of services. Setting a price too high may produce an incentive to utilize certain procedures too often. *Id.* at 6. Fee schedules also add administrative costs to insurers.

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[3] 32 states with relative value systems used more than one conversion factor across service areas. *Benchmark* at 7.

[4] According to NCCI, these databases are expensive to build, to implement, and to update. Moreover, there is concern over possible "legal challenges to basing reimbursement on usual and customary charges derived from insurance industry data." *Cost Containment* at 8.

NCCI has concluded that there is an increasing reliance on Medicare reimbursement rates as the benchmark in both group health and workers' compensation. NCCI suggests that the Medicare fee schedule "is very useful as a starting point for the design of WC medical fee schedules, but has notable shortcomings for WC, including too little emphasis on return to function and too little sensitivity to cost differences among states." *Technical Paper* at 1.

NCCI has also found a declining percentage of workers' compensation medical costs that come under the purview of the traditional physician fee schedule because of the growing use of hospital staff and ambulatory surgical centers. *Cost Containment* at 24. There is more billing by facilities that do not fall under the fee schedule. There is also more bundling of services where payment is for treatment of a medical condition rather than for individual procedures. *Technical Paper* at 2-3. Medicare has adapted to this by requiring facilities to assign Diagnosis Related Groups (DRGs) for inpatient care and Ambulatory Payment Classifications (APCs) for outpatient surgery. *Id.* at 3; *Cost Containment* at 24. NCCI suggests that "in order to better control the cost of care provided by hospitals and other outpatient care facilities, fee schedules must incorporate more bundling of services" and consider using Medicare billing approaches such as DRGs and APCs. *Technical Paper* at 3.

The WCRI conducts a benchmark study to aid states in designing workers' compensation medical fee schedules. The 2009 study compared each state workers' compensation fee schedule to the Medicare fee schedule in that state and referred to this comparison as "premium over Medicare." *Benchmarks* at 13. The study showed premium over Medicare for each state for eight service groups – emergency services,

evaluation and management, major radiology, minor radiology, neurological testing, physical medicine, major surgery, and surgical treatment. The study found a range of premiums over Medicare from as low as 8 percent over Medicare in Massachusetts to as high as 215 percent over Medicare in Alaska. Only nine of the 43 states with fee schedules set rates that resulted in the premium over Medicare being relatively the same for each of the service groups. In most states, the premium over Medicare varied substantially across the service groups.

WCRI compared the premium over Medicare for major surgery with the premium over Medicare for evaluation and management as well as physical medicine services. Only five states had premiums within 11 percentage points of one another. Seven states set service rates for evaluation and management and physical medicine at premiums over Medicare that were more than 200 percentage points less than the premium over Medicare for major surgery. *Id.* at 24. All of this suggests that there is an incentive to utilize more invasive procedures. WCRI found that "[t]ypically more invasive and specialty care is reimbursed at a higher premium over Medicare in workers' compensation fee schedules, which may result in distorted utilization incentives toward more invasive specialty care." *Id.* at 24. WCRI concluded that keeping the premium over Medicare substantially the same across service groups "may neutralize some utilization incentives for invasive and specialty care." *Id.* at 29.

The WCRI study also found that some states were below or very close to the Medicare rates for some service areas. WCRI suggests that these states may have set fee schedule rates too low, creating potential access to care issues. *Id.* at 27.

An NCCI study found similar results. NCCI concluded that many states with fee schedules reimburse radiology and surgery at higher levels, relative to Medicare, than other medical services. Robertson *2007* at 2. Another NCCI study found that workers' compensation reimbursement levels were consistently above those of group health insurance for surgery and radiology while workers' compensation levels for physical medical, for general medicine, and for evaluation and management were at or near group health reimbursement rates. *Technical Paper* at 2.

States without Fee Schedules

In Indiana, charges are limited to such charges as prevail in the same community for a like service or product to injured persons. Indiana uses an 80th percentile standard and places the burden of proof on the employer to prove whether charges exceeded the 80th percentile threshold. Ind. Code § 22-3-3-5 (2010).

In Iowa, medical fees must be "reasonable." If a dispute arises regarding the reasonableness of a fee for medical services, the parties must engage in informal dispute resolution procedures. Iowa Code § 85.27(3) (2010).

In Missouri, fees and charges must be "fair and reasonable," and are subject to regulation by the commission. A health care provider must not charge a fee for treatment greater than the "usual and customary fee the provider receives for the same treatment or service when the payor for such treatment or service is a private individual or a private health insurance carrier." Mo. Rev. Stat. § 287.140(3) (2010).

In New Hampshire, the employer or carrier are to pay the full amount of the health care provider's bill unless the employer or carrier can show just cause as to why

the total amount should not be paid. The parties are to make efforts to resolve any dispute as to the "reasonable value of service" prior to applying to the commissioner for resolution. N.H. Rev. Stat. Ann. § 281-A:24(I) (2010).

New Jersey workers' compensation law provides that "[a]ll fees and other charges for such physicians' and surgeons' treatment and hospital treatment shall be reasonable and based upon the *usual fees and charges which prevail in the same community for similar physicians', surgeons' and hospital services*." N.J. Stat. Ann. § 34:15-15 (emphasis added).

The Wisconsin workers' compensation statute provides for the establishment of a formula to determine whether a fee charged by a health care provider is reasonable. After a fee dispute is submitted to the Department of Workforce Development (department), the insurer or self-insured employer provides the department with information on fees charged by other health service providers for comparable services. This information must be obtained from a database certified by the department. The department uses that information to determine the reasonableness of the disputed fee. If the disputed fee is "at or below the mean fee for the health service procedure...plus 1.5 standard deviations from that mean," the department shall determine that a disputed fee is reasonable. Unless the health care provider proves to the satisfaction of the department that a higher fee is justified because the service provided in the disputed case was more difficult or more complicated to provide than in the usual case, the department makes a determine that a disputed fee is unreasonable and orders that a reasonable fee be paid. Wis. Stat. § 102.16(2) (2010).

Summary of Border States/Regions

All of the states that border Virginia have some form of fee schedule. Kentucky, Maryland, Tennessee, and West Virginia all base their fee schedules on Medicare RBRVS (Resource-Based Relative Value System) with multiple conversation factors. Washington, D.C. does not have its own fee schedule but uses the Medicare fee schedule and authorizes reimbursement to medical providers at 113% of the Medicare fee.

Several of Virginia's border states, including Kentucky, North Carolina, Tennessee, and West Virginia, have legislation providing guidelines for the creation of state-approved managed care organizations (MCO). The MCOs must meet certain criteria and are not subject to the state's medical fee schedule because the MCOs contract with healthcare providers for payment of services. Table 7 contains a summary of the border states/region's fee schedule basis as well as whether that state has MCO legislation.

FEE SCHEDULES AND MANAGED CARE ORGANIZATIONS
STATES THAT BORDER VIRGINIA

TABLE 7

State/Region	**Does state have Managed Care Plan legislation?**	**Basis of Fee Schedule**	**Website**
Kentucky	Yes – approved managed care organizations are exempt from fee schedule	Medicare RBRVS x conversion factors	Fee Schedule http://www.labor.ky.gov/workersclaims/ MCO - http://www.labor.ky.gov/workersclaims/medicalservices/managedcare.htm
Maryland	No	Medicare RBRVS x conversion factors depending on service area	http://www.wcc.state.md.us/MFG/Medical_Fee_Schedule.html
North Carolina	Yes - MCOs are not subject to the medical fee schedule	Uses CPT codes for each area of medicine and uses multiple conversion factors based on area	Fee Schedule - http://www.ic.nc.gov/ncic/pages/feesched.asp MCO - http://www.ic.nc.gov/ncic/pages/mgdcare.htm
Tennessee	Yes – MCO contract governs fees but cannot exceed fee schedule amount	Medicare RBRVS x multiple conversation factors depending on service area	Fee Schedule - http://www.tennessee.gov/sos/rules/0800/0800-02/0800-02-18.20090826.pdf MCO - http://www.tennessee.gov/sos/rules/0800/0800-02/0800-02-07.pdf
West Virginia	Yes – approved MCOs are exempt from fee schedule	Maximum Medicare Reimbursement x 1.35	Fee Schedule – http://www.wvinsurance.gov/Default.aspx?tabid=372 MCO - http://www.wvinsurance.gov/Default.aspx?tabid=254
Washington, D.C.	No	113% of Medicare Fee Schedule	http://www.wvinsurance.gov/Default.aspx?tabid=372

Kentucky

Fee Schedule

Under Kentucky's Medical Fee Schedule for Physicians, the appropriate fee for a medical procedure is computed by multiplying a relative value unit for the medical procedure by the applicable conversion factor. This fee is the maximum fee allowed for the service provided. 803 KAR 24:089(3).

The Kentucky statute requires that every two years the Commissioner of the Department of Workers' Claims "adopt a schedule of fees for the purpose of ensuring that all fees, charges, and reimbursements under KRS 342.020 and this section shall be fair, current, and reasonable and shall be limited to such charges as are fair, current, and reasonable for similar treatment of injured persons **in the same community for like services, where treatment is paid for by general health insurers.**" Ky. Rev. Stats. Ann. § 342.035(1) (emphasis added).

Pursuant to that statute, the Department promulgated 803 KAR 25:089. This administrative regulation establishes the medical fee schedule for physicians. The Kentucky Workers' Compensation Medical Fee Schedule for Physicians governs "all medical services provided to injured employees by physicians. The schedule also applies to other health care or medical services providers to whom a listed CPT code is applicable unless:

> (a) Another fee schedule of the Department of Workers' Claims applies; (b) A lower fee is required by KRS 342.035 or a managed care plan approved by the commissioner pursuant to 803 KAR 25:110; or (c) An insurance carrier, self-insured group, or self-insured employer has an agreement with a physician, medical bill vendor, or other medical provider to provide

reimbursement of a medical bill at an amount lower than the medical fee schedule.

The Department also promulgated 803 KAR 25:091, which establishes the workers' compensation hospital fees for services and supplies provided to workers' compensation patients, and 803 KAR 25:092, which establishes the workers' compensation pharmacy fee schedule.

Managed Care Plans

In 1994, Kentucky established standards for managed care plans. 803 KAR 25:110. These approved plans are exempt from the state's fee schedule. Kentucky has numerous regulations governing the formation of MCOs which are outlined on its website, a section of which is attached below.

Managed Care
KY Agencies | KY Services Search
La~or,ky.g_o.v

for ...

of Workers' Claims> Medical Services
Last Modified: 6/21/2010

Managed Care Providers
Reporting Requirements

Approved Managed Care Organizations

Of all the medical cost-containment measures enacted in the amendment of KRS 342.020 in 1994, managed care is of the most historical significance. For the first lime employers are granted input into the matter of physician selection through managed care plans approved by the commissioner. Employees still have choice of physician but within the confines of the provider network. (803 KAR 25:110) The Administrative Regulation establishing the standards for managed care plans was adopted on July 15, 1994, The first plan was approved in October and by November 1994, Kentucky workers were being treated under approved plans. Managed care emphasizes controlling utilization through gatekeeper physicians, pre-certification of services, strong case management and coordination of medical treatment and return-to-work policies. Internal grievance procedures are required. Managed care affords insuring interests a strong voice in selecting network providers and results in the exclusion of some physicians from the workers compensation process whose practice patterns have proven to be outside of the norm as to utilization or outcomes.

Any managed care system may file a managed care plan for approval with the commissioner for the Department of Workers' Claims. Systems may operate more than one managed care plan. Employers and insurers may contract with multiple systems in order to maximize employee access. There is no application form nor application fee. Applications for certification must contain all the components of the regulation.

Plans are reviewed for compliance with the regulation. Some of the key requirements are:

- Identify the system and its components. Identify the key personnel including plan administrator, medical director (must have a Kentucky medical license) and case manager (must hold Kentucky certification).
- Demonstrate financial ability and professional expertise to perform all necessary functions. If applicants have previously provided managed care or similar services in the commonwealth, they must provide a summary of the administrative and medical services provided to which clients. If the applicant does not provide managed care in Kentucky, a performance bond or cash surety deposit of $500,000 will be required. A copy of the most recent audited financial statement is also required.
- The plan must demonstrate it will provide prompt and effective access to qualified medical services. The employees must have adequate choice and convenient geographic access to gatekeepers, specialists and facilities.

Conditions pre-requisite to out-of-plan provider access are:

- Emergency. Emergency means those medical services required for the immediate diagnosis or treatment of a medical condition that if not immediately diagnosed or treated could lead to serious physical or mental disability or death, or medical services that are immediately necessary to alleviate severe pain. "Emergency care" does not include follow-up care, except when immediate care is required to avoid serious disability or death. Employees who receive emergency care may elect to remain under the care of that physician as long as he or she complies with the utilization review and reporting requirements of the plan. Reimbursement of the non-plan providers will be at the level prescribed by applicable workers' compensation fee schedules.
- When referred by gatekeeper.
- When authorized treatment is unavailable within the plan.
- For a second opinion when surgery is recommended.
- When treatment is received for a work-related injury or disease prior to the plan being implemented with that employer, an employee may continue with that physician until treatment ends or until he or she changes physicians. Then the employee must choose a physician within the plan.

The plan must have the following:

- A grievance procedure.
- Provide utilization review and medical bill audit.
- Contracted medical fees.

Provide specimens of information materials and a toll-free phone number available 24 hours a day to inform all parties about plan operations, after-office-hours care and 24-hour access to emergency care.

Provide aggressive case management to coordinate the delivery of health services and return-to-work policies to promote an appropriate, prompt return to work and facilitate communication among the employee, employer and health care providers. The plan shall also describe the circumstances under which injured employees shall be subject to case management and the services to be provided.

To review 803 KAR 125:110, click here.

For more information, please contact Marilyn Thompson, Managed Care, Department of Workers' Claims, 502-782-4539; e-mail Marilyn.Thompson@ky.gov

Department of Workers' Claims
657 Chamberlin Avenue
Frankfort KY 40601
Phone: 502-564-5550
E-mail: Department of Workers' Claims

Maryland

Maryland utilizes the Medicare RBRVS, exclusive of the Federal Budget Neutrality Adjustment Factor, as the basis for calculating reimbursement rates for medical services and treatment. COMAR 14.09.03. Maryland uses the following formula for medical services and treatment (excluding anesthesiology and Ambulatory Surgical Centers):

> RBRVS relative value unit (("RVU") x geographic price cost index ("GPCI")) for each code multiplied by the applicable Maryland Specific Conversion Factor ("MSCF"):
>
> **Non-facility MRA = ((RVU Work x GPCI Work) + (RVU Transitioned Non-Facility PE x GPCI PE) + (RVU MP x GPCI MP)) x MSCF.**

Currently, Ambulatory Surgical Centers (ASC) facility fees are reimbursed by multiplying the ASC Medicare Reimbursement Rate by 128.396%

Maryland annually updates its fee schedule. On January 1 of each year, the Commission establishes a new MSCF by multiplying the MSCF in effect on December 31 of the prior year by the percentage change in the first quarter Medicare Economic Index ("MEI") and adding that amount to the prior year's MSCF. The Commission also annually establishes a new percentage multiplier for ASCs by multiplying the prior year's multiplier by the percentage change in the first quarter MEI and adding that amount to the prior year's multiplier.

For example, MSCF/Multipliers for services between January 1, 2010, and December 31, 2010, are as follows:

The Medicare Economic Index (MEI) for the first quarter of CY 2010 is +1.0%.

Medical services & treatment 2010 MSCF = $41.80
($41.39 X 1.0%) = .4139
($41.39+ .4139)= $41.80

Orthopedic & Neurological Surgical services 2010 MSCF = $55.23
($54.68 X 1.0%)= .5468
($54.68 + 0.5468)= $55.23

Anesthesiology Services MSCF = $19.92
($19.72 x 1.0%) = .1972
($19.72 + 0.1972)= $19.92

Ambulatory Surgical Center (ASC) 2010 is calculated as below
2010 MEI x 2009 ASC percentage multiplier
(1.0% x 127.125%) = 1.27125
(1.27125 + 127.125%)= 128.396%

2010 ASC Medicare Reimbursement Rate x 128.396%

North Carolina

North Carolina uses a fee schedule for all CPT codes provided by the American Medical Association. The fees are those which are the maximum allowed to be charged for treatment of injured workers under the North Carolina Workers' Compensation Act. If the usual and customary fees are less than this schedule, then the usual and customary fees must be used. Managed Care Organizations are not subject to the Medical Fee Schedule.

The North Carolina Fee Schedule contains the following sections: 1) evaluation and management; 2) anesthesia; 3) surgery; 4) radiology; 5) pathology and laboratory; 6) medicine; 7) special services; 8) physical medicine; 9) chiropractic fee schedule; 10) industrial rehabilitation; 11) dental fee schedule; 12) hospital and ambulatory surgical

center; and 13) durable medical equipment/supply fee schedule. North Carolina uses CPT codes for each area of medicine and uses multiple conversion factors based on area of medicine. For example, the most recent updated schedule provides that fees are calculated for general medicine based on North Carolina Medicare values x 1.58 and for physical medicine based on North Carolina Medicare values x 1.30. The North Carolina Fee Schedule Data uses six columns – total fee; follow-up days included in a surgical procedure's global charge; physician component; technical component; a split component; and the CPT code from the AMA.

Tennessee

Fee Schedule

Tennessee uses a Medical Fee Schedule based on Medicare's RBRVS. The fees are a cap over which a payer or medical provider cannot exceed without facing civil penalties. Tennessee encourages contracts between payers and providers. Tennessee mandates that reimbursement should be the lesser of the provider's usual charge, the maximum fee set in the schedule, or the contracted amount (including MCO contracts).

The introduction to Tennessee's Medical Fee Schedule states:

> Unlike fee schedules in some other states, Tennessee's Medical Fee Schedule does not set an absolute fee for services, but instead, sets a maximum amount that may be paid. Providers and payers are encouraged to negotiate amounts below the maximum set in the Medical Fee Schedule, but shall not pay an amount above the Fee Schedule maximum amount. A payer paying in excess of the Fee Schedules and a provider retaining excessive reimbursement over 90 days is a violation of the Fee Schedule Rules and may result in penalties up to a $10,000.00 civil penalty against both payer and provider, among other measures, based on the Commissioner's (or the Commissioner's Designee's) discretion. *See* Rule 0800-2-18-.02(2)(b)(4.)

> The Medical Fee Schedule applies to ***all*** medical services and medical equipment or supplies. Reimbursement to all providers ***shall be the lesser of***: (1) the provider's usual charge, (2) the maximum fee schedule under these Rules, or (3) the MCO/PPO or any other negotiated and contracted amount. *See* Rule 0800-2-18-.02(b). **This lesser of comparison must be done on the total bill or amount due, NOT a line-by-line comparison of items.**
>
> When there is no specific methodology in these Rules for reimbursement, the maximum reimbursement is 100% of Medicare. Whenever there is not Medicare methodology, maximum reimbursement is Usual & Customary or U & C (80% of billed charges). *See* Rule 0800-2-18-.02(a).
>
> Procedure codes for unlisted procedures should only be used when there is no procedure code which accurately describes the services rendered. These codes require a written report and are paid at a maximum allowable amount of usual and customary (80% of billed charges.) *See* Rule 0800-2-17-.06.
>
> Unless otherwise stated in the Rules, the current effective Medicare procedures and guidelines are to be used. *See* Rule 0800-2-18-.02(a).

Medical Case Management

Tennessee rules allow an insurer or self-insured employer to provide for a system of case management for compensable injuries. Tenn. Comp. R. & Regs. 0800-2-7-.02. The Medical Fee Schedule and Medical Cost Containment Program:

> Establish procedures by which a health care provider shall be paid the lesser of: (1) the provider's usual bill, (2) the maximum fee established under these Rules, or (3) the MCO/PPO or any other negotiated and contracted or lower price, where applicable. In no event shall reimbursement be in excess of these Rules.
>
> Rule 0900-02-17-.01(c).

Washington, D.C.

Washington, D.C. does not have its own fee schedule but uses the Medicare fee schedule and authorizes reimbursement at 113% of the Medicare fee. There is no provision in this region's law for formation of managed care organizations.

West Virginia

Fee Schedule

West Virginia's Workers' Compensation Schedule of Maximum Allowed Medical Reimbursement is updated July 1 of each year. The fee schedule serves as a "maximum allowable" and is applied to all workers' compensation medical care except for care provided under a West Virginia Offices of the Insurance Commissioner (OIC)-approved Managed Health Care Plan exempt from the fee schedule.

West Virginia uses the Medicare RBRVS + 35% for all listed procedures. The regulations are divided into the following sections: RBRVS-Based Procedures, Clinical Labs, Ambulatory Surgical Center, HCPCS Level II, Biological and Injectables, Anesthesia, Hospital Inpatient Services, and Hospital Outpatient Services. An example of the West Virginia calculations for RBRVS-based procedures are set forth below. *See* http://www.wvinsurance.gov/LinkClick.aspx?fileticket=aaULHr94I00%3d&tabid=372&mid=994.

Managed Care Organizations

West Virginia's Fee Schedule does not apply to managed care organizations. W. Va. Code § 85-20-1. West Virginia has a list of "WV Approved Workers' Compensation Managed Health Care Plans."

Detail Reference Guide to
Determining CMS Medicare + 35%
for Offices of the Insurance Commissioner (OIC)
Workers' Compensation Maximum Medical Reimbursement Fee Schedules
Effective: July 1, 2010
Subsequent schedules should be updated each July 1 until further notice.

Codes listed with "0" or not listed are carrier/payor priced.
The absence or presence of a code does not indicate workers' compensation coverage.

RBRVs

Calculate the OIC Maximum Medical Reimbursement with the following formula(s):
(Formula component 1.35 below represents Medicare + 35%)

Non Facility (NF)

Step 1: Adjusted work RVU, rounded*+Adjusted Mal Practice (MP), rounded**+Adjusted PE Non Facility, rounded*** = Total RVU NF
Step 2: (Total RVU NF, rounded x Medicare Conversion Factor) x 1.35 = OIC Maximum Medical Reimbursement, rounded

Facility (F)

Step 1: Adjusted work RVU, rounded*+Adjusted Mal Practice (MP), rounded**+Adjusted PE Facility, rounded**** = Total RVU F
Step 2: (Total RVU F, rounded x Medicare Conversion Factor) x 1.35 = OIC Maximum Medical Reimbursement, rounded

IMPORTANT NOTES:

1. The following tables are available from Medicare http://www.cms.hhs.gov/home/medicare.asp: *National Physician Fee Schedule Relative Value File*; and *Geographic Practice Cost Indices by Medicare Carrier and Locality*.

2. Within the Medicare website go to the *Physician Fee Schedule* link, and locate *PFS Relative Value Files*. Open the *PFS Relative Value Files*, click on the folder link for the July 1 update prior to date of service (generally labeled *RVU(year)*. For example, July 2010 file is called RVU10C_PCT22. Choose the July 1 update prior to date of service if there are multiple for that year. For date of service between July 1 and June 30, the reimbursement effective on the July 1 immediately prior to date of service would apply. For example, for a January 10, 2011 date of service, the Medicare reimbursement information effective on July 1, 2010 would apply. Within this file use the Excel sheet labeled *PPRRVU(year),* (i.e. 2010 is called PPRRVU10) to obtain the RVU and conversion factor information. The GPCI information can be found in the table labeled *GPCI(year),* (i.e. 2010 is called GPCI10V2).

3. To calculate adjusted numbers using information found in *National Physician Fee Schedule Relative Value File* and *Geographic Practice Cost Indices by Medicare Carrier and Locality*:
*Adjusted Work RVU = *Work RVU* x *Work GPCI*

**Adjusted Mal Practice=*MP RVU* x *MP GPCI*
***Adjusted Non Facility= *Fully Implemented Non-Fac PE RVU* x *PE GPCI*
**** Adjusted Facility= *Fully Implemented Facility PE RVU* x *PE GPCI*

4. Calculate the fee by taking the Rounded Total RVU NF and Rounded Total RVU F (independently) and multiplying by the Medicare conversion factor. Then take the result and multiply by 1.35 to get the OIC Max Allowable Fee, rounded.

5. Federal Budget Neutrality Factor is not used in this calculation.

SECTION THREE

RESPONSES TO VIRGINIA WORKERS' COMPENSATION COMMISSION'S REQUEST FOR COMMENTS

Summary of Stakeholder Comments

Several stakeholders, including the VTLA, VHHA, and MSV, oppose any efforts to implement a fee schedule in Virginia.

The VTLA and VHHA oppose any legislation imposing rules on multiple surgical procedures or assistants at surgery, stating that Virginia rates are reasonable, and insurers/providers can negotiate rates in contract provisions.

The Virginia AFL-CIO points out that Virginia costs are low compared to most other states and feels that the current system using the prevailing community rate is effective in retaining physicians in Virginia's workers' compensation system.

The other stakeholders consulted (BCWC, FairPay Solutions, PCI, VADA members, VCA, and VSIA) support consideration of implementation of rules governing multiple procedure discounts and assistants at surgery discounts. None of these stakeholders specifically recommend implementation of a fee schedule.

No stakeholder opposes implementation of prompt payment standards. MSV and VHHA suggest workers' compensation insurers be subject to Virginia's Fair Business Practice Act, Code § 38.2-3407.15.

Regarding the payment of out-of-state medical providers, the VTLA and MSV suggest application of Virginia law. VCA and VSIA suggest application of the foreign state law to the foreign medical providers. PCI agrees with application of the foreign law or, alternatively, application of the prevailing rate in the contiguous Virginia geographic area. Most stakeholders expressed concern about the availability of health care providers and the access to care for injured workers in rural areas bordering other states, particularly Tennessee.

Some stakeholders have recommended that the General Assembly authorize a Workers' Compensation Research Institute (WCRI) study of Virginia's current system, noting that such a study has not been conducted since 1994.

Background

On May 6, 2010, the Virginia Workers' Compensation Commission solicited comments from organizations and agencies with an interest in the Commission's review of the issues outlined in this report. The full written responses from the various stakeholders are attached at the end of this section. Below is a summary of the comments.

List of Stakeholders who Submitted Comments

Virginia Chamber of Commerce's Business Coalition on Workers' Compensation (BCWC)

FairPay Solutions, Inc.

Medical Society of Virginia (MSV)

Property Casualty Insurers Association of America (PCI)

Virginia Association of Defense Attorneys (VADA)

Virginia Coal Association, Inc. (VCA)

Virginia Hospital & Healthcare Association (VHHA)

Virginia Self-Insurers Association, Inc. (VSIA)

Virginia Trial Lawyers Association (VTLA)

Virginia ALF-CIO

Detailed Summary of Comments from Stakeholders

Virginia Chamber of Commerce's Business Coalition on Workers' Compensation (BMWC)

(These comments were gleaned from a January 13, 2010 letter to Hon. William J. Howell, Speaker of the House of Delegates.)

The BCWC supports efforts to control medical costs, especially in cases where multiple procedures are performed in one operative setting or in cases where surgical assistants are utilized. BCWC notes that Virginia law permits situations where a medical provider can bill for five separate operations where five surgical procedures are performed during one operative session. BCWC also notes that Virginia law permits situations where a physician's assistant bills up to 90 percent of the treating physician's charges. These situations are not permitted under Medicare or private health insurance plans.

FairPay Solutions, Inc.

FairPay Solutions, Inc. (FairPay) surveyed state statutes and regulations in offering recommendations for the adoption of formal rules for multiple surgery, assistant surgeon, and prompt payment in Virginia. FairPay offers proposed statutory language in its submission.[1]

FairPay found that 45 states have adopted multiple surgery rules. Medicare also has multiple surgery rules. FairPay notes that most rules provide payment at 100% for the first procedure and 50% for the second and subsequent procedures. Some states vary and assign lower values to subsequent procedures. There are clear cost efficiencies created by multiple surgeries performed in the same operative sessions. These surgeries share the costs of preparing the operating room, administering anesthesia, creating an incision,

[1] By letter dated June 9, 2010, Charles F. Midkiff, Esquire, stated that he had reviewed FairPay's comments concerning multiple procedures and assistants at surgery, and he concurred in their analysis. Mr. Midkiff noted the rising costs of medical expenses in Virginia and blamed this rise in part on the lack of multiple surgical procedure regulations or regulations governing assistant surgeons.

closing, and clean-up. FairPay argues that the lack of a multiple surgery rule allows for gross overpayment for services. FairPay recommends a rule that allows payment at 100% of the prevailing rate on the primary procedure (the procedure with the highest value); payment at 50% for the second through fifth procedures; and payment on six or more procedures on a "by report" basis.

FairPay notes that 45 states have formal assistant surgeon rules. The federal government also provides rules for assistants at surgery for Medicare claims, using specific modifiers for these health care providers. FairPay notes the policy considerations of cost containment and reasonableness of reimbursement – a primary surgeon fee should not be the same as an assistant's fee. According to FairPay, a majority of states make a distinction between physicians who assist at surgery (MD) and non-physician assistants (physician assistants, registered nurses, nurse practitioners). FairPay recommends a rule that (1) separately identifies assistants that are physicians from those non-physician assistants by using billing modifiers; (2) reimburses physicians at 20% of the rate the primary surgeon receives; and (3) reimburses non-physicians at 10% of the rate the surgeon physician receives.

According to FairPay, 42 states have enacted prompt payment statutes or regulations. FairPay recommends the following language for developing a prompt pay directive:

> A medical provider shall transmit the request for reimbursement for treating a claimant to the workers' compensation payor within 60 days of the last day of treatment covered in a discrete bill. The bill must be accompanied by sufficient documentation showing that the treatment is related to the injury and is medically necessary. A payor has 60 calendar days from receipt of the bill to pay all undisputed amounts. A payor, within 60 calendar days of receipt of the bill, must give written notice to the provider of any disputed, denied or reduced amounts, together with the reasons for the dispute, denial or reduction. The written notice must include a telephone number (for verbal communications) and address (for written communications) for receipt of any medical provider question, inquiry, or supplemental materials concerning the reimbursement request.

Medical Society of Virginia (MSV)

The MSV opposes all efforts to impose fee schedules in Virginia. MSV argues that the Virginia system is effective in controlling costs and that fee schedules negatively impact quality and access to care. MSV believes that Virginia should not adopt a prescriptive schedule for reimbursement of services. Rather, reductions and discounts should be negotiated via contracts between insurers and providers. MSV recommends that the Commission gather professional charge data to determine fair rates for multiple procedures and for payment of both physician and non-physician assistants. MSV recommends that the Commission require insurers challenging prevailing community rate decisions to provide source data that are the basis for their objections.

Regarding prompt payment to medical providers, MSV states that prompt and full payment of claims to physicians in Virginia is frequently reported to its organizations. MSV argues that workers' compensation insurers should be subject to the Fair Business Practice Act, Code § 38.2-3407.15. This act requires payment of clean claims within 14 days. MSV recommends that insurers pay for undisputed medical services even when other non-medical aspects of the claim are in dispute.

Regarding charges for services provided in foreign jurisdictions, MSV recommends that Virginia law govern these charges.

Property Casualty Insurers Association of America (PCI)

PCI notes that Medicare is commonly used as a basis for workers' compensation fee schedules. Medicare rules provide multiple surgery reductions and rules governing reimbursement of surgical assistants.

PCI recommends that Virginia consider implementing a multiple surgery reduction rule. Specifically, PCI recommends "that for operations performed by the same physician during the same operative session, at the same operative site, reimbursement should be made at 100 percent (100%) of the highest cost procedure for the procedure and 50 percent (50%) of the approved rate for five additional procedures which are related to the injury, medically necessary and not incidental to the other." PCI concurs with recommendations outlined by FairPay for other additional procedures.

PCI concurs with recommendations made by FairPay based on Medicare methodology for assistant at surgery services. Specifically, FairPay recommends a rule that (1) separately identifies assistants that are physicians from those non-physician assistants by using billing modifiers; (2) reimburses physicians at 20% of the rate the primary surgeon receives; and (3) reimburses non-physicians at 10% of the rate the surgeon physician receives.

PCI also concurs with FairPay's recommendations regarding prompt payment of medical bills. PCI includes an additional requirement, based on the West Virginia System. In West Virginia, providers must send their bills within six months of service to be considered for payment.

PCI recommends that if the foreign state in which treatment was provided has a fee schedule, the fee schedule should govern reimbursement. If not, the prevailing rate in the contiguous Virginia geographic area should be used.

Virginia Association of Defense Attorneys (VADA)

The VADA did not offer an official response but presented "a compilation of views expressed by some of the members" of the Workers' Compensation Section of the VADA.

Regarding multiple surgical procedures, members viewed a sliding scale as being the most equitable way to resolve the issue, i.e., 100% of the reasonable and customary charge of the most expensive procedure, 50% for the second, 33% for the next, and so on. The VADA members noted that such a sliding scale may result in excessive unbundling of services that would also need to be addressed by the legislature.

Regarding assistants at surgery, members agreed that requiring a payer to pay 100% of the surgeon's fee to the assistant was inappropriate. Payment at 15 to 20% of the surgeon's charge was viewed as reasonable.

The VADA members raised concerns about the practice of unbundling services. This includes charging 100% for each procedure performed during the same operative procedure and charging 100% for the surgeon as well as the assistant.

Regarding prompt payment of medical providers, members felt this could be addressed with proper documentation and billing. Members suggested imposition of a statutory time period for filling claims by providers with the potential for assessment of attorney's fees against medical providers for unreasonably bringing such claims.

Treatment in foreign jurisdictions can be a "hot button" issue in southwest Virginia where Tennessee physicians are often utilized especially since there are no Virginia neurosurgeons in the area. Some physicians refuse to participate in the Tennessee workers' compensation system because of their dissatisfaction with the fee schedule. Other members of the VADA did not object to application of a foreign fee schedule as long as insurers and self-insured employers are able to negotiate with providers for fees in excess of the Tennessee fee schedule.[2]

Virginia Coal Association (VCA)
Virginia Self-Insurers Association, Inc. (VSIA)

VCA and VSIA offered almost identical comments which are summarized below.

VCA and VSIA concur with the recommendations made by FairPay Solutions, Inc. Specifically, Virginia should adopt a formal multiple surgery rule mandating payment at 100% of the prevailing rate for the primary procedure, 50% for subsequent procedures through the fifth procedure, and payment on sixth or more procedures "by report." This would require general billing instructions informing health care providers to bill full rates for all procedures, and payers would apply the multiple surgery rules to the prevailing rate. VCA and VSIA note that the majority of states have adopted formal multiple surgery rules.

VCA and VSIA also concur with the recommendations made by FairPay regarding assistant surgeon reimbursement. Specifically, Virginia should adopt a formal rule on assistant surgeon reimbursement within the mainstream of payment methodologies employed in other states. VCA and VSIA recommend the following

[2]Under Tennessee law, providers accepting payments exceeding the fee schedule or insurers paying in excess of the fee schedule are subject to civil penalties.

standards: (1) separately identify assistants that are physicians from those non-physician assistants by using billing modifiers; (2) reimburse physicians at 20% of the rate the primary surgeon receives; and (3) reimburse non-physicians at 10% of the rate the surgeon physician receives. This would require general billing instructions informing health care providers to bill their full rates for procedures and rely on payers to apply assistant surgery rules to the prevailing rates. VCA and VSIA note that the majority of states have adopted formal assistant surgeon rules.

VSIA notes that self-insured employers and their administrators rarely have prompt payment issues. VCA and VSIA note that there might be difficulty enforcing a prompt payment statute as it would be difficult to determine when a complete bill adequate for a payment decision is actually received. Payers often return bills requesting additional information.

VCA and VSIA note that medical charges for Virginia claimants treated in foreign jurisdictions has been problematic for employers with operations in border areas since the inception of Rule 14. These organizations recommend that fee schedules of the jurisdiction where care is rendered should control the amount payable for the care received. VCA and VSIA note that community standard calculations for Virginia exceed the amount paid using fee schedules of the surrounding states resulting in a windfall to providers.

VCA and VSIA recommend a WCRI study of Virginia's current system, noting that one has not been completed since 1994.

Virginia Hospital & Healthcare Association (VHHA)

The VHHA states that the Virginia system is strong and relatively cost-effective. The VHHA would oppose any efforts to implement a fee schedule in Virginia. Regarding payments for multiple procedures and surgical assistants, VHHA states that Virginia rates are reasonable, and insurers and providers are free to negotiate rates in contract provisions.

VHHA expressed concern about the "inexcusably long adjudication periods" and administrative costs to the parties. VHHA considers prompt payment a critical issue. VHHA laments lengthy adjudication timeframes, delays in payments even after

compensability decisions have been made, and the lack of penalty to insurers or third-party administrators who delay payment or unreasonably reduce payments. VHHA suggests the legislature address the length of time required to reach a compensability decision, reduction in the time period for issuing payment once a compensability decision has been reached, and consideration of a 45-day timeframe in which a payer must make payment or deny payment from the time the medical record is complete (a clean claim). VHHA also suggests the use of penalties and interest to enforce timeliness. VHHA points to Virginia's Fair Business Standards Act as a resource. VHHA also recommends consideration of a rule whereby the loser on appeal is liable for administrative costs of the appeal.

VHHA recommends that any legislation ensure payment rates are appropriate to maintain an adequate supply of providers available and willing to care for patients.

Virginia Trial Lawyers Association (VTLA)

The VTLA opposes any proposed legislation that would require a predetermined fee schedule or rate structure for surgical procedures. The VTLA notes that such legislation would result in the loss of board certified surgeons who are willing to accept workers' compensation patients. From a medical provider's prospective, accepting workers' compensation cases significantly increases administrative costs including obtaining authorization for treatment, providing medical records, as well as producing special reports, submitting to depositions, subpoenas, records requests, phone calls, and correspondence with the parties. With its comments, the VTLA includes a study of fee schedules in Maryland, Hawaii, Florida, West Virginia, Texas, and Florida.[3] According to the VTLA, this study concluded that workers' compensation cases caused a significant increase in actual costs to providers, resulting in an alarming flight of specialists out of the workers' compensation system. The VTLA also notes concern with access to care.

[3] Steven E. Levine & Ronald N. Kent, *Workers' Compensation Medical Fee Schedules – New Findings & Implications for California* (2007). This study and two other studies submitted by the VTLA are included at the end of this section attached to the VTLA's comments.

The VTLA recommends that the issues of multiple surgical procedures and assistants at surgery be addressed on a case-by-case basis by the Commission. The VTLA believes a blanket reduction would have a disastrous impact on the number of physicians willing to take workers' compensation cases, especially in rural areas where specialists are not plentiful.

The VTLA supports any reform which would increase the speed of payment to physicians. The VTLA supports application of the Fair Business Practice Act to workers' compensation insurers. The VTLA also supports imposition of a 20% penalty against insurers who fail to make prompt payment without justification for the delay.

The VTLA recommends that Virginia law be applied to foreign medical providers and that the Virginia Workers' Compensation Commission retain jurisdiction to resolve disputes.

Virginia AFL-CIO

The Virginia AFL-CIO states that Virginia workers' compensation costs are consistently lower than at least 46 other states according to a 2010 Oregon Workers' Compensation Rate Survey. The Virginia AFL-CIO is concerned that attempts to lower payments to Virginia physicians in workers' compensation cases will result in a decrease in the number of physicians willing to treat injured workers. The Virginia AFL-CIO suggests legislation allowing injured workers to be treated by their primary care physicians, noting that restricting employee choice of physicians can result in higher health care costs. The Virginia AFL-CIO believes that existing law using the prevailing community rate standard seems to be effective in retaining physicians in the workers' compensation system.

VIRGINIA
CHAMBER OF COMMERCE
Business Leadership for Virginia's Future

January 13, 2010

The Honorable William J. Howell
Virginia House of Delegates
Richmond, VA 23218

Dear Speaker of the House Howell:

The Virginia Chamber's **Business Coalition on Workers' Compensation** (BCWC) is pleased to share its thoughts on a few of the workers' compensation issues that may come before the General Assembly this session.

We hope you find the enclosed overview useful. **Should you have any questions about workers' compensation issues during or after the session, please do not hesitate to contact me or any member of our steering committee.** We will be pleased to assist you.

On behalf of the BCWC and its members, we wish you productive session.

Sincerely,

Keith D. Cheatham
Vice President - Government Affairs

BUSINESS COALITION ON WORKERS' COMPENSATION

January 13, 2010

ASSOCIATIONS

American Insurance Association
Arlington Chamber of Commerce
Associated Builders & Contractors
Associated General Contractors of Virginia
Builders & Contractors Exchange, Inc.
Danville-Pittsylvania County Chamber of Commerce
Easter Associates
Fairfax County Chamber of Commerce
Greater Montross Chamber of Commerce
Greater Reston Chamber of Commerce
Greater Richmond Chamber of Commerce
Greater Springfield Chamber of Commerce
Greater Washington Board of Trade
Greater Williamsburg Chamber & Tourism Alliance
Halifax County Chamber of Commerce
Hampton Roads Chamber of Commerce
Hampton Roads Hospitality Coalition
Hampton Roads Maritime Association
Home Builders' Association of Virginia
Independent Insurance Agents of Virginia
Management Association of Western VA
Mid-Atlantic Cleaners & Launderers Association
Montgomery County Chamber of Commerce
New Kent Chamber of Commerce
National Federation of Independent Business
Northern Virginia Building Industry Association
Orange County Chamber of Commerce
Petersburg Chamber of Commerce
Powhatan Chamber of Commerce
Prince William County-Greater Manassas Chamber of Commerce
Prince William Regional Chamber of Commerce
Professional Insurance Agents of Virginia & the District of Columbia
Property Casualty Insurers Association of America
Richlands Area Chamber of Commerce
Roanoke Regional Chamber of Commerce
Russell County Chamber of Commerce
Salem-Roanoke County Chamber of Commerce
Scott County Chamber of Commerce
Scottsville Chamber of Commerce
Smyth County Chamber of Commerce
South Hill Chamber of Commerce
Staunton-Augusta County Chamber of Commerce
Verizon
Virginia Agribusiness Council
Virginia Association for Commercial Real Estate
Virginia Association of Health Plans
Virginia Association of Private Career Schools
Virginia Association of Realtors
Virginia Association of Roofing Contractors
Virginia Association of Temporary & Staffing Services
Virginia Association of Towing & Recovery Operators
Virginia Automatic Merchandising Association
Virginia Automobile Dealers Association
Virginia Automotive Recyclers Association
Virginia Beach Hotel & Motel Association
Virginia Cable Telecommunications Association
Virginia Career College Association
Virginia Chamber of Commerce
Virginia Coal Association
Virginia Farm Bureau Federation
Virginia Financial Services Association
Virginia Forestry Association
Virginia Hospitality & Travel Association
Virginia Manufacturers Association
Virginia, Maryland, Delaware Assn. of Electric Cooperatives
Virginia Movers & Warehousemens' Association
Virginia Municipal League Insurance Programs
Virginia Peninsula Chamber of Commerce
Virginia Poultry Federation
Virginia Propane Gas Association
Virginia Recreation and Park Society
Virginia Retail Federation
Virginia Retail Merchants Association
Virginia Self Insurers Association
Virginia State Association of Occupational Health Nurses
Virginia Telecommunications Industry Association
Virginia Transportation Construction Alliance
Virginia Trucking Association
Virginia Utility & Heavy Contractors Council
Virginia Veterinary Medical Association
Virginia Waste Industries Association
Virginia Wholesalers & Distributors Association
Virginia Wine Wholesalers Association
Virginia Women's Center/Summit Health Care
Westmoreland County Chamber of Commerce

INDIVIDUAL COMPANIES

ACE USA
Advantus Strategies
Aerofin Corporation
Aetna Life & Casualty
Alliance Coal, LLC
Amvest Corporation
Anthem Blue Cross Blue Shield
Aon Risk Services
Appalachian Power
Associated Rehabilitation Consultants
Barter Theater
BioMotion of America, LLC
Brown Bldg. & Remodeling
Catalina Cylinders
CenturyLink
Charles Ryan Associates
Chesapeake Corporation
Coldwell Banker Prof. Realtors
Columbia Gas of Virginia
Comp Quarterly
CorVel Corporation

COSHA, Inc.
Cost Control Consulting
Craft Machine Works, Inc.
CSX Corporation
Davis Consultants, Inc.
Degussa Goldschmidt Chemical
Dominion / Virginia Power
Du Pont
Fairfield Skanska
Farmers' Insurance Group
First Piedmont Corp.
Genworth Financial
Georgia-Pacific Corporation
Hampton Physical Therapy
Honeywell
Howmet Corporation
International Paper
International Veneer
Jewell Resources
Jo-Kell, Inc.
Johnson & Higgins of Va., Inc.
Kemper Insurance Companies
Kings Dominion
Law Offices of J. Christopher LaGow
LeClair Ryan
Liberty Mutual Group
Lindl Corporation
MacDougall's, Inc.
Managed Care Innovations, LLC
Marsh, Inc.
MeadWestvaco Corporation
Merck & Company
McGuireWoods
McGuireWoods Consulting, LLC
McNeil Roofing
MDV Nash Finch
Micron Technology
Midkiff, Muncie & Ross, P.C.
Mitsubishi Chemical America
National Council on Compensation Insurance
Nationwide Insurance
Noland Company
Norfolk Southern Corporation
Norfolk Warehouse Distribution Centers, Inc.
Northern Virginia Natural Gas
Northrop Grumman Shipbuilding
Old Dominion Electric Cooperative
Piedmont Virginia Companies
Pittston Coal Management Company
Personnel Remedies, LLC
Rappahannock Electric Cooperative
Reid, Smith, LLP
Reliance Services
Resource Opportunities, Inc.
Richmond City
Royal & Sun Alliance
Sands, Anderson, Marks & Miller
Simmons Manufacturing
Slone Chiropractic Clinic
Smithfield Packing Company, Inc.
Southern States Cooperative, Inc.
Southside Electric Cooperatives, Inc.
Sprint
State Farm
Stateside Associates, Inc.
STIHL Incorporated
Strongwell – Bristol Division
Temporary Solutions
The Life Insurance Company of Virginia
The PMA Group
The Smith Group
Tidewater SKANSKA
Travesky & Associates
Triumph Technologies
Troutman Sanders Public Affairs
Troutman Sanders, LLP
Two Rivers Law Group, LLC
Ukrops
United Airlines
United Parcel Service
Vandeventer Black, LLP
Verbatim Editing
Virginia Cardiovascular Specialists
Virginia Business Group
Virginia Eye Institute
Virginia Farm Bureau Mutual Insurance Companies
Virginia Gazette
Vulcan Materials Company
W. Thomas Hudson & Associates
Walmart
Washington Gas – Virginia Division
Wells Fargo Disability Services
Westmoreland Coal Company
Wharton, Aldhizer & Weaver, PLC
Whitt & Associates, P.C.
Williams, Mullen
Worldcolor
Wright, Robinson, Osthimer & Tatum

STEERING COMMITTEE

Keith D. Cheatham
Vice President - Government Affairs
Virginia Chamber of Commerce
(804) 237-1456
k.cheatham@vachamber.com

Robert T.C. Cone
Principal
Managed Care Innovations
(804) 344-0009
rcone@mcinnovations.com

P. Steven Craig
Managing Director
Virginia Municipal League Insurance Programs
(804) 273-0038
scraig@vmlins.org

John T. Heard, Esquire
Legislative Counsel
Virginia Coal Association
Virginia Self–Insurers Association
(804) 643-6697
jheard@i2020.net

J. Christopher LaGow, Esquire
NCCI/Nationwide/Property Casualty Insurance Assn.
(804) 225-8570
chris@lagowlobby.com

Charles F. Midkiff, Esquire
Virginia Manufacturers Association
Virginia Automobile Dealers Association
Midkiff, Muncie & Ross, P.C.
(804) 560-9600
cmidkiff@midkifflaw.com

George Peyton
Vice President – Government Relations
Virginia Retail Federation
(804) 662-5505
gpeyton@retailmerchants.com

Kenneth S. Shuman
Vice President, Va. Regional Office
Wells Fargo Disability Services
(540) 676-3603
kenny_shuman@wellsfargois.com

Anthony F. Troy, Esquire
AIA/Troutman Sanders, LLP
(804) 697-1318
tony.troy@troutmansanders.com

Ralph L. Whitt, Jr., Esquire
Whitt & Del Bueno
804/864-9660
rwhitt@whittanddelbueno.com

Business Coalition on Workers' Compensation

The **Business Coalition on Workers' Compensation (BCWC)** consists of individual companies and a broad range of business and trade associations. It was formed in 1993 by the Virginia Chamber of Commerce to generate a broader understanding of the issues relating to the Virginia workers' compensation system and to develop annually a business consensus on proposals which might be considered by the Virginia General Assembly.

Workers' compensation is a system funded entirely by employers that provides lost wage benefits, medical care and vocational rehabilitation to employees experiencing injuries or illnesses arising out of their employment. It is a system of justice based not upon theories involving fault, but upon providing support in a dignified and certain manner. Under it, both the employee and the employer surrendered rights available under common law to gain the advantages of the Act.

Compared to other states, **Virginia's workers' compensation system is effective.** This is a result that flows naturally from several important achievements:

- Compared to other states, ***Virginia worksites are safer.*** For years, Virginia has been among the states with the lowest OSHA reportable and lost-time incidence rates in the nation;

- ***Virginia policy makers have been diligent in maintaining the nexus between compensability and job causation,*** resisting efforts to transform the workers' compensation system into a general health insurance and disability benefit; and

- ***Virginia benefits from a combination of system features,*** including employee selection of a treating physician from a panel of at least three doctors named by the employer, open access to medical information, and a Commission that actively helps workers navigate the system, thereby reducing the need for attorney involvement..

During the 1997 session, the General Assembly successfully crafted legislation to restore compensability for job-caused carpal tunnel syndrome and gradual hearing loss. In doing so, the General Assembly was careful to ensure that the legislation would not encompass those conditions of life that are normal incidents of aging or not clearly caused by the job. **We believe that the 1997 legislation, supported by the business community, the Virginia AFL-CIO and the Virginia Trial Lawyers Association, effectively and adequately addressed one of the most contentious issues in recent years, and that efforts to alter or expand that agreement would be ill advised.** Legislators may nevertheless be asked to determine public policy on this and other important workers' compensation issues in the coming weeks.

The recommendations of the BCWC on several important workers' compensation issues that may come before the 2010 session of the Virginia General Assembly are provided on the following pages. Should you have any questions about these or other issues, please contact any BCWC steering committee member listed on the attached pages.

Recommendations of the BCWC

1. Expanding or eliminating the panel of physicians:

Workers' compensation insurance provides several benefits to injured or ill employees. One of these benefits includes *unlimited medical care* --- at no cost to the employee --- for as long as he or she may need it.

To control medical costs and to ensure that employees' injuries are properly treated and that they return to work as soon as they are able, employers are required to furnish a physician, chosen by the injured employee from a panel of at least three independent physicians supplied by the employer. If the employer fails to provide the required panel or the panel is in some way flawed, the injured employee is free to select a treating physician of his choice.

The current system works well. It promotes efficiency and wellness by providing an injured employee with a physician who is both experienced and knowledgeable regarding workplace injuries and occupational illnesses. The injured employee also benefits by having a physician who is familiar with the employee's specific job related duties and his workplace.

During the 1999 General Assembly session, a measure was introduced -- under the premise that "greater choice is good" -- to expand the panel of physicians from three to five. (It was ultimately amended to allow a maximum of two physicians from each of two different or independent practice groups.)

While the measure passed the House, it was defeated in the Senate after it became clear that "greater choice" would mean higher costs, less efficiency, reduced patient care, and could lead to "doctor shopping".

The BCWC supports retention of the current panel feature and opposes efforts to expand or eliminate it.

2. Redefining injury:

Workers' compensation insurance provides benefits to employees who are injured or killed on the job **if** the injury or death:

- *is caused by an accident;*
- *arises out of the employment; and*
- *occurs in the course of the employment.*

Each element has specific meaning and additional requirements that must be met before compensation is awarded. While this may sound complicated to those unfamiliar with our system, it really is quite simple.

The requirements simply enforce the Act's intent to compensate employees only for conditions that are clearly *caused* by the job. The requirements also guarantee that employers are not forced to provide benefits for injuries or conditions that fall outside the scope of the Act.

The Virginia Supreme Court's strict adherence to this definition and the Virginia General Assembly's reluctance to transform the workers' compensation system into a general health insurance and disability benefit for the employee has brought a level of certainty to our system that is absent in many other states.

The BCWC supports the current statutory framework under which work-related injuries are compensated and opposes efforts to relax or alter the standards for compensability.

3. Altering the exclusivity of the Workers' Compensation Act:

Virginia's Act is a compromise between employer and employee. It balances the interests of both and permits the settlement of differences arising out of personal injuries on the job in a prescribed manner, generally without assigning fault to either the employer or the employee.

Under the Act and by agreement, both employer and employee surrender all former legal rights in return for certain, defined statutory rights. Under the Act, the question of the employee's negligence is eliminated, common law defenses (e.g., assumption of risk, fellow servant and contributory negligence) are abolished, and the rules of evidence are relaxed.

The employee surrenders his right to bring an action at law against his employer for damages and agrees to accept a sum fixed by statute for his work-related injuries or illnesses. The relief afforded is certain and speedy. As a result, there is no doubt as to the right of recovery.

By agreement, the Act provides an *"exclusive remedy"* for covered injuries and illnesses. To the extent that a work-related condition is covered by the Act, both the employer and employee are bound by the agreement and the remedies afforded by it to the exclusion of all others.

In recent years, attempts have been made to "relax" the agreement by subjecting employers to personal injury suits, remedies and sanctions never envisioned by the agreement. Such efforts are clearly out of step with the Act's intent and if passed would fuel litigation and drive up costs.

The BCWC opposes efforts to alter the Act's exclusivity or allow employers to be sued by employees in any cases involving workplace injury.

4. Containing medical costs:

Workers' compensation is an insurance system that provides lost wage (indemnity) benefits, medical care and vocational rehabilitation to employees experiencing injuries or illnesses arising out of their employment. It is funded entirely by employers.

In recent years, medical expenses have risen faster than expected to the point where today these expenses significantly exceed indemnity payments and even exceed the national average for such costs.

Two identified "drivers" of these exorbitant cost increases in Virginia are (1) **simultaneous or concurrent billing** (where a medical provider performs, for example, five surgical procedures during one operative session and bills for five separate operations) and (2) the practice of **billing a physician's assistant** to the treating surgeon in amounts up to 90 percent of the treating surgeon's charges. Current law permits these situations under workers' compensation, but not under Medicare or private health insurance plans.

In an effort to address this problem, in part, the attached language amending §65.2-605 is supported by the BCWC, the Virginia Orthopedic Society and the Medical Society of Virginia.

The BCWC supports efforts to control medical costs, especially in cases where multiple procedures are performed in one operative setting and billed as if the services were rendered in separate operations on different days or when a treating surgeon bills an amount nearly equal to their own charges for a surgical assistant who is often one of their salaried employees.

5. Expanding Virginia's death presumption:

As discussed above and in more detail here, workers' compensation insurance provides certain benefits to employees who are killed or injured on the job if the death or injury is caused by an accident, arises out of the employment, and occurs in the course of the employment. These benefits are paid for entirely by the employer.

Under certain circumstances, Virginia courts have relieved death claimants of the burden of proving all of the elements listed above by "presuming" the accident which caused their death arose out of and in the course of employment. Unless the employer can refute the "presumption", benefits are awarded.

That presumption is narrow and only applies to cases where the employee is found dead at work, or nearby. Since its creation a half century ago, the courts and the Virginia General Assembly have wisely chosen not to expand it. That could change.

Last year, the General Assembly was asked to expand the presumption to include cases where an employee is found severely brain injured – but not dead – at their place of work. It was broadly written and would have made it practically impossible for any employer to defend. It was defeated on a 4-11 vote.

In the end, most agreed that the measure was too broad and simply not needed. The Commission has routinely awarded benefits in the past without the benefit of any presumption in cases where a claimant is unable to recall the specifics of the accident and is unable to offer other direct evidence of the cause of the accident.

The courts' strict adherence to these definitions and the Virginia General Assembly's reluctance to transform the workers' compensation system into a general health insurance and disability benefit for the employee has brought a level of certainty to our system that is absent in many other states.

The BCWC opposes efforts to expand Virginia's death presumption to cases where a person is injured and simply can not recall what caused his injury.

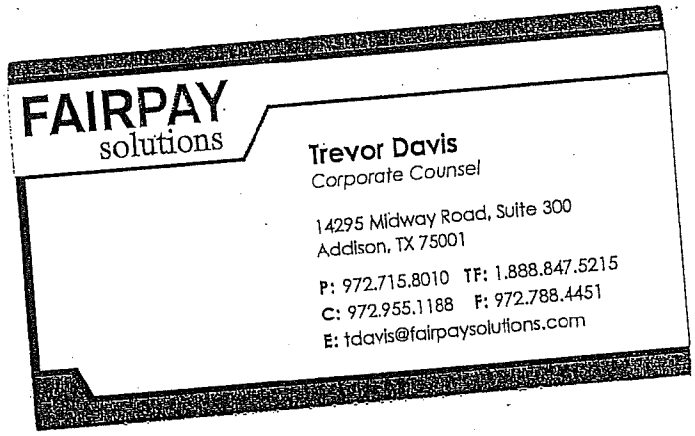
§ 65.2-605. Liability of employer for medical services ordered by Commission; malpractice.

A. The pecuniary liability of the employer for medical, surgical, and hospital service herein required when ordered by the Commission shall be limited to such charges as prevail in the same community for similar treatment ~~when such treatment is paid for by the injured person~~ and the employer shall not be liable in damages for malpractice by a physician or surgeon furnished by him pursuant to the provisions of § 65.2-603, but the consequences of any such malpractice shall be deemed part of the injury resulting from the accident and shall be compensated for as such.

B. A health care provider rendering medical services in a state other than Virginia to an injured worker whose claim and injuries have been accepted as compensable under the Virginia Workers' Compensation Act shall be reimbursed for authorized, reasonable and necessary medical treatment in an amount equal to the worker's compensation fee schedule, if any, adopted by the state where the services were rendered. If the state has not adopted a fee schedule, the health care provider shall be reimbursed consistent with this section.

2. The Commission shall appoint a task force to develop recommendations for: (i) the implementation of regulations that authorize reductions or discounts for multiple surgical procedures performed during a single operative session; (ii) the implementation of regulations that establish the pecuniary liability of an employer for the services of an assistant-at-surgery; (iii) the implementation of alternative methods to determine fee disputes between health care providers and employers to reduce docket congestion for the benefit of injured workers seeking a hearing; (iv) the implementation of electronic filing with the Commission of claims by health care providers for medical, surgical and hospital services provided to a claimant; and (v) the implementation of any regulations that will increase efficiency or reduce the cost to the workers' compensation system as directed by the Commission to the task force. Such task force shall be comprised of members recommended by interested parties including but not limited to the Virginia Manufacturers Association, the Business Coalition on Workers' Compensation, the Virginia Hospital and Healthcare Association, and the Medical Society of Virginia. The task force shall gather information and receive testimony from all interested parties with recommendations to be received by the Commission no later than August 1, 2010. Thereafter the Commission shall act in accordance with the Virginia Administrative Process Act so as to promulgate final regulations governing the aforementioned subjects, which regulations shall be effective no later than June 1, 2011.

3. That an emergency exists and this Act is in force from its passage.


FAIRPAY
solutions
Trevor Davis
Corporate Counsel
14295 Midway Road, Suite 300
Addison, TX 75001
P: 972.715.8010 TF: 1.888.847.5215
C: 972.955.1188 F: 972.788.4451
E: tdavis@fairpaysolutions.com

Efficacy of Multiple Surgery, Assistant Surgeon and Prompt Pay Rules

FairPay Solutions, Inc. is offering comment on the efficacy of multiple surgery, assistant surgeon, and prompt pay rules in workers' compensation laws and regulations. Because the Chairman of the Senate Commerce and Labor Committee has requested the Virginia Workers' Compensation Commission review these points, we appreciate the opportunity to offer our insights to the Commission on these matters. We believe that any formal policy statement or adoption should be measured in terms of serving three important public policy goals of a robust and sound workers' compensation system: (1) securing access for injured workers to quality care that quickly and safely heals the individual for return to work; (2) recognizing rational and sustainable cost containment processes to appropriately manage the expense outlay of workers' compensation payors; and (3) facilitating reasonable and fair reimbursement to medical providers treating compensable injuries. FairPay holds the opinion that formal adoption of multiple surgery, assistant surgeon and prompt pay rules in the Virginia workers' compensation system would serve all three of the foregoing public policies.

Multiple Surgery Rules

Multiple surgery rules limit the reimbursement for a given (secondary) surgery to a reduced percentage of the normal reimbursement for that given surgery when the (secondary) procedure is performed on the patient during the same operative session as another (primary) procedure. Typically, the first (primary) procedure (or the most expensive procedure) will be reimbursed at the full rate permitted by applicable law, while the second and subsequent procedures performed during the same session (or on the same day) will be reimbursed at a lesser rate.

While Virginia does not currently have a formal statement on a multiple surgery rule, a survey of workers' compensation statutes and administrative rules across the other 49 states and District of Columbia (DC) reveals that 45 states have adopted formal multiple surgery rules. The fact that 90% of the states have such a rule speaks to the overwhelming recognition between legislators, providers, and payors that formalizing such a rule is desirable to effect at least the public policy of establishing a reasonable cost to employers in meeting their duty to reimburse compensable care.

The federal government also has implemented a multiple surgery rule for all claims paid by Medicare. Title 42 Part 416.120 of the Code of Federal Regulations for several years contained language for Ambulatory Surgical Centers ("ASC"):

> (ii) If more than one surgical procedure is furnished in a single operative session, payment is based on--
>
> (A) The full rate for the procedure with the highest prospectively determined rate; and
>
> (B) One half of the prospectively determined rate for each of the other procedures.

Part 419.44 of the CFR contained this language for the Hospital outpatient services:

> (a) Multiple surgical procedures. When more than one surgical procedure for which payment is made under the hospital outpatient prospective payment system is performed during a single surgical encounter, the Medicare program payment amount and the beneficiary copayment amount are based on--
>
> (1) The full amounts for the procedure with the highest APC payment rate; and

(2) One-half of the full program and the beneficiary payment amounts for all other covered procedures.

When CMS updated the ASC payment system starting January 1, 2008, the multiple surgery rules were kept in place, as seen in Medicare Claims Processing Manual, Chapter 14, Section 40.5, which states:

> When the ASC performs multiple surgical procedures in the same operative session that are subject to the multiple procedure discount, contractors pay 100 percent of the highest paying surgical procedure on the claim, plus 50 percent of the applicable payment rate(s) for the other ASC covered surgical procedures subject to the multiple procedure discount that are furnished in the same session. The OPPS/ASC final rule for the relevant payment year specifies whether or not a surgical procedure is subject to multiple procedure discounting for that year.

CMS succinctly stated the rationale for the federal government's multiple surgery rule:

> We currently discount the APC payment for the second and subsequent procedures performed during a single encounter by 50 percent in the expectation that the same efficiencies of service that are demonstrated to exist in the provision of physician services also exist in the provision of outpatient hospital services. In general, when a second or subsequent service is performed at the same time as an initial service, we believe that the combined resource costs associated with operating room time, recovery room time, anesthesia, supplies, and other services are less than if the procedures were performed separately... (Emphasis added)

See CMS-1206-P at 98 (discussing possible changes to 42 CFR Parts 405, 410 and 419 in 2003).

Comments to CMS by medical professionals support this notion that multiple procedures create certain efficiencies that should result in a lower reimbursement. Wiston Mebust, M.D., President of the American Urological Association, stated, "We agree that some efficiencies are realized when multiple procedures are performed." Likewise, in a letter dated October 7, 2002, Jordan Cohen, M.D. of the Association of American Colleges stated, "The rationale for a discounting policy is that the costs of performing multiple significant procedures are less when they are performed in the same operative session because of efficiencies achieved through readying one operating room, one anesthesia session and other comparable items."

This industry standard exists for a reason: to avoid paying twice for an expense already reimbursed. If part of the cost of any given surgical procedure is readying an operating room, administering anesthesia, creating an incision, closing it and clean-up, then these costs are incurred only once for any session. Any additional procedures do not have this "overhead." Because the federal rules allow the most expensive procedure to be paid at 100% of the applicable rate, including the initial overhead, additional less expensive procedures are not paid at a full rate as if they were being performed stand-alone. Indeed, under this rationale, it can be argued that the cost of each additional procedure would decrease exponentially and the reimbursement for such procedures should be reduced accordingly. This rationale is reflected in the administrative rules governing the workers' compensation reimbursement systems of states such as Arizona (100/50/25/10/5), Connecticutt (100/50/25/25/25), Louisiana (100/60/40/25/25) or Maine (100,50,25,10).

Given the clear cost efficiencies created by multiple surgeries, the lack of a multiple surgery rule allows for gross overpayment for services. The rate of the reduced reimbursement on multiple

procedures differs between jurisdictions, but nearly all agree that payment at 100% for secondary procedures cannot be permitted.

Some states even go to the detail of distinguishing between multiple surgery rules for facilities versus surgeons. All pay the primary procedure at 100% of the applicable value. The "primary procedure" is usually defined as the procedure with the highest value. Likewise, 44 of 45 states pay the second procedure at 50% (the exception being 60%). However, payment for additional procedures varies:

- All Subsequent Procedures -- When all additional procedures are referred to as a group (typically as all "subsequent" procedures), 28 states pay those additional procedures at 50% of the applicable value.
- Third Procedure -- 5 states pay the third procedure at 25%; 4 states pay at 50%; 1 state pays 30%, and 1 state pays 40%.
- Fourth Procedure -- 5 states pay the fourth procedure at 50%, 2 states pay at 10%, 2 states pay at 25% and 1 state pays at 30%.
- Fifth Procedure -- 5 states pay the fifth procedure at 50%, while 2 pay at 25%, one pays at 30% and 1 state pays at 5%.
- Sixth Procedure and Beyond -- 2 states pay the sixth and additional procedures at 10% and 9 states designate these procedures be paid by report. Having more than five procedures in the same session implies that special examination of these procedures may be required because: (1) unnecessary procedures may be being performed or (2) an exceptionally complex or traumatic incident may have occurred. Either way, paying "by report" allows a nurse reviewer to look at the context and make a judgment call on how best to handle the situation.

In addition, a review of state rules on multiple procedures reveals other variances related to the number of procedures:

- Two states set a maximum of 4 procedures total.
- Ten states have specific codes that are either considered as "add-ons" or excluded for other reasons, usually because they are accounted for in a fee schedule where specific amounts have already been calculated.
- Three states make a distinction between procedures using the same incision and additional procedures at a separate incision site.
- One state sets a maximum charge for additional procedures at two times the highest charge (or primary procedure).

Recommendation

Given the widespread use and acceptance of multiple surgery rules both by the vast majority of state workers' compensation systems and the federal government and given the prudent policy concerns, FairPay recommends formal recognition of a multiple procedure rule that would allow: (i) payment at 100% of the prevailing rate on the primary procedure, defined as the procedure

with the highest value; (ii) payment at 50% on the second through fifth procedures;[1] and (iii) payment on six or more procedures on a "by report" basis.[2]

Because Virginia has no fee schedule, there would need to be general billing instructions informing professionals and facilities to bill their full rates for all procedures. Payors would then apply the multiple surgery rule to the prevailing rate, thereby eliminating any confusion among payors regarding whether a provider has already applied a reduction factor to the bill. If a fuller fee schedule were adopted, the exempt and/or add-on codes might need to be enumerated in an appendix for professional fees for the surgeons, although not for facility fees.

Following is proposed language for a multiple surgery rule:

***y*. MULTIPLE OR BILATERAL PROCEDURES RULE**
This rule applies when modifiers 50 (Bilateral Procedure) or 51 (Multiple Procedures) are used in accordance with CPT 2008.

> A. MULTIPLE PROCEDURES: When multiple procedures are performed on a patient during the same operative session, the total reimbursement shall be (i) reimbursement at full value for the highest cost procedure; (ii) 50 percent of the value for the second through the fifth procedures; (iii) for sixth and subsequent procedures, by report. The primary procedure should reflect the highest cost procedure and should not be billed with modifier 51. All other procedures should be billed with modifier 51 appended.
>
> B. BILATERAL PROCEDURES: When procedures are performed bilaterally (i.e., on both left and right sides), the procedures should be billed with the use of modifier 50 for the second procedure, with the resulting reimbursement for the combination of the two procedures being 150% of the value of the primary procedure.

[1] Though exponential drops in reimbursement might make sense, we are not comfortable recommending such exponential drops without more concrete evidence to support the drop in costs or the adoption by more states of such an approach.

[2] Even though few states have adopted such a policy, the extraordinary circumstances that lead to six or more procedures being performed in the same operative session leads FairPay to believe that more careful consideration by a trained professional and payment by report makes the most sense in such situations.

Assistant Surgeon Rules

Assistant surgeon rules typically provide that, when more than one surgeon is involved in a single operative session with a patient, the second surgeon (who is designated as the assistant surgeon) will receive only a fraction of the reimbursement that the primary surgeon receives.

As with the multiple surgery rule, while Virginia has no formal rule on point, a survey of state workers' compensation statutes and administrative regulations reveals 45 states have implemented assistant surgeon rules, again emphasizing the widespread formal recognition of this type of reimbursement practice.

The federal government also instructs that for "a physician serving as an assistant at surgery, the payment amount shall not exceed 16 percent of the fee schedule amount" and actually denies payment of any kind in certain circumstances.[3] 42 U.S.C. §1395w–4(i)(2)

The federal government also requires that the amounts paid for a physician's assistant ("PA"), nurse practitioner ("NP"), or clinical nurse specialist ("CNS") assisting in surgery is the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician serving as an assistant at surgery. *See* 42 U.S.C. §1395l(a)(1)(O)(ii). In conjunction with these rules, 42 CFR 414.40 defines modifiers to be used:

- Modifier 80 (assistant surgeon), 81 (minimum assistant surgeon), or 82 (when qualified resident surgeon not available) is used to bill for assistant at surgery services. When billed without modifier AS (PA, NP or CNS services for assistant at surgery) the use of these modifiers indicates that a physician served as the assistant at surgery.
- Modifier AS is billed to indicate that a PA, NP or CNS served as the assistant at surgery. Modifier 80, 81 or 82 must also be billed when modifier AS is billed.
- Claims submitted with modifier AS and without modifier 80, 81 or 82 are returned to the provider (RTPd).

Again, this rule is supported by prudent policy considerations of cost containment and reasonableness of reimbursement, which dictate that if physician fees are established at rates for the surgeon primarily performing the procedure, then an additional physician serving in an assistant capacity would not receive the same payment. Similarly, that a PA, NP or CNS would receive less pay than a physician in the capacity of assistant makes sense given the lesser degree of knowledge, experience, and skill that must be assumed.

Of the state workers' compensation systems surveyed, 15 states limit reimbursement for assistant surgeons but appear to make no distinctions between physician (MD) assistants and non-MD assistants. For these states, the rates vary between 15% and 20% of the primary surgeon's fee.

Another 30 states do make a distinction between assistant surgeons who are physicians and those who are not (including physician assistants, registered nurses, and nurse practitioners). In many of these states, an assistant physician is specified or identified by using the modifiers 80 or 82 as appropriate. Payment rates for MD assistants vary between 16% and 25% of the amount paid to the primary surgeon, but most states use a 20% rate. Non-physician assistant payment rates vary

[3] Payment is denied when the Secretary of Health and Human Services determines that an assistant is used in less than 5% of the average cases nationwide.

from 10% to 25%, but the vast majority of states use either 10% or 15% of the fee paid to the primary surgeon.[4]

Recommendation

FairPay recommends that, in order to fall within the mainstream of payment methodologies employed in other states, Virginia adopt an assistant surgeon rule for its workers' compensation system including the following standards:

- Separately identify assistants that are physicians from those non-physician assistants by using billing modifiers.
- Reimburse physicians who are assistants in the surgery at 20% of the rate the primary surgeon receives.
- Reimburse non-physicians who are assistants in the surgery at 10% of the rate the surgeon physician receives.

This rule should be accompanied by general billing instructions telling professionals and facilities to bill their full rates for procedures and relying upon payors to apply the assistant surgery rules to the prevailing rates. Again, this clear rule ensures that there is no confusion on behalf of the payor as to whether the provider has already applied an assistant surgeon billing reduction.

The following proposed language could be used for such an assistant surgeon rule:

> ***x.* Modifiers Affecting Payment**
>
> **Modifier 80 (Assistant Surgeon)**
> When a physician assists at surgery, the assistant surgeon should use modifier 80, and the reimbursement shall be 20 percent of the fee for the procedure.
> **Modifier 81 (Minimum Assistant Surgeon)**
> When a non-physician such as a physician's assistant, nurse practitioner or registered nurse serves as an assistant surgeon, a minimum assistant surgeon fee is payable. Modifier 81 should be used and the fee shall be 10 percent of the fee for the procedure.
> **Modifier 82 (Assistant Surgeon when qualified resident surgeon not available)**
> Assistant surgeon fees are not payable when a qualified resident surgeon assists or is available to assist at surgery. When a physician serves as an assistant surgeon fees are payable. Modifier 82 should be used and the fee shall be 20 percent of the fee for the procedure.
>
> Under no circumstances will a fee be allowed for a physician assistant surgeon and a non-physician assistant surgeon during the same surgical encounter.

[4]These non-physician assistant surgeons are identified using modifiers (in order of predominance) 81, AS, NP, 29.

Prompt Pay Rules

Forty-two states have enacted prompt pay statutes or rules. Currently, Virginia is not among those states. Of these, 40 states have promulgated clear and explicit rules, while two other states require payment in a timely or reasonable fashion without providing specific measurable deadlines.

In fashioning clear rules, the following factors must be considered:
1) Will a specific time frame be given?
2) If so, what should be the start date for the time frame?
3) In paying undisputed amounts, what notice of the disputed amounts should be given?

Only three states have one timeframe for payment and another for notice of dispute (usually provided through an Explanation of Benefits or Explanation of Review [EOB/EOR]). Almost all the states use the date of the payor's receipt of the bill as the start date for the payment time frame. Over half the states (24) allow thirty calendar days from this receipt date for payment to be made. Almost all the states require payment of the undisputed portion of the bill to be paid at the end of the time frame. All states require a notice or explanation of review or benefits indicating disputed amounts and the reasons for dispute.

Typical reasons for disputed amounts include, but are not limited to:

- Charges in excess of fee schedule/maximum allowance
- Charges in excess of statutory requirements
- Charges whose reimbursement was already covered under the reimbursement of another item or service
- Charge is a duplicate
- Charges without appropriate documentation (e.g., implants)

Effective and rational prompt payment rules incorporate at least two top public policy considerations: 1) minimizing the additional administrative costs medical providers may experience in participating in the treatment of workers' compensation claimants; and 2) clear notice to the medical providers for the reasons of any deviations from the expected reimbursement. Timeliness of payment is a key consideration in medical providers' willingness to treat patients covered under workers' compensation systems.

Recommendation

FairPay recommends the following or similar language for developing a prompt payment directive:

A medical provider shall transmit the request for reimbursement for treating a claimant to the workers' compensation payor within 60 days of the last day of treatment covered in a discrete bill. A payor has 60 calendar days from receipt of the bill to pay all undisputed amounts. A payor, within 60 calendar days of receipt of the bill, must give written notice to the provider of any disputed, denied or reduced amounts, together with the reasons for the dispute, denial or reduction. The written notice must include a telephone number (for verbal communications) and address (for written communications) for receipt of any medical provider question, inquiry, or supplemental materials concerning the reimbursement request.

MIDKIFF, MUNCIE & ROSS, P.C.
ATTORNEYS AND COUNSELLORS AT LAW
300 ARBORETUM PLACE, SUITE 420
RICHMOND, VIRGINIA 23236

(804) 560-9600
FAX (804) 560-5997
HTTP://WWW.MIDKIFFLAW.COM

June 9, 2010

The Honorable William L. Dudley, Jr.
Chairman
Virginia Workers' Compensation Commission
1000 DMV Drive
Richmond, VA 23220

Dear Commissioner Dudley:

I have reviewed the FairPay Solutions, Inc. comments concerning multiple procedure recommendations and recommendations related to assisted surgeons. I concur in their detailed analysis. Medical expenses in Virginia have risen at an alarming rate, far and above medical expenses being considered and paid in sister states. The two primary culprits in this cost rise are the lack of any multiple procedure regulations as well as the lack of any procedures related to assistant surgeons. We have found that certain physicians are being paid 300% of Medicare reimbursement because of these cost drivers.

Thank you for considering these comments.

Sincerely,

Charles F. Midkiff

CFM/pwc

MEDICAL SOCIETY OF VIRGINIA

June | 22 | 2010

William L. Dudley, Jr.
Chairman
Workers' Compensation Commission
1000 DMV Drive
Richmond, Virginia 23220

Dear Chairman Dudley:

You have requested comment on issues raised in SB 367 and HB 1326 relating to reimbursement and payment to physicians and other providers for care provided under Virginia's workers' compensation system. Below the physician community has made some general observations about medical costs for workers' compensation care and then we provide detailed responses to the issues you enumerated in your May 6 letter to stakeholders.

"Compared to other states, Virginia's workers' compensation system is effective." This is a recent quote from the Virginia Coalition on Workers' Compensation (BCWC), who consistently argues that the status quo has provided for an efficient, navigable system that results in savings for Virginia businesses and access to high-quality care for injured workers. National Council on Compensation Insurance (NCCI) data demonstrate how Virginia is well below other states regarding the cost of workers' compensation to businesses. According to information from the American Academy of Orthopaedic Surgeons (AAOS), reducing reimbursements for workers' compensation care reduces patient access to highly-qualified specialists.

For example, in Texas and Florida, fee schedules, limits or caps on provider reimbursement for workers' compensation cases have resulted in orthopaedic surgeons being forced to limit the number of claimants that they treat and a number of claimants are forced to turn to physicians who are less-likely to be board-certified or trained in U.S. medical schools. Fee schedules negatively impact quality and access to care. We oppose all efforts to impose fee schedules in Virginia.

The Commission may and does rule on reimbursements based on information gathered to determine the prevailing community rate (PCR). When challenging a provider's charges for care provided a patient/claimant, insurers have been unable or unwilling to present the Commission with source data that refute the PCR. We conclude this is for two reasons: (1) the reduced rates that the insurers would prefer may be based on averaged reimbursements paid to a range of providers which, for example, can include non-physicians, and (2) those rate schedules may be based on medical insurance reimbursement that do not account for the case complexities, administrative burdens, or lack of volume

2924 Emerywood Parkway
Suite 300
Richmond, VA 23294

T 804|353-2721
TF 800|746-6768
FX 804|355-6189

www.msv.org

inherent in workers' compensation cases. Our organizations offer our assistance to the WCC in collecting any charges data that would assist in determining PCR. We also encourage the WCC to order insurers to provide all data and methodology used to formulate the data bases that use regarding the PCR.

Proponents of severe changes to the current system lament that Virginia has a higher percentage of its costs attributable to medical care than other states. It could be reasonably argued that our system keeps administrative, third party, and legal costs lower and keeps dollars for the intended purpose of providing medical care for injured workers. While we strive to keep health care costs as low as possible, we can celebrate that Virginia's system focuses on the treatment and rehabilitation of our workers and patients.

Responses to Issues Raised in SB 367 and HB 1326

1. **The extent to which reductions and discounts are allowed for multiple procedures performed during a single operative session**
   - Virginia should not engage in price fixing by adopting in statute or regulation a prescriptive schedule for reimbursement of services.
   - Reductions and discounts can be negotiated and established in contracts between insurers and providers.
   - The Commission is currently charged with determining the PCR. The WCC should gather professional charges data to determine fair rates for multiple procedures in each workers' compensation district.
   - The Commission should demand that insurers or other parties who challenge PCR decision provide source data that are the basis for their objections.

2. **The extent to which an employer is liable for the costs of assistants at surgery**
   - Reimbursements for assistants-at-surgery and physician assistant services can be negotiated and established in contracts between insurers and providers
   - The Commission should compile professional charges data to determine PCR for payment of both physician and non-physician assistants.
   - The Commission should consider rules that would reimburse academic medical centers for assistant services provided by resident physicians.

3. **The extent to which prompt payment to medical providers should be required**
   - First, prompt and full payment of claims to physicians in Virginia is frequently reported to our organizations.
   - Workers' compensation insurers should be subject to the "fair business" requirements placed on insurers under the Fair Business Practice Act (Virginia Code Section 38.2-3407.15) as are health insurers. One aspect of the Act requires payment of clean claims within fourteen days which would go along way to solving the prompt payment issues.
   - Second, when claims are considered compensable, providers should be paid for the undisputed services even if there is a pending challenge non-medical aspects of the claim.

4. **How charges for medical services are provided for treatment to Virginia claimants in foreign jurisdictions are determined to be appropriate under Virginia law**
    - Virginia patients and their claims should be subject to Virginia laws and rules rather than the rules of other jurisdictions.
    - We should be mindful that in some regions, especially along Virginia's rural borders, that the closest specialist maybe in a sister state.

In conclusion, our organizations see no compelling reason to alter current statutory or regulatory law unless the WCC has exhausted other avenues already available. We appreciate the opportunity to comment on these matters. Please let us know if we can provide additional information. Likewise, if the WCC intends to have a hearing on these issues, we request to be included on the agenda to present.

Respectfully,

Daniel Carey, M.D.
President
Medical Society of Virginia

Bobby Chhabra, M.D.
President
Virginia Orthopaedic Society

Cc: The Honorable Richard L. Saslaw
The Honorable Phillip Puckett
The Honorable Donald Merricks

PCI Property Casualty Insurers Association of America
Shaping the Future of American Insurance

July 6, 2010

William L. Dudley, Jr.
Chairman
Virginia Workers' Compensation Commission
1000 DMV Drive
Richmond. Virginia 2322

RE: Multiple Surgical Procedures, Assistants at Surgery and Prompt Payment to Medical Providers.

Dear Mr. Dudley:

The PCI is a national property/casualty trade association representing over 1,000 property/casualty insurance companies. Our members write 39.4 percent of the Virginia workers compensation insurance premium and 41.7 percent of the national workers compensation premium. We thank the commission for the opportunity to express our views on the issues listed above.

Multiple Surgeries Performed During a Single Operative Session

Medicare is commonly used as a basis for workers compensation fee schedules across the states. States use Medicare as a base for workers compensation fee schedules because Medicare provides a payment standard, allows for consistent and timely updates to the fee schedules and leads to additional cost savings through lower administrative costs on implementing and updating the schedules.

Regulations regarding Medicare payments for multiple surgical procedures performed in an ASC are contained in Title 42 Part 416.120 of the Code of Federal Regulations (42CFR416.120). According to 42CFR416.120, when one covered surgical procedure is furnished to a beneficiary in an operative session, payment is based on the prospectively determined rate for that procedure. When more than one covered surgical procedure is furnished in a single operative session, payment is based on the full rate for the procedure with the highest prospectively determined rate and one-half of the prospectively determined rate for each of the other procedures. Most states using Medicare as a basis include a multiple surgery reduction rule.

2600 South River Road, Des Plaines, IL 60018 Telephone 847-297-7800 Fascimile 847-297-5064 www.pciaa.net

PCI recommends that Virginia consider implementing a multiple surgery reduction rule. Without such a rule employers/insurers will be paying twice for an expense already reimbursed. We suggest that for operations performed by the same physician during the same operative session, at the same operative site, reimbursement should be made at 100 percent (100%) of the highest cost procedure for the procedure and 50 percent (50%) of the approved rate for five additional procedures which are related to the injury, medically necessary and not incidental to the other. For other additional procedures, PCI concurs with the recommendation as outlined by FairPay.

Assistants at Surgery

Under Medicare, reimbursement for assistant at surgery services provided by a physician is 16 percent of the Medicare Physician Fee Schedule. Only a physician who assists at surgery may be reimbursed as a surgical assistant - 42 U.S.C. §I 395w-4(i)(2).

Medicare reimbursement for assistant at surgery services provided by a physician assistant is 13.6 percent (16 percent x 85 percent) of the Medicare Physician Fee Schedule - 42 U.S.C. §13951(a)(I)(O)(ii).

PCI concurs with the recommendations made by FairPay because it is based on Medicare methodology.

FairPay recommends that, in order to fall within the mainstream of payment methodologies employed in other states, Virginia should adopt an assistant surgeon rule for its workers' compensation system including the following standards:

- Separately identify assistants that are physicians from those non-physician assistants by using billing modifiers.
- Reimburse physicians who are assistants in the surgery at 20% of the rate the primary surgeon receives.
- Reimburse non-physicians who are assistants in the surgery at 10% of the rate the surgeon physician receives.

Prompt Pay

Our members providing input on this recommendation concur with FairPay's recommendations as follows:

> A medical provider shall transmit the request for reimbursement for treating a claimant to the workers' compensation payor within 60 days of the last day of treatment covered in a discrete bill. The bill must be accompanied by sufficient documentation showing that the treatment is related to the injury and is medically necessary. A payor has 60 calendar days from receipt of the bill to pay all undisputed amounts. A payor, within 60 calendar days of receipt of the bill, must give written notice to the provider of any disputed, denied or reduced amounts, together with the reasons for the dispute, denial or reduction. The written notice must include a telephone number (for verbal communications) and address (for

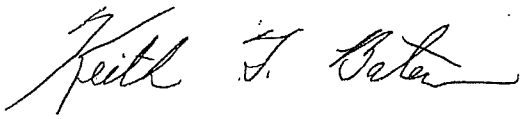
written communications) for receipt of any medical provider question, inquiry, or supplemental materials concerning the reimbursement request.

However, our members would like to include an additional requirement, which is based on the West Virginia system. Providers in West Virginia must send their bills within six (6) months of the date of service to be considered for payment. (§23-4-3b(b) -- Bills must be received within six (6) months of the date of service to be considered for payment. Injured workers cannot be billed for any invoice denied under this provision.). By incorporating this requirement into FairPay's recommendation, the reimbursement system should be effective for all stakeholders.

Medical Services Provided to Virginia Claimants in Foreign Jurisdictions

Because the Commission does not have prevailing community rate data for foreign jurisdictions, PCI recommends that if the foreign state in which treatment was provided has a fee schedule that reimbursement be in accordance with it. If not, the prevailing rate in the contiguous Virginia geographic area should be used.

Please feel free to contact PCI if you need further assistance.



Keith Bateman
Vice President
Workers Compensation
Property Casualty Insurers
Association of America (PCI)
Ph: 847.553.3802
Cell: 630.338.5674
Fax: 847.759.4361
keith.bateman@pciaa.net

GEO. E. PENN (1895-1931)
WM. A. STUART (1922-1976)
J. STUART (1952-1991)

W. ESKRIDGE
STEPHEN M. HODGES
W. CHALLEN WALLING [III]
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W. BRADFORD STALLARD
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JOHN A. MARTIN [III]
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ATTORNEYS AT LAW

Post Office Box 2288
Abingdon, Virginia 24212-2288

208 East Main Street
Abingdon, Virginia 24210-2904

Telephone 276/628-5151
Facsimile 276/628-5621

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BRUCE E. GIBSON OF COUNSEL [III]
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J. RANDALL BROOKS, JR. [I, II, III]
JOSEPH S. HALL
WESLEY B. BOGGS [I, III]
HOLLY N. MANCL [IV, V, •]

Direct Dial 276.623.4412
rmurthy@pennstuart.com

July 6, 2010

Honorable William L. Dudley Jr.
Chairman
Virginia Workers' Compensation Commission
1000 DMV Drive
Richmond, Virginia 23220

Re: Virginia Association of Defense Attorneys

Dear Chairman Dudley:

I am writing in response to your May 6, 2010 letter addressed to Leigh Farmer, Executive Director of the Virginia Association of Defense Attorneys. I am currently Chair of the Workers' Compensation Section of the Virginia Association of Defense Attorneys.

Initially, let me thank you for seeking our input into this matter pertaining to medical billing.

The VADA has chosen not to provide an official response. Outlined below constitutes views of representative members of the Workers' Compensation Section of the Virginia Association of Defense Attorneys.

Your initial inquiry is with regard to the extent to which reductions and discounts are allowed for multiple surgical procedures performed during a single operative session. It may be worthwhile to independently review how other jurisdictions handle this issue to provide additional guidance. Many of our members view a sliding scale for payment as being the most equitable way of resolving the issue. For example, 100% of the reasonable and customary

charge of the most expensive procedure with 50% for the second, and 33% for the third, etc. There was concern, however, that unbundling has become a major issue and, at points, has reached a level of absurdity. That is to say, many are concerned that placing a sliding scale fee schedule in place may result in excessive unbundling and therefore any legislation would need to address limits on unbundling as well.

You also inquired as to the extent to which an employer is liable for cost of assistants at surgery. Physician extenders have become a major issue through the utilization of physician's assistants, nurse practitioners, and the like. Many believe that requiring any party to pay 100% cost for not only the surgeon but the physician's assistant to be inappropriate. Compensating the physician's assistant or the physician extender at 15 to 20% of the surgeon's charge seems to be viewed as being reasonable. As you are aware, what we are seeing now in many cases is extensive unbundling with a request that 100% of the surgeon's and extender's charges be paid. This is resulting in, what we believe to be, not only an inherently unfair system but also a system in which the medical expenses are far out of line with what is appropriate.

You have also asked the extent to which prompt payment of medical providers should be required. Although this does at times appear to be a problem, we believe this can be resolved initially through the proper documentation being submitted with the proper bill. Any time limit imposed should not begin to run until the party seeking payment has certified that the proper documentation has been submitted.

The other issue that arises is when, for example, a surgical bill is sent in with complex unbundling and dual charges for surgeons and physicians' extenders. Repricing vendors are requiring longer periods of time to review these bills. Certainly addressing the initial issues outlined above may help speed up the pace of pay. Similarly, the General Assembly should consider imposing a statutory time period within which any such claims may be filed. If that was accompanied by legislation that imposed the potential for the assessment of attorney's fees for unreasonably bringing such claims on medical providers, that may also assist in streamlining the issues at hand.

Finally, you have asked how charges for medical services provided for treatment to Virginia claimants in foreign jurisdictions are determined to be appropriate under Virginia law. For many of us, this is a hot button issue as our practices are on the borders of states which have fee schedules. From a personal standpoint, my practice requires the utilization of Tennessee physicians. This is because most of the orthopedic surgeons in deep Southwest Virginia practice in Tennessee. There are no neurosurgeons between Roanoke, Virginia, and Bristol Tennessee. The only hospitals in the deep southwest portion of the state that offer neurosurgical services are

on the Tennessee side. Given my practice in Tennessee, I note that many physicians decline to participate in the Tennessee workers' compensation system because of their dissatisfaction with the Tennessee fee schedule. I do have some concerns about injured employees not being able to receive reasonable neurosurgical care, for example, if such a system is imposed.

Others within our group do not object to the application of a foreign fee schedule as long as carriers and self-insured employers were able to negotiate with providers to agree upon a fee that may exceed the Tennessee fee schedule to ensure service to their insureds or employees, respectively.

The final area of concern, on this issue, would be the waiver of authority to set rates for physicians providing care to Virginia claimants.

Again, I apologize that we are not able to provide an official Virginia Association of Defense Attorneys response. However, the above represents a compilation of views expressed by some of the members. Should you need anything further, please do not hesitate to give me a call.

Sincerely yours,

PENN, STUART & ESKRIDGE

Ramesh Murthy

RM/gg

THE VIRGINIA COAL ASSOCIATION, INC.

W. THOMAS HUDSON
PRESIDENT

JOHN T. HEARD
LEGISLATIVE COUNSEL

THORNTON L. NEWLON
LEGISLATIVE COUNSEL

1001 EAST BROAD ST.
SUITE 425
OLD CITY HALL
RICHMOND, VIRGINIA 23219
804 / 643-6697

BY HAND

July 2, 2010

The Honorable William L. Dudley, Jr., Chairman
Virginia Workers' Compensation Commission
1000 DMV Drive
Richmond, VA 23220

Re: Comments On Issues Raised by Senator Saslaw / SB 367 & HB 1326 (2010)

Dear Chairman Dudley:

The Virginia Coal Association, Inc. (VCA) appreciates this opportunity to offer our comments on the four workers' compensation issues raised by Senator Saslaw with respect to SB 367 (2010) and HB 1326 (2010). The VCA's membership consists of coal companies that produce approximately 87% of the coal mined annually in the Commonwealth. Our comments follow.

(1) The extent to which reductions and discounts are allowed for multiple surgical procedures performed during a single operative session.

The VCA has reviewed and concurs with the detailed comments and recommendations on this issue submitted by FairPay Solutions, Inc. Virginia should adopt a formal multiple surgery rule which mandates (1) payment at 100% of the prevailing rate on the primary procedure, defined as the procedure with the highest value; (2) payment at 50% on the second through fifth procedures; and (3) payment on sixth or more procedures on a "by report" basis. There would need to be general billing instructions informing professionals and facilities to bill their full rates for all procedures. Payors would then apply the multiple surgery rule to the prevailing rate, eliminating any confusion among payors whether a provider has already applied a reduction factor to the bill. It should be noted that the vast majority of states have adopted a formal multiple surgery rule.

(2) The extent to which an employer is liable for the costs of assistants at surgery.

The VCA has reviewed and concurs with the detailed comments and recommendations on this issue submitted by FairPay Solutions, Inc. Virginia should adopt a formal rule on assistant surgeon reimbursement that is within the mainstream of payment methodologies employed in other states. In doing so, Virginia should adopt the following standards: (1)

separately identify assistants that are physicians from those non-physician assistants by using billing modifiers; (2) reimburse physicians who are assistants in the surgery at 20% of the rate the primary surgeon receives and (3) reimburse non-physicians who are assistants in the surgery at 10% of the rate the surgeon physician receives. VSIA recognizes that there may be certain medical surgical procedures which necessitate the participation of more than one "primary" physician surgeon, but we also believe those procedures will be relatively rare in workers' compensation cases. The rule should include general billing instructions telling professionals and facilities to bill their full rates for procedures and relying upon payors to apply the assistant surgery rules to the prevailing rates. It should be noted that the vast majority of states have implemented assistant surgeon rules.

(3) The extent to which prompt payment to medical providers should be required.

The VCA would ask the Commission the extent to which prompt payment is an issue in their oversight of claims. We believe the Commission should already have a feel for the status of issues relating to delayed medical payments. While a prompt payment statute may seem simple it can be difficult to enforce. For example, it may be difficult to determine when a complete bill that is adequate for a payment decision is actually received. Similarly, many bills are denied or returned to the vendor for additional information. While we assume good faith denials or additional requests will not be deemed untimely, denials or requests for additional information may not always be in good faith. Action from the Commission may be required should controversy arise. It is very possible that a relatively benign concept like prompt payment of medical bills will require more attention from the VWCC than the status quo. If there is information that demonstrates a need to address prompt payment concerns, the VCA has information regarding statutes adopted in other jurisdictions and would be happy to discuss this matter further.

(4) How charges for medical services provided for treatment to Virginia Claimants in foreign jurisdictions are determined to be appropriate under Virginia law.

Medical charges for Virginia claimants treated in foreign jurisdictions have been problematic for employers with operations in border areas since the inception of Rule 14. This is especially true for the VCA's members given their location in far Southwest Virginia. The related issues have been the subject of controversy before the Commission on many occasions. For the following reasons, it is our position that the fee schedules of the jurisdiction where care is rendered should control the amount payable for the care rendered:

- It is the consistent observation of our members that in most cases community standard calculations for Virginia exceed the amount paid using fee schedules of the surrounding states. Therefore, non-Virginia providers are often compensated at a higher rate for services they provide to Virginia workers than they are for providing the same services to workers who reside in that foreign jurisdiction. In our view, such providers now receive a windfall for services rendered to Virginia workers. This practice mitigates against efficient care. It would be wise to confirm our members' observations using empirical data provided by an independent third party such as the Workers' Compensation Research Institute (WCRI). WCRI has done studies on the workers' compensation systems of

many of our surrounding states but has not conducted an in-depth study of the Virginia workers' compensation system since 1994. The Virginia Workers' Compensation Commission and the Virginia General Assembly would benefit for many years by having all the baseline information that could be generated by a WCRI study of Virginia's current system.

- Community standard calculations or other network reductions require using a managed care company or renting software to establish the amounts payable for different CPT codes (codes which define services rendered). State fee schedules are free of charge. Therefore, even if medical charges calculated using the community standard and those governed by the fee schedule are similar, the net cost is higher for Virginia employers for community standard calculations.

- Many of the providers who have argued against using the fee schedules of the states in which they provide services to govern VA charges are the same ones challenging community standard calculations before the VWCC. Such challenges increase costs for Virginia employers.

We appreciate your consideration of these comments.

Sincerely,

John T. Heard
Legislative Counsel

Trish - FYI

VIRGINIA HOSPITAL & HEALTHCARE ASSOCIATION

4200 INNSLAKE DRIVE, SUITE 203, GLEN ALLEN, VIRGINIA 23060-6772
P.O. BOX 31394, RICHMOND, VIRGINIA 23294-1394
(804) 965-1227 FAX (804) 965-0475

July 2, 2010

The Honorable William L. Dudley, Jr
Chairman
Workers' Compensation Commission
1000 DMV Drive
Richmond, Virginia 23220

Dear Chairman Dudley:

Thank you for the opportunity to comment on the issues outlined in your letter regarding Workers' Compensation in the Commonwealth. The Virginia Hospital & Healthcare Association (VHHA) represents health systems and hospitals, including psychiatric, rehabilitation and specialty hospitals throughout Virginia. Our members treat a wide variety of workers' compensation cases. The payment policies and rates associated with the program affect their ability to care for these patients as well as the broader patient populations in the communities they serve. Additionally, hospitals and health systems are large employers and so view workers' compensation issues not only as providers of medical care but as businesses who must pay for workers' compensation costs.

The Commonwealth's workers' compensation system is respected nationally and considered a strong, relatively cost-effective system for its stakeholders. Virginia's health care is low-cost. We are in the:

- Lowest 10 percent of states in Medicare spending per beneficiary (Dartmouth Atlas); and
- Lowest quartile in insurance premium costs for the private, small group market and nearly lowest quartile in private, individual insurance market (AHIP).

Given these rankings it comes as no surprise that our workers' compensation system is strong. As the Commission explores potential changes, it should follow the medical maxim, "First, do no harm," and ensure we do nothing to weaken the system. That noted, as with any program, there clearly are areas that merit attention and potential improvement. Your letter focused on four key areas.

1 & 2. The first two issues the Virginia's Workers' Compensation Commission is examining, **multiple surgical procedures in a single operative session and the costs of assistants at surgery,** deal with payment rates. Virginia's workers' compensation system typically and responsibly covers the costs of care, as do other private payers. Conversely, government payers

extract below-cost rates from providers, including the state-run Medicaid and the federal Medicare and TRICARE programs. *We would oppose any efforts to implement a fee schedule in Virginia.* Many believe Virginia's workers' compensation rates are reasonable, and insurers and providers are free to negotiate payment rates in contract provisions if they feel that rates as currently structured are not reasonable.

Additionally, unlike most private and governmental payers, Virginia's workers' compensation payments routinely take inexcusably long adjudication periods and are unnecessarily administratively costly for all parties. This must be addressed, as noted in the next section of this letter.

3. The third issue your letter raises, **prompt payment**, is a critical one for Virginia's health care providers. Frequently, it can take months, or in more than a few cases, years of legal wrangling for payment to be received by a hospital or health system, and at that point payment levels are eroded by inflation and the cost of recovery. There may be several reasons why workers' compensation payments are so egregiously delayed:

- Time to reach a compensability decision, i.e., determining whether a claim is payable under workers' compensation or must be filed with another insurance. While awaiting a decision, providers are unable to bill commercial insurance until a compensability decision regarding the workers' compensation claim has been reached, interrupting cash flow and creating an administrative burden.

  These delayed decision times are challenging for the patients/employees, too, who are waiting to see how their claim will be covered, whether by workers' compensation or some other payer, and what services they may have covered at what cost to them.

- Time required to obtain payment even after a compensability decision has been made. This often results in having to pay a specialist or legal counsel to follow up on payments for workers' compensation claims.

- Lack of accountability. There is no penalty to an insurance carrier or third party claims administrator dragging out the payment process or taking unilateral rate cuts, thereby applying usual and customary rate (UCR) PPO contract rates years after the fact when the law requires the prevailing community rate, and often times offering to pay some small percentage above below-cost Medicare rates as if Medicare were the starting benchmark for paying workers' compensation medical fees.

Virginia must address the length of time required to reach a compensability decision and reduce the length of time required for issuing payment once a compensability decision has been reached. Virginia should consider requiring payment or denial within 45 days from the time the medical

record is complete (a "clean claim") and provided to the workers' compensation payer. The time for receipt of payment should not be tied directly to the compensability decision or payers would be incentivized to simply deny all claims, thus avoiding the start of a payment timeframe.

Both penalties and interest should be used to enforce timeliness. If a payer exceeds the reasonable time for payment, interest should accrue on the account as it does in private insurance and civil cases. There should be significant penalties if a payer's failure to pay promptly is determined to be an intentional business practice. The Commonwealth's Fair Business Standards Act, by which many insurers must abide, may serve as a resource in considering potential improvements to workers' compensation procedures.

In addition to these interest and fines policies, Virginia should consider implementing a workers' compensation claim "loser pays" policy where, if the initial workers' compensation payment denial is successfully appealed, the payer would be liable for the administrative costs associated with the appeal. If the appeal fails, the provider would be liable for the administrative costs. The timeframe for completion of such appeals decisions should be limited.

Finally, the Commission should be aware that some providers negotiate a PPO contract with a workers' compensation carrier including rates at less than the prevailing community rate as well as payment timeframes. Sometimes, after a workers' compensation claim has taken years to finally be paid, payers still lean on the original negotiated PPO rates as a starting point for payment rather than the prevailing community rate even though the time was exceeded. For example, assume a medical facility has provided inpatient trauma care to an injured worker for 45 days. The medical bill for services totals $500,000. The payer typically unilaterally deducts 15% to bring the bill to the UCR rate as established in the PPO contract even though the payment timeframes were not met. If the bill or claim is contested, there will be an attorney fee of 20% to 25%. Before any additional negotiations take place, the starting point for the payer on this bill becomes $318,750. This is not a sustainable method for paying large, complex medical bills on serious injuries.

If this is to be a standard by which payment levels are judged, the Commission should consider all components of such PPO contracts, including prompt payment provisions, and ensure that all provisions of the contract were met. If prompt pay requirements embedded in the private contract examined as a reference point for payment levels are exceeded, then those negotiated payment amounts should not be considered an appropriate starting point for the workers' compensation payer.

4. Maintaining access to care should be the overriding priority in determining whether **charges for Virginia claimants in foreign jurisdictions are adequate**. Jurisdiction over a workers' compensation case generally resides with the state where an injury has occurred. That means that a worker injured in Virginia receiving care in another state will have his care paid at the Virginia levels of compensation and benefit coverage. Our general comment here, whether related to workers injured in Virginia or another jurisdiction, is to ensure that payment rates are appropriate to maintain an adequate supply of providers available and willing to care for patients.

VHHA also wants to make clear that **data used to conduct workers' compensation studies should be as accurate and comprehensive as possible, including data on the self-insured and/or self administered employers.** Workers' Compensation Research Institute (WCRI) data is a thorough and appropriate data source as you move forward with your study of these matters.

We greatly appreciate this opportunity for comment and look forward to continuing to work with you as you continue your study. Please let us know how else we may be helpful.

Sincerely,

Laurens Sartoris
President

THE
VIRGINIA
SELF - INSURERS
ASSOCIATION, INC.

BY HAND

July 2, 2010

The Honorable William L. Dudley, Jr., Chairman
Virginia Workers' Compensation Commission
1000 DMV Drive
Richmond, VA 23220

Re: Comments On Issues Raised by Senator Saslaw / SB 367 & HB 1326 (2010)

Dear Chairman Dudley:

The Virginia Self-Insurers Association, Inc. (VSIA) appreciates this opportunity to offer our comments on the four workers' compensation issues raised by Senator Saslaw with respect to SB 367 (2010) and HB 1326 (2010). As you know, VSIA's 100+ members include public and private employers that are self-insured for purposes of satisfying their workers' compensation obligations in Virginia. Our comments follow.

(1) The extent to which reductions and discounts are allowed for multiple surgical procedures performed during a single operative session.

VSIA has reviewed and concurs with the detailed comments and recommendations on this issue submitted by FairPay Solutions, Inc. Virginia should adopt a formal multiple surgery rule which mandates (1) payment at 100% of the prevailing rate on the primary procedure, defined as the procedure with the highest value; (2) payment at 50% on the second through fifth procedures; and (3) payment on sixth or more procedures on a "by report" basis. There would need to be general billing instructions informing professionals and facilities to bill their full rates for all procedures. Payors would then apply the multiple surgery rule to the prevailing rate, eliminating any confusion among payors whether a provider has already applied a reduction factor to the bill. It should be noted that the vast majority of states have adopted a formal multiple surgery rule.

(2) The extent to which an employer is liable for the costs of assistants at surgery.

VSIA has reviewed and concurs with the detailed comments and recommendations on this issue submitted by FairPay Solutions, Inc. Virginia should adopt a formal rule on assistant surgeon reimbursement that is within the mainstream of payment methodologies employed in other states. In doing so, Virginia should adopt the following standards: (1) separately identify

assistants that are physicians from those non-physician assistants by using billing modifiers; (2) reimburse physicians who are assistants in the surgery at 20% of the rate the primary surgeon receives and (3) reimburse non-physicians who are assistants in the surgery at 10% of the rate the surgeon physician receives. VSIA recognizes that there may be certain medical surgical procedures which necessitate the participation of more than one "primary" physician surgeon, but we also believe those procedures will be relatively rare in workers' compensation cases. The rule should include general billing instructions telling professionals and facilities to bill their full rates for procedures and relying upon payors to apply the assistant surgery rules to the prevailing rates. It should be noted that the vast majority of states have implemented assistant surgeon rules.

(3) The extent to which prompt payment to medical providers should be required.

It is our impression that for self-insured employers and administrators who serve them, prompt payment of medical bills is rarely an issue. The majority of self-insured employers insist on prompt payment of medical charges in order to avoid unnecessary conflict with employees. VSIA would ask the Commission the extent to which prompt payment is an issue in their oversight of claims. We believe the Commission should already have a feel for the status of issues relating to delayed medical payments. While a prompt payment statute may seem simple it can be difficult to enforce. For example, it may be difficult to determine when a complete bill adequate for a payment decision is actually received. Similarly, many bills are denied or returned to the vendor for additional information. While we assume good faith denials or additional requests will not be deemed untimely, denials or requests for additional information may not always be in good faith. Action from the Commission may be required should controversy arise. It is very possible that a relatively benign concept like prompt payment of medical bills will require more attention from the VWCC than the status quo. If there is information that demonstrates a need to address prompt payment concerns, VSIA has information regarding statutes adopted in other jurisdictions and would be happy to discuss this matter further.

(4) How charges for medical services provided for treatment to Virginia Claimants in foreign jurisdictions are determined to be appropriate under Virginia law.

Medical charges for Virginia claimants treated in foreign jurisdictions have been problematic for employers with operations in border areas since the inception of Rule 14. The related issues have been the subject of controversy before the Commission on many occasions. For the following reasons, it is our position that the fee schedules of the jurisdiction where care is rendered should control the amount payable for the care rendered:

- It is the consistent observation of our members that in most cases community standard calculations for Virginia exceed the amount paid using fee schedules of the surrounding states. Therefore, non-Virginia providers are often compensated at a higher rate for services they provide to Virginia workers than they are for providing the same services to workers who reside in that foreign jurisdiction. We believe such providers are now receiving a windfall for services rendered to Virginia workers. This practice mitigates against efficient care. It would be wise to confirm our members' observations using empirical data provided by an independent third party such as the Workers' Compensation Research Institute (WCRI). WCRI has done studies on the workers'

compensation systems of many of our surrounding states but has not conducted an in-depth study of the Virginia workers' compensation system since 1994. The Virginia Workers' Compensation Commission and the Virginia General Assembly would benefit for many years by having all the baseline information that could be generated by a WCRI study of Virginia's current system.

- Community standard calculations or other network reductions require using a managed care company or renting software to establish the amounts payable for different CPT codes (codes which define services rendered). State fee schedules are free of charge. Therefore, even if medical charges calculated using the community standard and those governed by the fee schedule are similar, the net cost is higher for Virginia employers for community standard calculations.

- Many of the providers who have argued against using the fee schedules of the states in which they provide services to govern VA charges are the same ones challenging community standard calculations before the VWCC. Such challenges increase costs for Virginia employers.

We appreciate your consideration of these comments.

Sincerely,

John T. Heard
Legislative Counsel

THE HARBISON LAW FIRM PLLC

July 6, 2010

VIA HAND DELIVERY

The Honorable William L. Dudley, Jr.
Virginia Workers' Compensation Commission
1000 DMV Drive
Richmond, Virginia 23220

Re: Virginia Workers' Compensation Commission Recommendations to the Senate Commerce and Labor Committee

Dear Chairman Dudley:

I serve as the VTLA Workers' Compensation Section Legislative Chair. In collaboration with other section leaders and VTLA Legislative Counsel, Steve Pearson, we would like to comment on the issues raised in your May 6, 2010 letter to Jack Harris, Executive Director of the VTLA. We thank you for the invitation to present our position. The four issues to address are:

1. The extent to which reductions and discounts are allowed for multiple surgical procedures performed during a single operative session;
2. The extent to which an employer is liable for the costs of assistants at surgery;
3. The extent to which prompt payment to medical providers should be required; and
4. How charges for medical services provided for treatment to Virginia claimants in foreign jurisdictions are determined to be appropriate under Virginia law.

Issues 1 and 2

The Virginia Trial Lawyers Association opposes any proposed legislative action that would require a predetermined fee schedule or rate structure for surgical procedures. We object because: fee schedules will most certainly result in the loss of board certified surgeons who are willing to accept workers' compensation cases; injured workers already face an access to care problem if a claim is denied, that will only compound if fee schedules are adopted; and the Commission already has full authority to rule on surgical charges on a case by case basis.

The primary purpose of the Workers' Compensation Act is to provide necessary medical treatment so the injured worker can heal and return to competitive employment. However, the Virginia Trial Lawyers Association is concerned that reduced payments to surgeons will reduce the number of physicians willing to accept workers' compensation cases. From the medical provider's perspective, accepting workers' compensation cases significantly increases administrative costs. These costs include such burdens as obtaining authorization for treatment, providing medical records, production of special reports, submission to depositions, subpoenas, medical record requests, phone calls, and correspondence with the parties.

Although voluminous, I enclose for your review, "Workers' Compensation Medical Fee Schedules – New Findings & Implications For California", Steven E. Levine, M.D., Ph.D., F.A.A.N. and Ronald N. Kent, M.D., Ph.D. (2007).[1] This is a very compelling study of the impact of the implementation of Medicare-based workers' compensation fee schedules in Maryland, Hawaii, Florida, West Virginia, Texas, and Florida. Approximately 1400 medical offices were contacted. The study concluded that workers' compensation cases caused a significant increase in actual financial cost to providers. The study also found that reductions in medical reimbursements caused an alarming flight of American trained, board certified specialists out of the workers' compensation system. We want to avoid the same disastrous result in Virginia.

Even if Issues 1 and 2 pertain only to surgeons, if other providers cannot rely upon surgeons to accept workers' compensation cases, they will be reluctant to get involved if they cannot effectively refer patients to surgeons. The most seriously injured workers will be denied access to care.

Injured workers already face an access to care problem if a claim is denied. If the claimant has no health insurance, then public assistance or emergency room care may be the only option. Even if an injured worker has health insurance, once a denied claim is designated as "on the job" the health insurance carrier typically denies treatment pending an outcome of the workers' compensation claim. This process can take months or years.

If a claim is accepted, the injured worker still faces access to care problems. The injured worker can only treat with an insurer authorized physician selected from a panel. Then, each office visit, imaging study, physical therapy plan, orthotic device, prescription medication, injection, surgery, and any other prescribed care must be pre-authorized by the carrier before the treatment occurs.

Authorization will not occur until the medical provider has satisfied the workers' compensation carrier that the treatment is reasonable, necessary, and related to the accident. Even once this occurs, the carrier may still demand an Independent Medical Evaluation or Peer Review before providing authority. Of course, the treatment may still be denied requiring the injured worker to file a claim and request adjudication by the Commission. Furthermore, insurers can, and do, use their negotiating power to establish fee contracts with surgeons.

The Virginia Trial Lawyers Association wants injured workers to have access to the best providers in Virginia so they can return to work as soon as possible. The Virginia Trial Lawyers believe that Issues 1 and 2 should continue to be addressed on a case by case basis by the Commission. If a provider is improperly billing for surgical procedures or assistants, the Commission can review the case and make the appropriate adjustment. Any attempt to make blanket reductions will have a disastrous impact on the number of physicians willing to accept workers' compensation cases. The negative impact would be heightened in rural areas where specialists are not as plentiful as in the metropolitan areas. This would be a devastating blow to injured workers and the entire workers' compensation system.

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[1] Also enclosed please find a publication from the American Association of Orthopaedic Surgeons citing the *Levine, M.D. and Kent, M.D.* study as well as a shorter summary article of the *Levine, M.D. and Kent, M.D.* study.

Issue 3

The Virginia Trial Lawyers support any reform which increases the speed of payment to physicians. Late payment is a serious administrative difficulty providers face when accepting workers' compensation cases. We support subjecting workers' compensation insurers to the fair business requirements pursuant to the Fair Business Practice Act (Virginia Code Section 38.2-3407.15) We support imposition of a 20% penalty against the insurer for failing to make prompt payment without any justification for the delay. Without a penalty, the insurer has little incentive to make prompt payment.

Issue 4

As set forth in the enclosed article, medical provider fee reductions have reduced the number of physicians accepting workers' compensation cases in other states. It can be very difficult for a worker covered under the laws of Virginia to find an out of state physician willing to accept Virginia cases. Virginia insurers have the right to contract with an out of state panel physician. If the negotiation is not successful, the injured worker should be able to select his own physician who can charge the prevailing community rate. In either scenario, the Virginia Workers' Compensation Commission should retain jurisdiction to resolve disputes.

Summary

The Virginia Trial Lawyers Association sees no benefit to injured workers', the Commission, or employers to reducing the number of medical providers accepting workers' compensation cases. Issues 1 and 2 are already adequately addressed by the Virginia Workers' Compensation Commission. Only Issues 3 and 4 present potential improvements to the current system. The Virginia Trial Lawyers Association appreciates the opportunity to comment on these issues and requests the opportunity to present testimony at any hearings scheduled on these issues in the future.

Respectfully submitted,

Gregory O. Harbison

Workers' Compensation Section Legislative Chair
Virginia Trial Lawyers Association

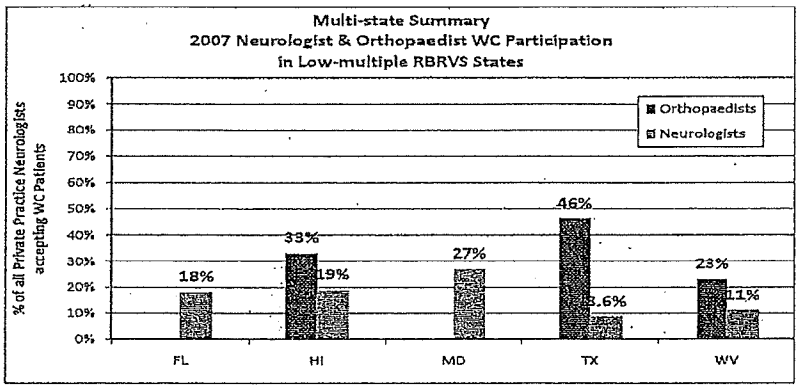
Cc: The Honorable Richard L. Saslaw
The Honorable Phillip Puckett
The Honorable Donald Merricks
Jack Harris, Esquire

AAOS
American Association of Orthopaedic Surgeons

Reductions in Workers Compensation Fee Schedules Threaten Patient Access to Quality Care

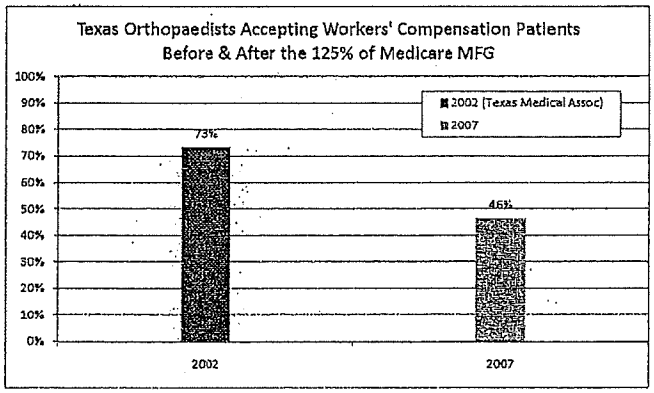
Studies show that every state that has adopted a low RBRVS fee schedule demonstrated a markedly low rate of orthopaedic participation in workers' compensation.

- In every one of the states with low-multiple fee schedules, less than half of private practice orthopaedist offices are willing to treat workers' compensation patients at the mandated fee schedule amount.



Following 2002 cuts in the fee schedule, the number of physicians in Texas willing to treat all work-related injuries dramatically declined from 2002-2004.

- Three quarters (77%) of orthopedic surgeons in Texas now limit workers compensation cases, dramatically up from (29%) two years ago. Similar declines in access have occurred for general surgeons and other surgical specialists.



The decline in physician specialists accepting workers' compensation caused by low-multiple RBRVS fee schedules is immediate and long-lasting.

- As seen in Texas and Florida, physician participation declines significantly within the first 2-3 years after a low-multiple fee schedule has been put in place.

- Physician workers' compensation participation levels in Hawaii remained largely unchanged even ten years after the original fee schedule was adopted, with less than 25%% of physician specialists accepting workers' compensation patients in 2005.

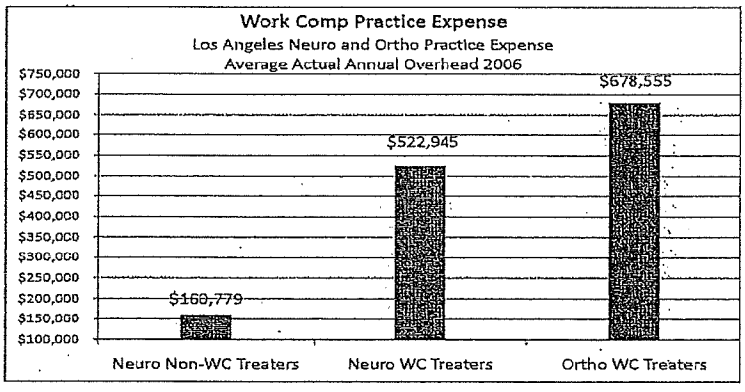
Reductions in Workers Compensation Fee Schedules Threaten Patient Access to Quality Care (cont.)

A reduction in RBRVS fee schedules also threatens patient access to quality care because physicians who do accept workers' compensation patients under low-multiple RBRVS fee schedules tend to be less qualified, as demonstrated by board certification and education.

- Only 33% of those who continue to accept workers compensation patients in Texas and West Virginia attended a U.S. medical school and are board-certified.
- A reduction or loss of access to those providers with experience and expertise in certain specialties reduces the chance of receiving high quality care.

Specialist workers' compensation participation after the adoption of a low-multiple Resource-Based Relative Value Scale (RBRVS) fee schedule was strikingly less than for lower-paying alternatives such as Medicare and Medicaid.

- The additional administrative and regulatory burdens associated with workers' compensation cases are often too cumbersome for providers to justify the insufficient compensation resulting from low-multiple RBRVS fee schedules. These administrative burdens include:
  - Obtaining PPO and/or MPN network certification,
  - Interfacing with Nurse Case Managers,
  - Seeking approval for treatment from Utilization Review,
  - Transcribing dictated medical reports and,
  - Reconciling medical invoices that have been reduced to state fee schedules
- The hourly practice expense for physicians who accepted workers' compensation patients was determined to be 2.5 to 3 times the hourly Medicare practice expense.
- If practice expenses associated with treating workers' compensation patients are 247-295% of Medicare for neurologists and orthopaedists, fee scales set at 100-125% of Medicare fees do not provide enough financial incentive to maintain high physician participation levels.



In order to maintain access to quality providers, states should consider alternative Workers compensation reforms including:

- Preserving existing specialist fees allowing gradual decreases due to inflation, while access is monitored;
- Using an RBRVS base, but with higher fees for specialty codes reflecting other fee data, as was done recently in Hawaii; and
- Using multiple RBRVS conversion factors, higher for specialty areas, as has been done in Tennessee, Oregon and many other states.

Sources: "Workers Compensation Medical Fee Schedules: New Findings and Implications for California."
"The Medical Fee Schedule Under The Workers' Compensation Law." Report No. 8, 1998. Hawaii Legislative Reference Bureau"
"Workers' Compensation Special Report – 2004 Survey of Texas Physicians." Texas Medical Association

Trends in Medical Specialist Participation in Workers' Compensation Systems – Implications for California

Steven E. Levine, M.D., Ph.D., F.A.A.N.

Clinical Professor of Neurology, David Geffen School of Medicine at UCLA

Medical specialists' willingness to accept workers' compensation (WC) patients has been trending downward in a number of states over the past 10 years. This is due to two major categories of factors: declines in specialist fees; and increased regulatory burdens.

Regulatory burdens have been increasing in many states due to attempts to rein in WC medical costs. Chief among these regulatory regimes have been total employer control of choice of treating physician; pre-authorization for treatment; utilization review systems; and network arrangements creating panels of accepted physicians.

Declines in specialist fees have been accomplished chiefly through the implementation of state official fee scales which mimic to a greater or lesser degree the payment distributions of the federal Medicare Fee Scale. This fee scale, developed in the late 1980s, and implemented for Medicare in 1992, attempts to pay according to the relative effort and expense involved in providing various medical treatments. The result of this methodology, called the Resource Based Relative Value Scale (RBRVS) was to shift payment resources away from specialists and toward primary care providers. This is achieved by devaluing specialty procedures and tests in favor of evaluation and management services (more commonly known as office visits and consultations).

My colleague, Ronald Kent, M.D., Ph.D., and I have studied the effects of the implementation of Medicare-based WC fee scales in other states where the premium over Medicare paid is small[1]. Neurologist acceptance of new WC patients was studied in Maryland (109% of Medicare paid for WC treatment), Hawaii (110%) Florida (110%), West Virginia (113%) and Texas (125%)[2]. Orthopedist acceptance of WC was studied in Hawaii, West Virginia and Texas (Florida and Maryland have different pay scales for surgeons). A total of approximately 1,400 physician offices were surveyed.

The results were striking: Neurologist participation ranged from a low of under 9% in Texas to a high of 27% in Maryland, and averaged in the teens. In Texas and Hawaii, where there was pre- and post-implementation data, neurologist participation had fallen 75% and 86% respectively with the implementation of a low-premium Medicare-based WC fee scale.

Orthopedist participation ranged from 23% to 46% in the three states studied, which is very low, since traditionally most orthopedists treat WC patients.

A possibly important additional metric is that neurologists who now refuse WC patients in these states are significantly more likely to be American-educated and board-certified.

As noted, the states we studied ranged from 109% to 125% of Medicare for WC payments. The reason this range was chosen is that California's Division of Workers' Compensation is going to transition from the current, non-Medicare-based payment system to one based on the Medicare RBRVS in 2008 or 2009. Currently, California's fee scale pays about 121% of Medicare. Therefore, a revenue-neutral conversion to an RBRVS system of payments at this level would put it in the middle of the states we studied.

For perspective, it must be noted that regardless of methodology, the average state in the U.S. allows fees of 160% of Medicare, and the four most recently adopted fee scales average over 190%. The reason for this is that it is difficult to attract physicians into WC treatment for the reasons that have been referred to as "paperwork" or the "hassle factor." Paperwork unique to treating WC patients includes obtaining pre-authorization from the insurance adjustor for all treatment; appealing negative utilization review decisions; submitting transcribed reports of all visits and treatments; pursuing payments for months or years; providing disability status and rating reports; submitting applications and credentials for medical provider panels; responding to nurse case managers and attorneys; and submitting to sworn depositions.

While these factors might be seen as "hassle factors," Dr. Kent and I suspected that they might translate into expense items -- space, equipment and personnel to meet these requirements. Consequently, we convinced 13 neurologists to share their 2006 practice overhead data with us. Seven of these did not treat WC patients, and six did. This data revealed that neurologists who did not routinely accept WC patients had an hourly practice overhead of 91% of Medicare's estimate of neurologist hourly overhead. By contrast, we found that neurologists who routinely accepted WC patients had an hourly overhead of 295% of Medicare's estimate. Six orthopedists who routinely accept WC patients had an average practice overhead of 247% of Medicare's estimate for orthopedists. Similarly, a study by Brinker, *et al* in 2002[3] found that practice cost in an orthopedic group was 202% that of a Medicare patient for the same diagnosis.

Another way of measuring the value of these factors was to compare the willingness of neurologists to accept WC patients compared to their willingness to accept Medicaid and Medicare patients. In all the study states except Hawaii, Medicare acceptance was over 90%. In all the states, however, WC acceptance was well below not only Medicare, but Medicaid acceptance. For example, in Texas, Medicaid pays only 42% of what WC pays, but four times as many Texas neurologists routinely accept Medicaid as accept WC.

Preliminary data from other states show that WC fees need to be 160% to 200% to attract the majority of neurologists into WC treatment.

As recently as 2002, participation of neurologists and orthopedists in California stood at 80% and 92%, respectively[4]. In 2002, California's WC fee scale paid about 120% of Medicare. However, payments were (and still are) distributed according the California Relative Value Scale (RVS), which, though out of date, was based on relative charges submitted by doctors in the past. Many states, even states with recently adopted fee scales, use such charge-based relativities to establish fees, since there is reason to believe that such charges more accurately reflect physician experience and perception of effort and cost than do government social science research data, and therefore more efficiently distribute resources.

The WC reforms of 2003 and 2004 have been enormously successful in reducing employer costs. Pure premium costs in California (costs aside from insurance company profit and administration) have fallen by nearly two-thirds since 2002. Premiums employers pay have fallen by half. This is an historic achievement.

However, the regulatory regime which accomplished this feat has increased the burdens faced by physicians. The reforms of 2004 established total employer control of choice of treating physician, medical provider panels, utilization review, and new and unfamiliar disability rating guidelines. Each of these is a significant disincentive to physicians contemplating treating WC patients. Additionally, on January 1, 2004, California cut WC specialist fees 5%. Specialist fees have declined 15% on an inflation-adjusted basis since 2003, and 51% since 1986.

As a result of the erosion of fees and the increased regulatory burdens, participation of neurologists in California WC in 2007 has fallen to 37% from 80% in 2002, and participation of orthopedists to 65% from 92% in 2002[1].

Prior to the recent fee cut and increased regulation, California enjoyed very high specialist participation in WC despite low average fees, sixth lowest in the U.S. in 2002. In our view, this is because California's charge-based fee scale has been efficient in distributing scarce fees. A survey of recent events in other states underscores this view:

1. Maryland changed in 2004 from the California RVS to a *revenue-neutral* 109% of Medicare for WC treatment. This precipitated a crisis in access to care, necessitating an urgent 34% raise for orthopedic and neurosurgical treatment. Fees for other services were not raised, and participation for neurologists is still very low at 27%[1].

2. Texas changed from a charge-based fee scale at an average of 134% of Medicare to a Medicare-based fee scale of 125% of Medicare in 2003. This resulted in a 36% increase in evaluation and management (E/M) fees, but a sharp decline in specialty procedure fees.

Neurologist participation fell to 8.6%[1] in 2007, from 63%[4] in 2002, an 86% decline. In fact, we could locate only 13 American-educated, board-certified neurologists still routinely accepting WC in a state of 11 million workers. Orthopedist participation fell to 46%[1] from 79% in 2002[7]. In response to these findings, Texas recently announced a fee increase to an average of 147% of Medicare, with the highest amounts going to surgical procedures, thus abandoning the straight Medicare approach.

3. Hawaii changed from a charge-based fee scale based on Hawaii Medical Association data to 110% of Medicare in 1995. The Hawaii Legislative Reference Bureau[5] estimated that prior to the change, 77% of neurologists, neurosurgeons, rehabilitation physicians and orthopedists accepted WC. As of 2007, only 19% of neurologists accepted WC, and only 33% of orthopedists. In the face of chronic access problems (which the state refused to acknowledge for 11 years), Hawaii on January 1, 2007, raised fees to an average of 135% of Medicare. More importantly, Hawaii chose not to simply raise their fee scale to 135% of Medicare, but rather to implement charge-based fees from the old Hawaii Medical Association for hundreds of procedures, raising orthopedic procedures to over 170% of Medicare and neurology procedures to 158% of Medicare[1].

4. Other states that have recently adopted or modified fee scales have avoided low-premium Medicare models: Tennessee in 2006 adopted an RBRVS-based fee scale at 177% of Medicare[2], modified to pay specialty procedures the most; Idaho in 2006 adopted an RBRVS-based fee scale averaging 202% of Medicare[2], again with the highest fees going to procedures; Illinois adopted a charge-based fee scale in 2006 averaging 263% of Medicare[2]; Connecticut is converting to RBRVS next year, but at about 200% of Medicare[6]; and Wisconsin negotiators settled recently on a charge-based fee scale, but it is meeting resistance in the legislature. Since the Texas and Maryland fiascos, no state has tried a low-premium Medicare model.

Specialist participation in WC systems is crucial, since WC medical care is not based on the Medicare priorities of primary care, gate-keeping and disease management, but rather on trauma (acute or chronic) and disability requiring rapid and accurate diagnosis, curative intervention and return to function. Curiously, when Texas specialist participation collapsed, so did primary care participation[7], likely due to the unwillingness of primary care physicians to become involved in treating WC injuries without specialists to whom to refer patients.

In California, there are indications that the state may adopt a low-premium Medicare model, with higher payments not for specialty procedures, but for E/M services. The experiences of Maryland and Texas in reducing specialty fees and increasing E/M fees via conversion to Medicare are not encouraging in this regard. Our preliminary data in other states suggest that in fact specialist participation is more sensitive to specialty fees than to E/M fees. Additionally, overall fees in the range of California's are inadequate to preserve specialist participation in a

Medicare-based fee regime. We estimate that for a Medicare-based fee scale to succeed in a state with the regulatory burden faced in California, 160% of Medicare or more is likely to be required.

Hopes for adequate WC medical fees in California are dimmed by the unique political isolation of physicians in this state, created by opposition from both business and labor. In all or nearly all other states, labor supports adequate physician fees (e.g., organized labor recently negotiated on behalf of physicians in Wisconsin; the AFL-CIO joined the Texas Medical Association in seeking to block implementation of the 2003 fee scale change to Medicare, and the building trades led the effort to increase surgical fees in Maryland). But for a variety of historical reasons, the traditional labor-physician alliance does not exist in California.

Currently, California has the fifth lowest fee scale in the nation[2], and possibly the highest regulatory burden. The fact that one third of neurologists and two thirds of orthopedists still accept WC in California – higher than any Medicare-based state at similar payment levels – is an indication of the efficiency of the current charge-based California RVS. We predict that such a thorough inversion of the distribution of fees away from specialists as is currently under consideration in California, without *significantly* increasing overall payments, will result in markedly reduced access to specialty care for injured workers.

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2. Eccleston SM, Liu Tc. Benchmarks for designing workers' compensation fee schedules: 2006. Workers' Compensation Research Institute, Cambridge, MA, 2006

3. Brinker MR, et al. The Effect of Payer Type on Orthopaedic Practice Expense. J Bone Joint Surgery (Amer.). 2002 Oct; 84: 8116-22.

4. Johnson C, Huth D, Bush R. RBRVS-Based Fee Schedules in Workers' Compensation: Implications for California. HJH Group Inc. 2002. p 4-5.

5. Martin P. The Medical Fee Schedule Under the Workers' Compensation Law. Hawaii Legislative Reference Bureau, Report No. 8. 1998. p 11-13.

6. Michael W. Doctors backing RBRVS in Connecticut. WorkCompCentral, Oct 4, 2007.

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WORKERS' COMPENSATION MEDICAL FEE SCHEDULES

NEW FINDINGS & IMPLICATIONS FOR CALIFORNIA

STEVEN E. LEVINE, M.D., PH.D., F.A.A.N.
CLINICAL PROFESSOR OF NEUROLOGY
DAVID GEFFEN SCHOOL OF MEDICINE AT UCLA

RONALD N. KENT, M.D., PH.D.
CLINICAL PROFESSOR OF NEUROLOGY
DAVID GEFFEN SCHOOL OF MEDICINE AT UCLA

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WORKERS' COMPENSATION MEDICAL FEE SCHEDULES: NEW FINDINGS & IMPLICATIONS FOR CALIFORNIA

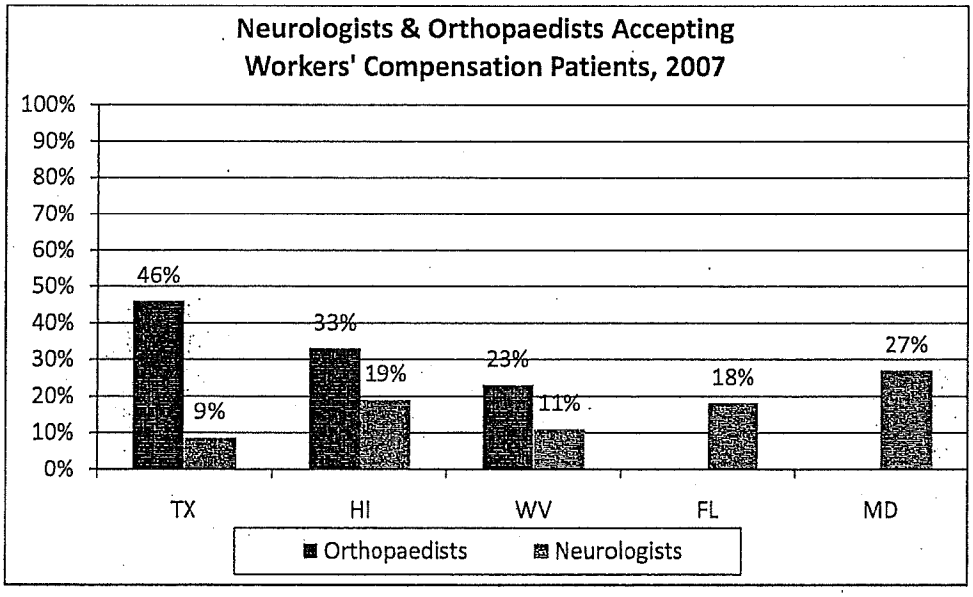
EXECUTIVE SUMMARY

We recently completed a comprehensive multi-state study of the impact of medical fee schedules on provider participation rates in workers' compensation systems. Specifically, the goal of the study was to determine whether the adoption of a workers' compensation medical fee schedule based on a low-multiple of the Medicare Resource-based Relative Value Scale (RBRVS) affected physicians' willingness to continue to treat workers' compensation patients.

For the purposes of this study, "low-multiple" was defined as a workers' compensation fee schedule that was at or below 125% of the Medicare RBRVS fee scale values. Five states in the country met the definition for neurologists — Florida, Hawaii, Maryland, Texas and West Virginia. Three states met the definition for orthopaedists — Texas, West Virginia and Hawaii. On January 1, 2007, Hawaii raised fees for specialists, and the present survey may overestimate specialist participation for that state. Nearly 1,400 neurologist and orthopaedist offices in these states, together with California, were included in a comprehensive telephonic survey to determine whether these doctors were accepting new workers' compensation patients. Responses were categorized as either: 1) Accepting workers' compensation patients without significant limitations, or; 2) Not accepting workers' compensation patients.

Every state that adopted a low-multiple RBRVS fee schedule demonstrated a markedly low rate of neurologist and orthopaedic participation in workers' compensation. In West Virginia, one of the states that has utilized a low-multiple RBRVS fee schedule the longest, less than a quarter of all orthopaedists and only 11% of all neurologists still accept workers' compensation patients.

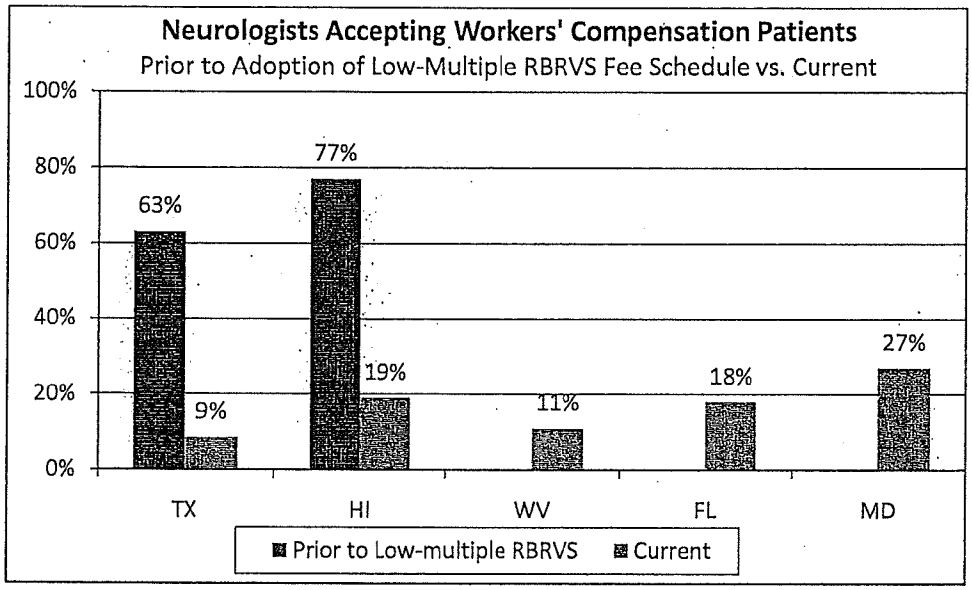
Figure 1



In the two states where pre-RBRVS and post-RBRVS data are available, there was a dramatic decline in participation with the adoption of a low-multiple RBRVS fee schedule. Neurologist

participation levels continued to decline in Hawaii more than a decade after it first adopted its low-multiple fee schedule. In Florida, where fees were raised three years ago to a low-multiple RBRVS level, participation among neurologists nevertheless continued to decline. Two states, Texas and West Virginia, now have neurologist participation rates of approximately ten percent. In contrast, participation in Texas was documented to be 63% a year before the adoption of a low-multiple (125%) RBRVS fee scale in 2003.

Figure 2



The results also demonstrate that specialist workers' compensation participation after the adoption of a low-multiple RBRVS fee schedule was strikingly less than for lower-paying alternatives such as Medicare and Medicaid. This appears largely due to additional administrative and regulatory burdens associated with workers' compensation that are not sufficiently compensated by low-RBRVS fee schedules. An analysis of physician offices in the Los Angeles metropolitan area showed that the hourly practice expense for offices accepting workers' compensation patients was 2.5 to 3 times higher than the Medicare practice expense rate.

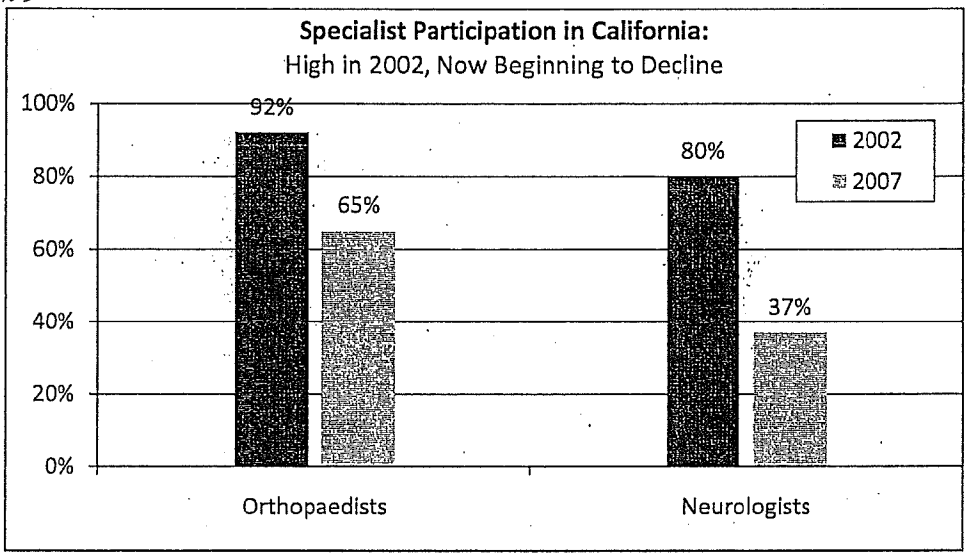
The telephonic surveys also revealed significant differences in the qualifications of neurologists who continued to treat workers' compensation patients after the adoption of a low-multiple RBRVS fee schedule. Only 33% of those who continue to accept workers' compensation patients in Texas and West Virginia attended a U.S. medical school and are board-certified, while more than 50% of those who do not accept injured workers have these qualifications.

The dramatic departure of physicians from workers' compensation systems in states with low-multiple RBRVS fee scales appears to have been precipitated in all cases by decreases in reimbursement for specialist procedures, regardless of changes in other fees. For example, in Texas, the RBRVS conversion, which dramatically lowered specialty fees, also raised office visit fees 36%. It is worth noting that of the three most recent major workers' compensation fee schedule changes (in Hawaii, Tennessee and Illinois), each of the states elected to adopt fee schedules with higher relative fees for specialty providers in order to maintain or restore provider access.

The present survey also indicates that in California, specialist participation has already begun to decline. While 92% of orthopaedists and 80% of neurologists reported accepting workers'

compensation patients in California in 2002, only 65% of orthopaedists and 37% of neurologists continue to do so in 2007.

Figure 3



Our findings suggest the need for an alternative to an unmodified low-multiple RBRVS fee schedule if medical access is to be maintained in California after the upcoming fee scale conversion to the RBRVS systems. Alternatives include 1) preserving existing specialist fees allowing gradual decreases due to inflation, while access is monitored; 2) using an RBRVS base, but with higher fees for specialty codes reflecting other fee data, as was done recently in Hawaii; and 3) using multiple RBRVS conversion factors, higher for specialty areas, as has been done in Tennessee, Oregon and many other states. Regardless of the particular approach, some modification of the RBRVS coupled with access monitoring would appear prudent. Such approaches would potentially allow implementation of a low-cost RBRVS-based fee scale for California, while reducing the likelihood of substantial declines in medical access.

PHYSICIAN WORKERS' COMPENSATION PARTICIPATION IN LOW-MULTIPLE RBRVS STATES

The initial phase of the research study was designed to determine whether the adoption of a workers' compensation medical fee scale that was based on a low-multiple of the Medicare resource-based relative value scale (RBRVS) schedule affected physicians' willingness to participate in that state's workers' compensation system and thereby impacted injured workers' access to care. For the purposes of this study, "low-multiple" was defined as anything at or below 125% of the Medicare RBRVS fee scale values.

According to data from the Workers' Compensation Research Institute in Cambridge, MA, five states in the country met the definition for neurologists: Texas, Florida, Maryland, West Virginia and Hawaii. Three states met the definition for orthopaedists: Texas, West Virginia and Hawaii. As the following table illustrates, these states could also provide insight into both the immediate and longer-term impacts of low-multiple RBRVS fee schedules, as two of the jurisdictions to be studied have had their RBRVS-based fee schedules in place for over a decade while three have only recently converted to this methodology.

Table 1: States with low-multiple RBRVS-based Workers' Compensation fee schedules

JURISDICTION	YEAR ADOPTED RBRVS-BASED FEE SCALE	CURRENT OVERALL % OF MEDICARE RBRVS	MET LOW-MULTIPLE RBRVS DEFINITION FOR
West Virginia	1994	113%	Neurologists & Orthopaedists
Hawaii	1995	110%	Neurologists & Orthopaedists
Texas	2003	125%	Neurologists & Orthopaedists
Maryland	2004	109%	Neurologists only
Florida	2005	110%	Neurologists only

Once the jurisdictions were selected, neurologists and orthopaedists practicing in those states were targeted as potential survey participants. All private practice neurologists were identified in Texas, West Virginia and Hawaii utilizing databases maintained by each state's Board of Medical Examiners. In Maryland, Florida and California, where such databases were not publically available, searches were performed using the American Academy of Neurology 2006-07 membership directory in an attempt to identify active neurologists in private practice within each respective state.

All private practice orthopaedist offices identified in Hawaii and West Virginia using the American Academy of Orthopaedic Surgeons (AAOS) 2006-07 membership directory and 411.com were contacted in addition to a random sample of 502 orthopaedist offices identified in Texas and California using the Texas Board of Medical Examiners database and the AAOS membership directory respectively. The Online telephone directory services 411.com and Yellow.com were then used to obtain current telephone numbers for all the physician offices identified.

The conclusions and opinions expressed in this study are solely those of the authors and do not represent the views of the David Geffen School of Medicine at UCLA.

This study was funded in part by a contribution from the California Society of Industrial Medicine and Surgery, Inc.

This process produced a data set of 1,398 physician offices (790 neurologist offices across six states and 608 orthopaedist offices in four states) to be surveyed. All 1,398 physician offices were contacted telephonically and asked whether the doctor was accepting new workers' compensation patients. Responses were categorized as either:

- Accepting workers' compensation patients without significant limitations, or;
- Not accepting workers' compensation patients

CASE STUDIES – PHYSICIAN PARTICIPATION IN TX, HI, WV, FL & MD

TEXAS

The Texas Workers' Compensation Commission adopted §134.202, the Medical Fee Guideline (MFG) in April 2002, with the new fee schedule officially going into effect on August 1, 2003. It was part of HB2600, a comprehensive package of workers' compensation reforms intended to control rising medical costs while also attempting to minimize the expense of administering the state workers' compensation fee schedule. Whereas the previous workers' compensation fee schedule was based on provider charge data, the new Texas MFG adopted a simple 125% of Medicare RBRVS fees across all procedure groups.

Interestingly, according to the preamble to §134.202, which officially implemented the 125% of Medicare MFG in 2002, the Workers' Compensation Commission received numerous comments expressing concern over whether the new MFG would negatively impact injured workers' access to quality healthcare in Texas.[1] According to the preamble,

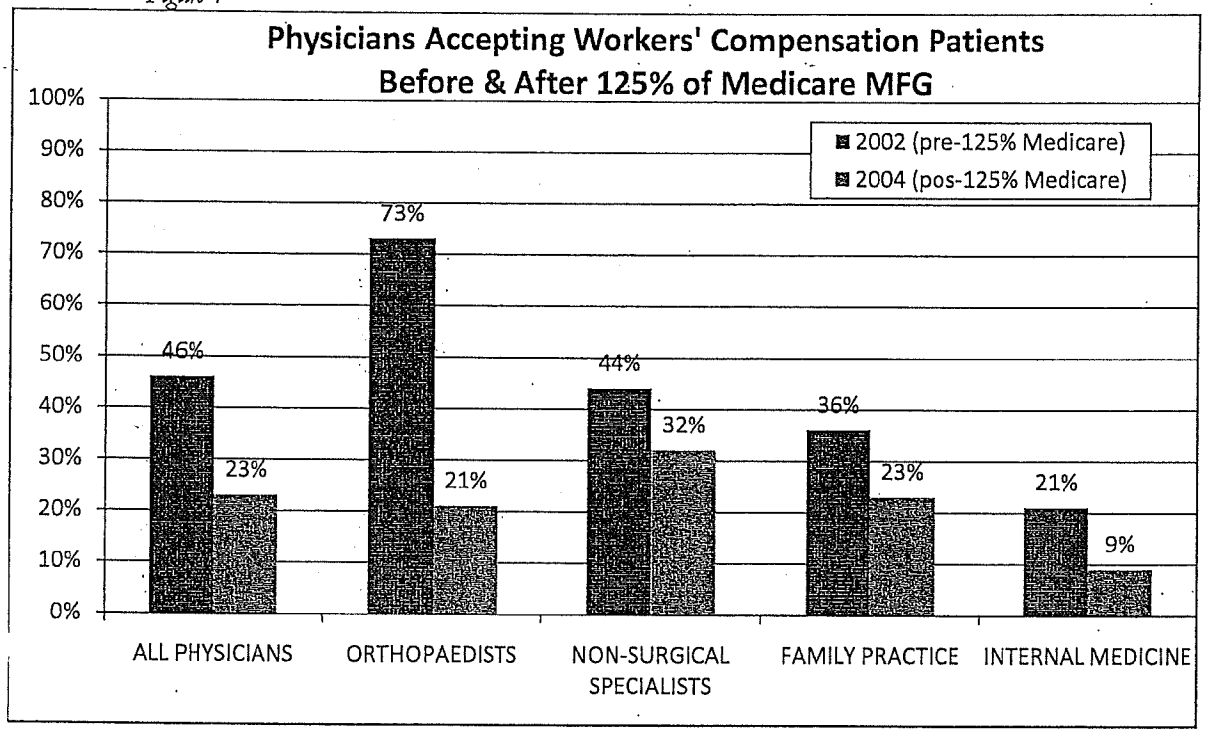
> *"Commenters stated the proposed reduction in reimbursement will greatly affect the residents of Texas and impact injured employee by inhibiting care; it will be cost prohibitive to provide quality care, resulting in a lower standard of care. Commenters stated reducing reimbursement to curb costs would directly affect and jeopardize patient access to quality medical care by decreasing medical treatment options and driving ethical quality healthcare providers out of the workers' compensation system. Commenters stated healthcare providers would begin seeing more patients per hour, reducing quality of care. Commenter stated it is already difficult for injured employees to access health care. Commenters stated it would be an injustice for injured employees who will suffer emotional distress due to harassment and delays. Commenter stated the percentage of injured employees who transition from the acute to the chronic stage may increase. Commenters stated injured employees would resort to expensive care in emergency rooms or to poor health care in workers' compensation clinics or end up in the Medicaid system. Commenter stated a loss of access to quality medical care for injured employees will have a negative impact on the Texas labor pool, Texas businesses, and our economy in general."*[2] *(Commission, 2002)*

In response to these concerns, the Workers Compensation Commission published comments prepared by the Texas Association of Business Chambers of Commerce (TABCC) which stated, "While there were expressions of concern about potential access problems, no actual access problems have been documented in any specialty. The current level of Medicare payment to physicians is sufficient to provide reasonable access to quality medical care to injured workers."

Perhaps in response to the lack of research concerning physician access issues in Texas, two separate studies have been conducted since the adoption of the 125% of Medicare MFG. The first is a survey study now conducted bi-annually by the Texas Medical Association[3]. The goal of the Medical Association's surveys is a broad analysis of access issues throughout Texas and only a small portion of their survey focuses on workers' compensation. However, their workers' compensation

findings are not encouraging. As shown in the figure below, the percentage of physicians who accept workers' compensation patients has declined significantly across all specialties since the adoption of the 125% of Medicare MFG.

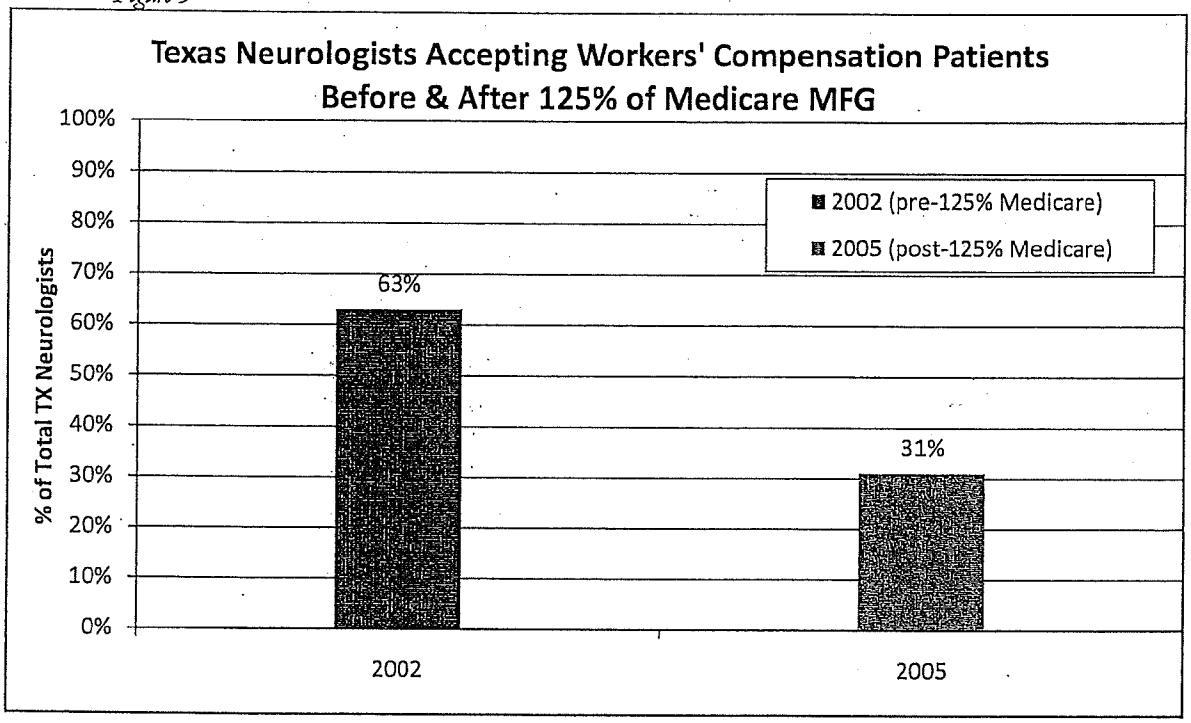
Figure 4



A second relevant study was conducted from December, 2004 to January 2005 by the Association of California Neurologists Workers' Compensation Committee (ACN).[4] The ACN study focused specifically on workers' compensation via a telephonic survey of all neurologists in Texas which specifically asked physicians if they accepted workers' compensation patients without significant limitations. If the provider's office responded that they were not accepting workers' compensation patients without significant restrictions as of the end of 2004, the survey staff then asked follow-up questions. The office was asked whether they had accepted workers' compensation patients without restrictions in 2002 (prior to the 125% of Medicare MFG) and what the most important factors were in their decision to no longer accept workers' compensation patients (reimbursement rates, administrative requirements, etc).

The ACN study of Texas neurologists yielded results that were strikingly similar to the findings of the subsequent Texas Medical Association study. As illustrated below, neurologist participation in the Texas workers' compensation system was cut in half, from 63% of all neurologists accepting injured workers in 2002 to only 31% by 2005.

Figure 5



It is worth noting that in addition to the changes to the medical fee schedule, the Texas Workers Compensation Commission introduced several administrative changes for providers as part of the HB2600 reform package. Perhaps the most important of these in terms of the potential impact on provider participation rates was a requirement that medical providers needed to apply to be on the state's "Approved Doctor List" (ADL) if they intended to treat workers' compensation patients. The primary administrative requirements for providers to be added to the Approved Doctor List were:

- The submission of a financial disclosure document that outlined the identity of any health care provider in which the doctor had a financial interest, an immediate family member of the doctor who had a financial interest, or the health care provider that employed the doctor who had a financial interest.

- The completion of a mandatory ADL training course - Level 1 training was for providers who anticipated treating 18 or fewer workers' compensation patients per year and Level 2 was for those who anticipated treating more than 18 patients per year.

While it could be argued that these additional administrative requirements played a role in the decrease in physicians willing to treat workers' compensation patients in Texas, a closer look at the actual requirements as well as the results of the ACN interviews suggest they were likely not a major factor.

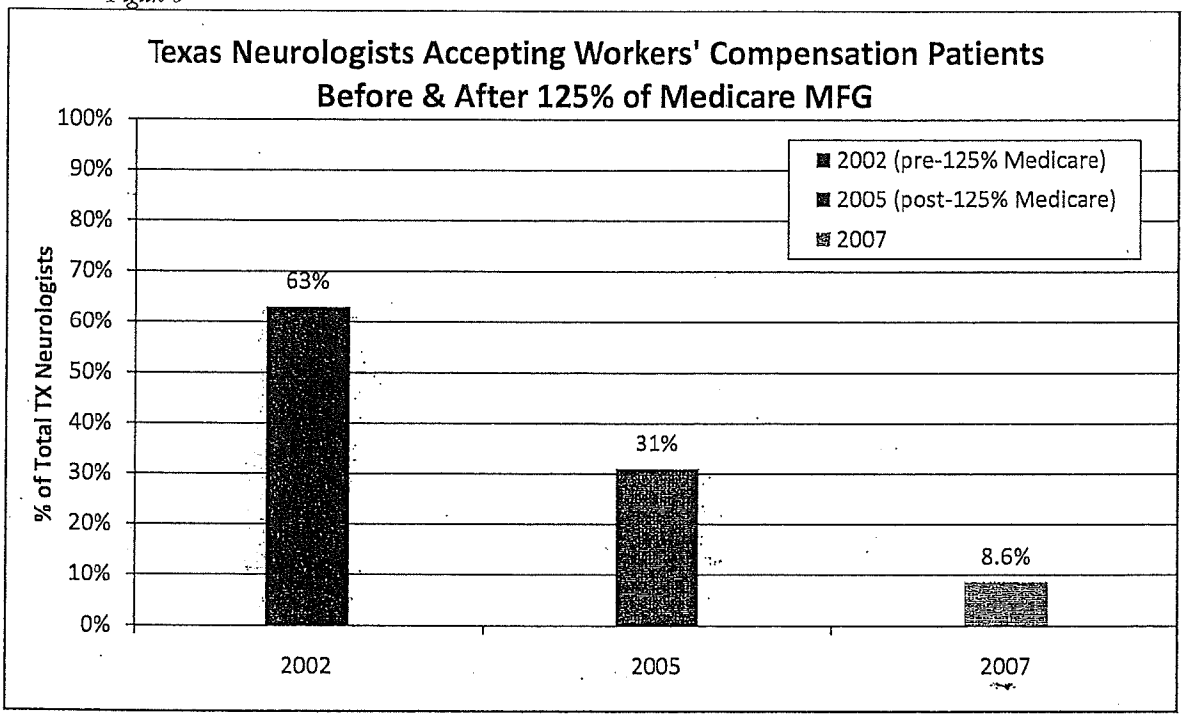
The financial disclosure statement was a straightforward two-page form that would have required less than an hour to complete. The ADL training sessions were very carefully structured to mirror the form and function of the Continuing Medical Education (CME) courses that physicians were routinely required to complete. The training courses were in fact administered jointly by the Workers' Compensation Commission and the Texas Medical Association and were offered as either one-day workshops at locations across the state or as an online training course that could be completed at the

provider's leisure. Considering the numerous financial disclosure forms and continuing education requirements with which all physicians must routinely comply, it seems unlikely that the Texas administrative requirements would have represented a significant impediment to physicians who wished to participate in the workers' compensation system.

Perhaps most telling regarding physician participation is that the ACN study specifically asked those Texas neurologists who had stopped accepting workers' compensation patients between 2002 and 2004/5 why they had done so. Sixty-three percent of those Texas neurologists who stopped seeing workers' compensation patients reported doing so either solely or primarily due to the introduction of the 125% of Medicare MFG[5].

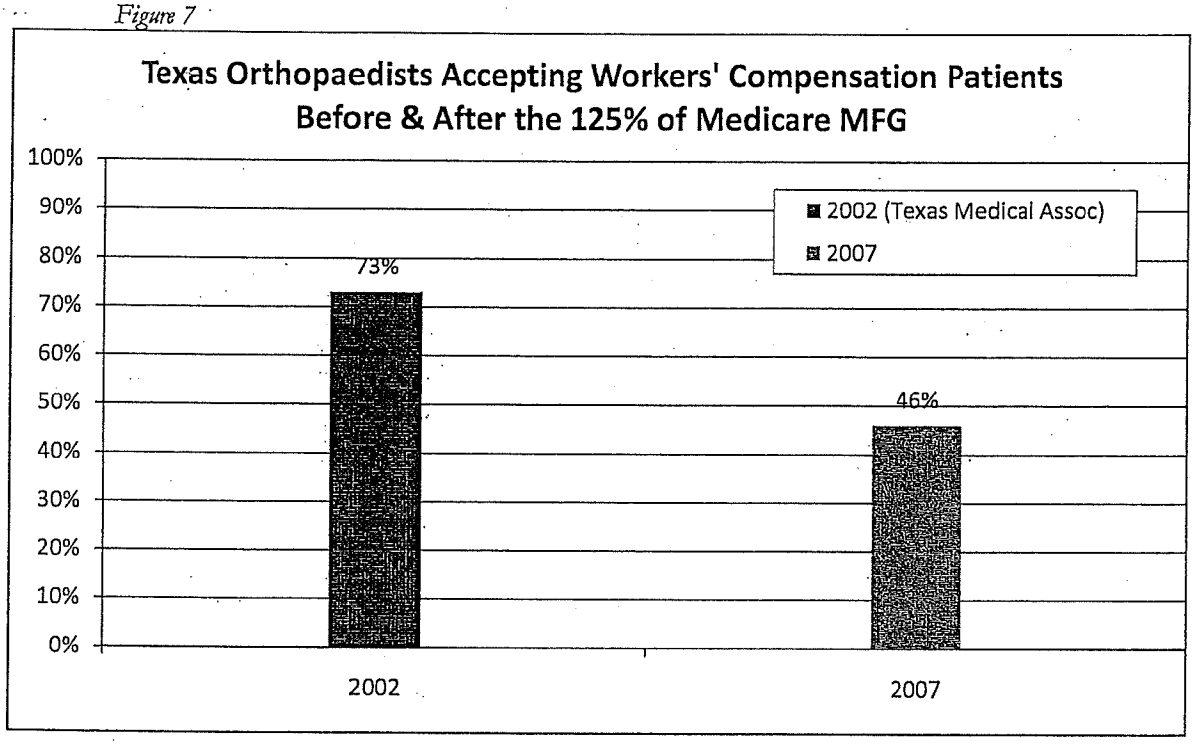
Supporting the notion that it is the fees, not any new administrative requirements that are driving neurologists out of the workers' compensation system, the present survey results suggest that neurologist participation in Texas has continued to decline sharply despite the fact that the Texas Legislature effectively relaxed the ADL administrative/training requirements for providers as part of House Bill 7 in September, 2005. Using telephonic survey methods identical to the 2005 ACN study, we found that less than 9% of all neurologists still accept Texas workers' compensation patients as of 2007.

Figure 6



The latest survey results also show a similar, though not quite as dramatic, continued decline in orthopaedist participation in the Texas Workers' Compensation system.

Figure 7



These trends are even more concerning when placed into their geographic context. According to the most recent survey data, there are now entire regions of Texas without close proximity to a neurologist willing to accept workers' compensation patients. As shown in the maps below, while there was good rural access to neurologists across the state in 2002, by 2007 most of the remaining neurologists willing to accept workers' compensation patients are limited to the major metropolitan areas of Dallas/Fort Worth, Houston and San Antonio. Over a span of only 5 years, access to neurologists for the vast majority of injured workers in Texas has evaporated.

Figure 8: Texas Neurologists Accepting Workers' Compensation Patients, 2002

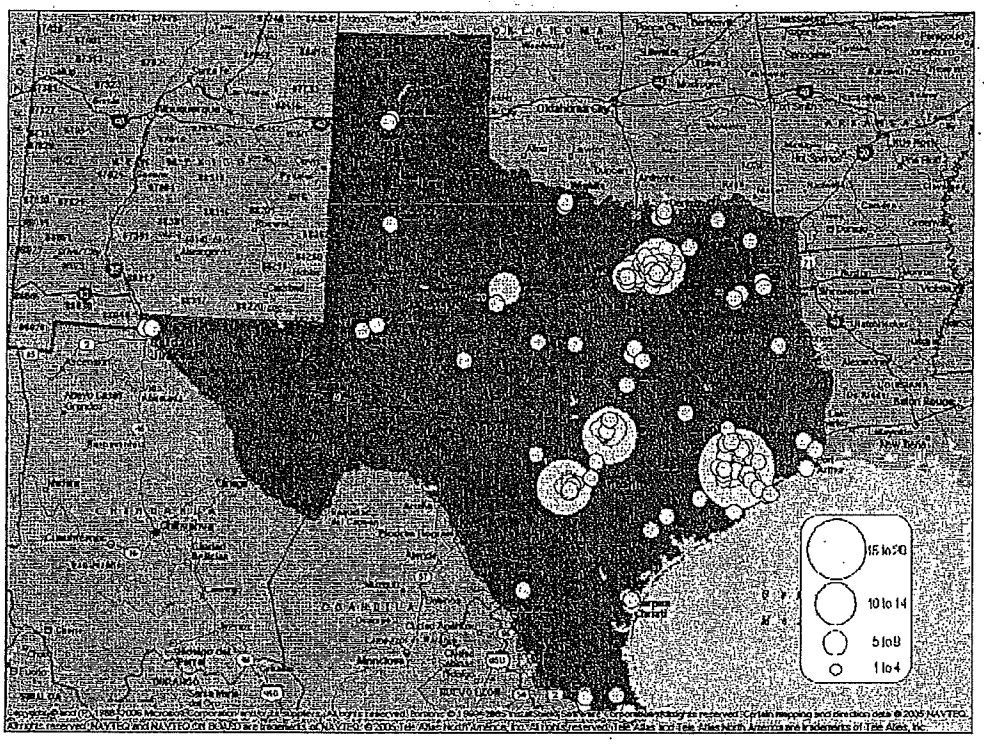
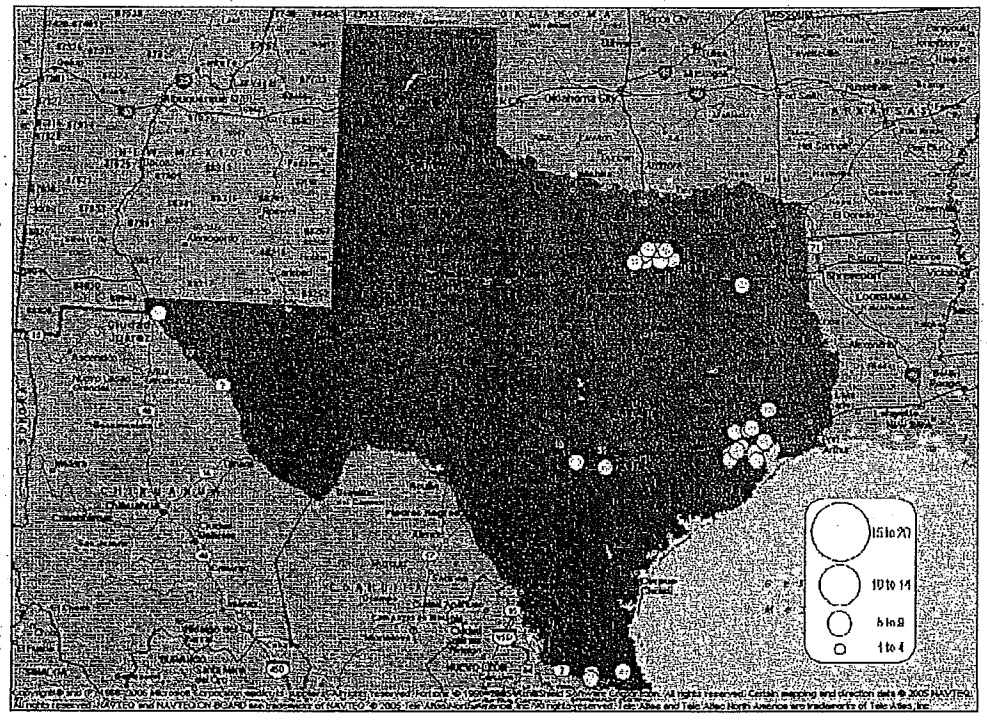


Figure 9: Texas Neurologists Accepting Workers' Compensation Patients, 2007



HAWAII

While Texas provides evidence of a disturbing trend with regard to physician participation in the years immediately following the adoption of a Medicare-based RBRVS workers' compensation fee schedule, Hawaii offers an opportunity to study the longer term effects of such fee schedules.

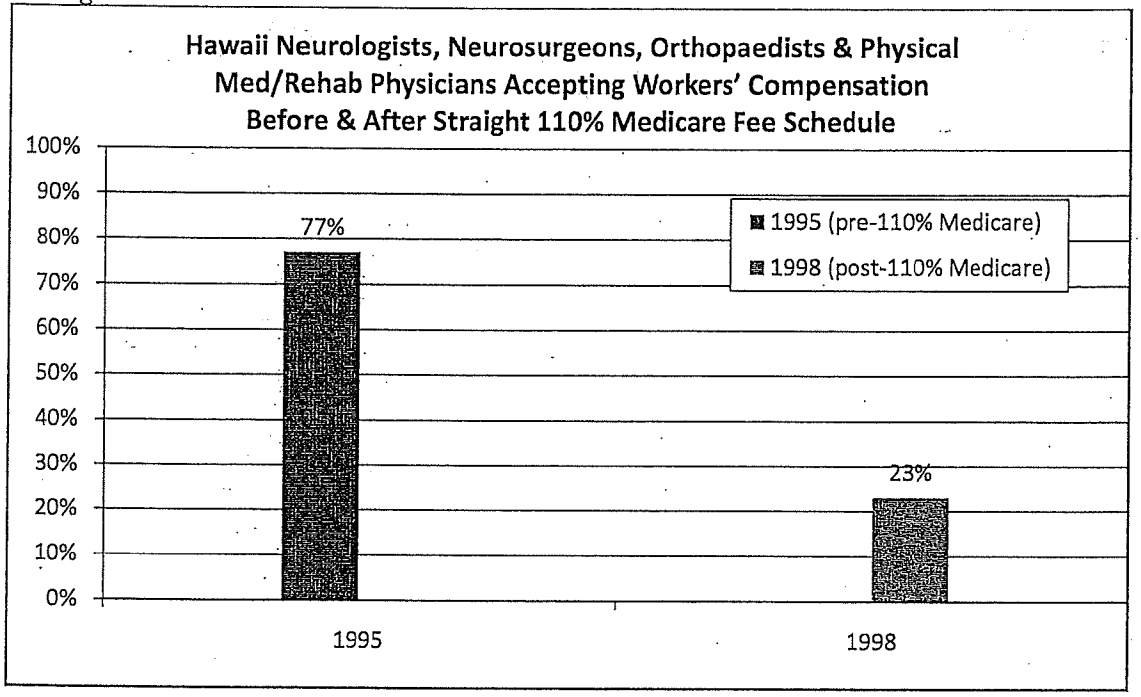
Hawaii adopted its first medical fee schedule more than 40 years ago. The state's Disability Compensation Division is responsible for developing the medical fee schedule with input from the state medical association and public comment. The fee schedule was originally based on relative values supplied by the Hawaii Medical Association, but in 1995 the system converted to a flat 110% of the state's Medicare RBRVS values.

In 1998, in response to growing concerns about injured workers' access to medical care, Hawaii's state legislature commissioned a study by the Legislative Reference Bureau to determine, "if the 110% ceiling on the workers' compensation medical fee schedule should be adjusted, whether the workers' compensation fee schedule has had a negative impact on the access to specialty care or diminished the quality of care, and what the conditions are for adjusting the fee schedule."[6] Completed in December of 1998, the study did find evidence that the fee schedule was having a negative impact on injured workers' access to medical care, particularly specialty care. According to the report,

> *"The Bureau identified a significant trend in health care providers that is shifting away from accepting all patients with workers' compensation injuries and moving towards policies that limit or totally reject prospective patients with work-related injuries covered under the workers' compensation law. The most common reason given for this trend is the change to the medical fee schedule level of reimbursement."*[7]

The chart below summarizes the Reference Bureau's finding with regard to the significant decline in the percentage of Neurologists, Neurosurgeons, Orthopaedists and Physical Medicine/Rehab Physicians accepting workers' compensation patients within just three years of the adoption of the 110% of Medicare fee schedule.

Figure 10



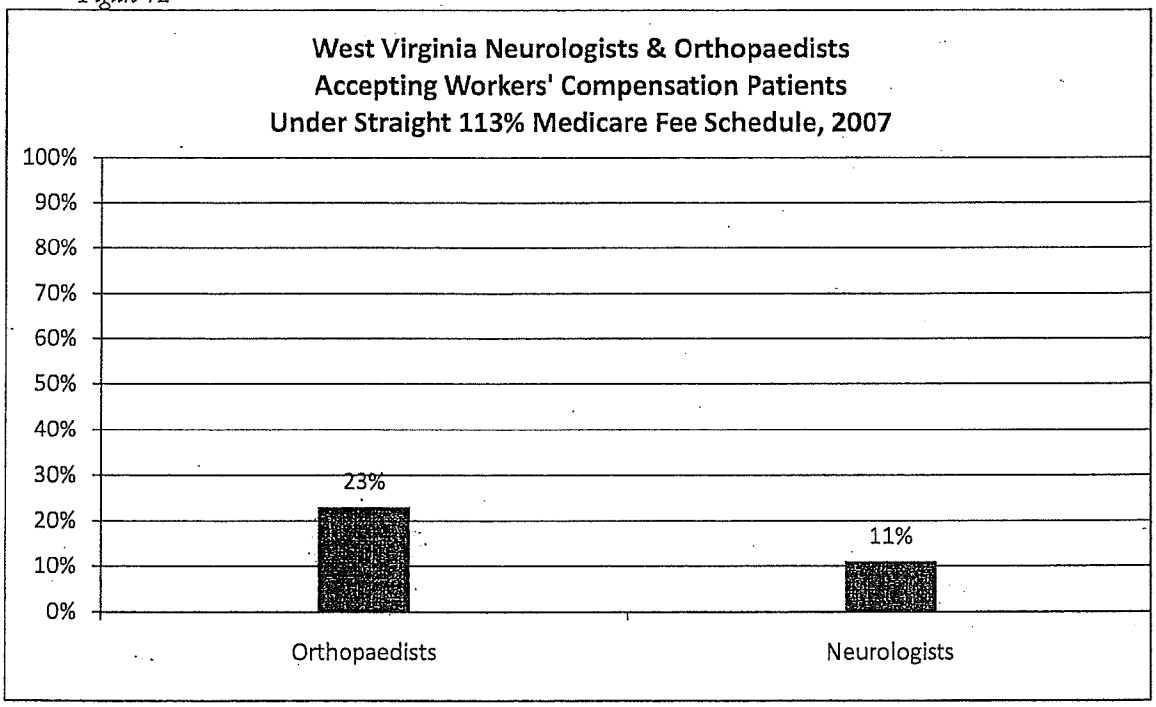
Perhaps the most troubling finding with regard to Hawaii is that it appears that the decline in physicians accepting workers' compensation caused by low-multiple RBRVS fee schedules is extremely long-lasting. As follow-up to their Texas study the Association of California Neurologists (ACN) interviewed all Hawaii neurologists in private practice in 2005 to assess whether workers' compensation participation levels were improving as physicians adjusted their practices to the reality of the 110% fee schedule. As the chart below illustrates, physician workers' compensation participation levels remained largely unchanged even ten years after the original fee schedule was adopted, with less than 30% of all neurologists accepting workers' compensation patients in Hawaii in 2005.

The results of the current research, in which all private practice neurologist and orthopaedist offices that could be identified in the state of Hawaii were interviewed telephonically, suggests that participation levels have dipped even further in 2007, with only 19% of neurologists and 33% of orthopaedists indicating that they still accept workers' compensation patients.

submitting medical bills for treatment of injured workers, minimizing a significant portion of the administrative complexity usually attributed to the claims payment process in workers' compensation.

Nevertheless, even though the administrative burden was less, our most recent provider surveys found that similar to Hawaii, another state that has been using a low-multiple RBRVS fee scale for more than ten years, less than twenty-five percent of the private practice orthopaedist offices in West Virginia still accept workers' compensation patients. Perhaps even more striking, the number of neurologists still willing to treat workers' compensation patients in West Virginia as of 2007 has declined to only 11%.

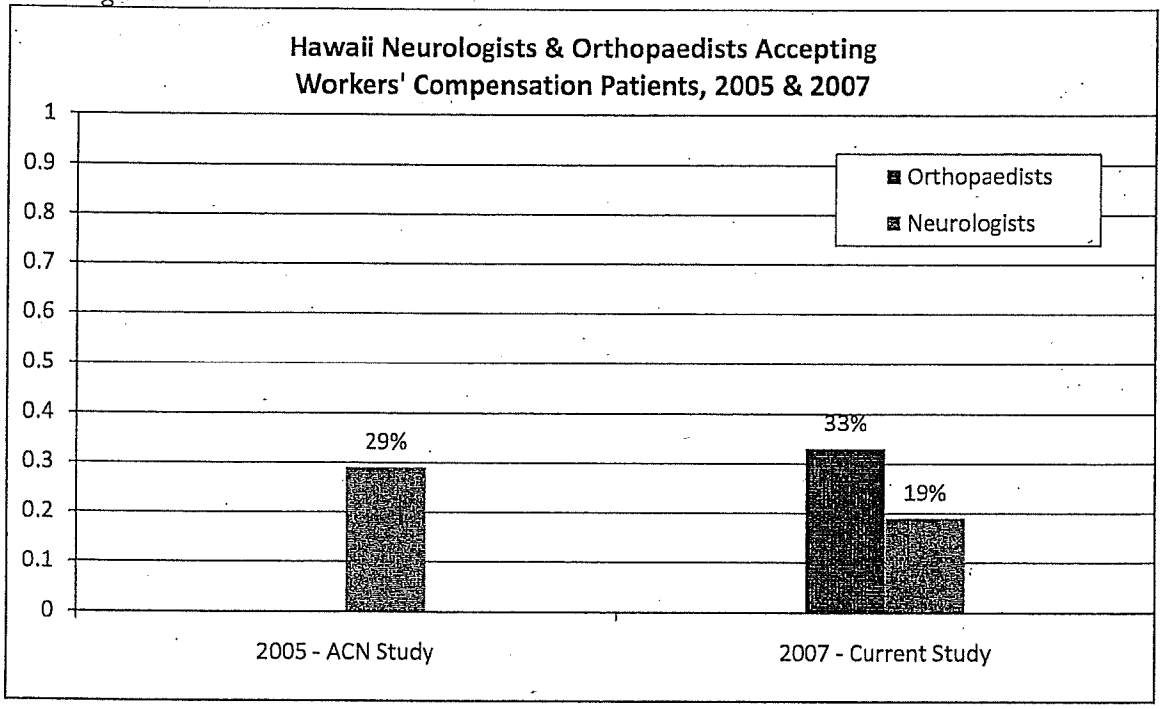
Figure 12



FLORIDA

Florida provides a slightly different example of a state that recently turned to a low-multiple RBRVS fee schedule in an attempt to actually improve its' provider reimbursements. Florida had been using a resource-based relative value scale managed by the Department of Insurance to set maximum medical reimbursement levels in workers' compensation since 1993. This fee schedule system actually yielded some of the lowest unit cost reimbursement rates to providers treating workers' compensation patients in the country – estimated at only 83% of the Medicare RBRVS rates. However, Florida's workers' compensation costs continued to rise and as a result, in 2003 the governor appointed a commission to review the entire system and make recommendations designed to address the major cost drivers. With regard to medical reimbursement levels, the governor's commission recommended increasing fees to a straight 150% of Medicare values in order to improve and maintain injured workers' access to care. However, the bill ultimately passed by the Florida legislature in May of 2003 opted instead to set surgical procedures at 140% of Medicare and all other procedures at 110% of Medicare.

Figure 11



This decline continues in spite of a recent increase in Hawaii's workers' compensation neurological procedure fees (announced in September 2006, effective 1/1/2007). The orthopaedist portion of the study was conducted in June 2007, nearly six months after specialist fees were raised, and may significantly overstate orthopaedist participation that existed in 2006 under the 110% of Medicare regime.

Some of the arguments presented in the original Reference Bureau study[8] and even in the preamble to the Texas Medical Fee Guide[9], suggested that although specialists appeared to be leaving the workers' compensation system immediately after the adoption of the low-multiple RBRVS fee schedule, they would return once they had adapted their practices and/or treatment patterns to the reality of the new rates. This look at the long term impact of low-multiple RBRVS fee schedules would appear to refute that notion and instead suggests that once physicians choose to exit the workers' compensation system, they are unlikely to return while the fee schedule remains unchanged.

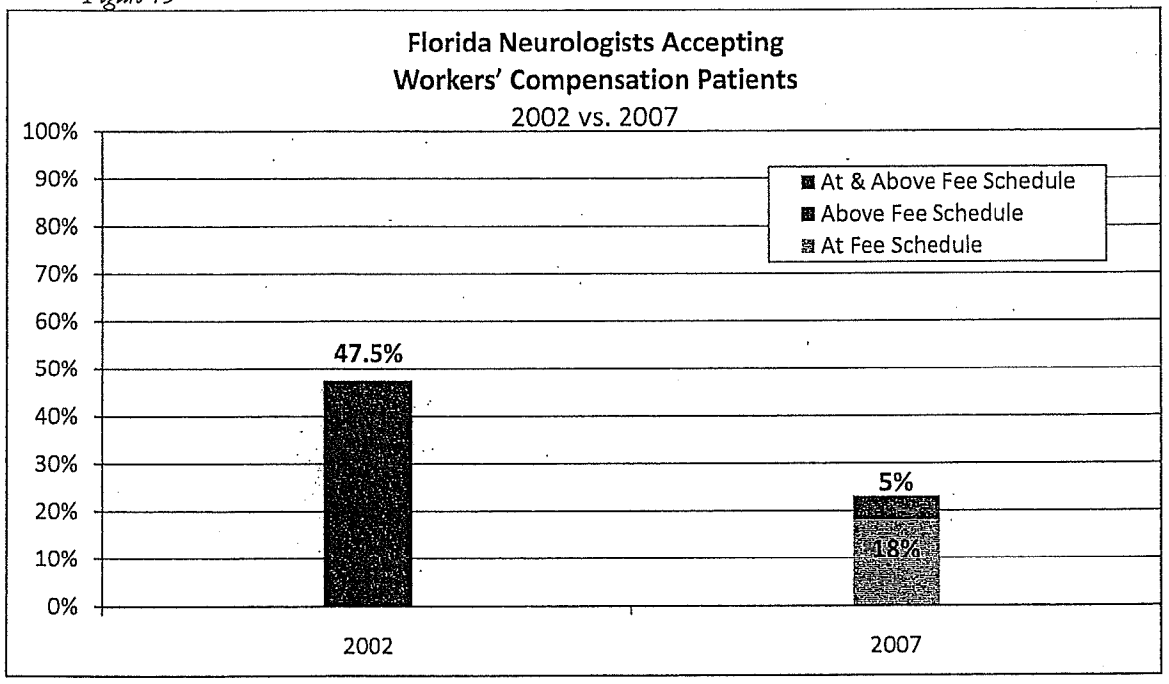
WEST VIRGINIA

The state of West Virginia offers another potential look at the long term effect of low-multiple RBRVS fee schedules on physician's willingness to participate in the workers' compensation system. West Virginia implemented its first workers' compensation medical fee schedule in April 1988, but changed to a resource-based relative value scale in November 1994. The fee schedule is managed by the state's Workers' Compensation Division (WCD), which most recently moved to a straight 113% of Medicare effective 1/1/2006.

Until recently, West Virginia has also had the relatively unique distinction of being a monopolistic workers' compensation system – a state with only a single workers' compensation carrier, the West Virginia Workers' Compensation Fund. In effect, the Fund (a part of the state's Workers' Compensation Division) was the only source of workers' compensation insurance to employers in the state. This meant that medical providers had to deal with only a single payer when

A telephonic survey of neurologists practicing in the state of Florida in 2002 conducted by the HJH Group in Tampa, FL determined that 47.5% of all neurologists were accepting workers' compensation patients under the previous fee schedule.[10] Interviews conducted in March of 2007 found that neurologist participation in the workers' compensation system had fallen to just 23% after the adoption of the 110% Medicare RBRVS schedule. In fact, 5% of the neurologists surveyed in 2007 disclosed that they only accepted workers' compensation patients if the payer agreed to reimburse them at rates above the official fee schedule. This means that the number of neurologists actually willing to treat Florida injured workers' at the rates specified by the fee schedule has fallen to only 18%.

Figure 13

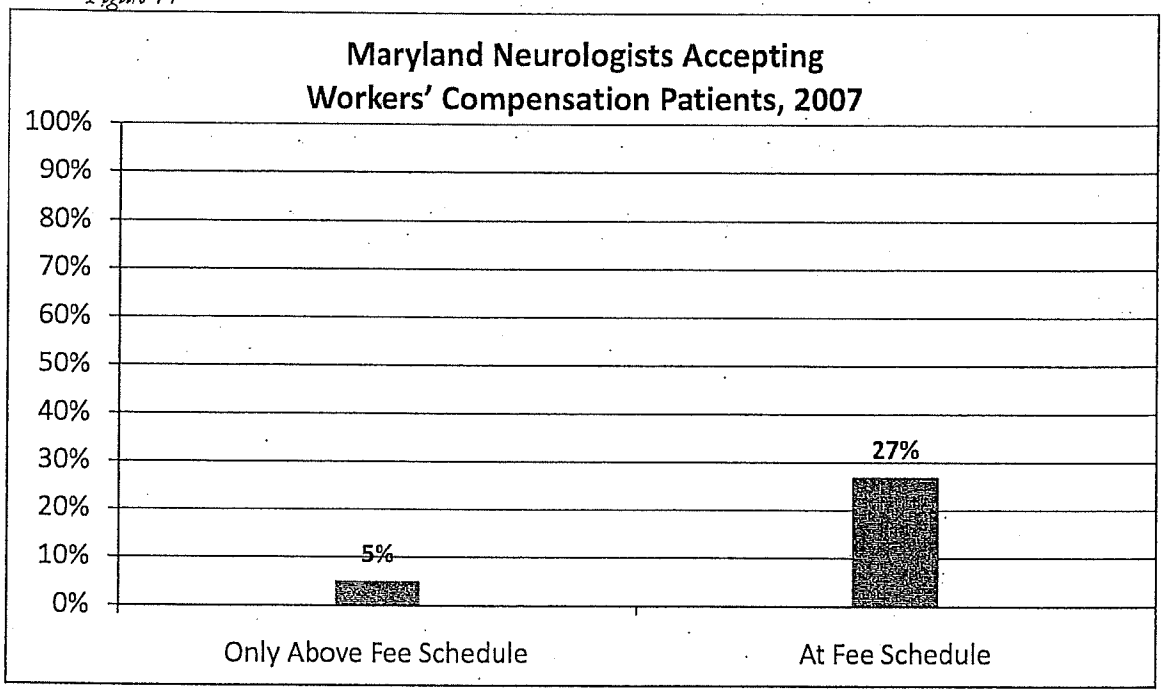


MARYLAND

Maryland represents the final state that has adopted a low-multiple RBRVS fee scale for workers' compensation. Maryland actually based its first workers' compensation medical fee schedule on the California Relative Value Study (CRVS), with a fee schedule committee responsible for updating the relative values and conversion factors bi-annually. In 2004, Maryland replaced the CRVS-based fee schedule with one set at 109% of the Medicare RBRVS values. Effective February 2006, Maryland has increased the reimbursement rate for Orthopedic and Neurosurgical procedures to 144% of Medicare, while all other procedures remain at 109% of Medicare.

While no historical data is available for Maryland providers, the 2007 survey data suggests a similar pattern to the other states studied. Twenty-seven percent of neurologists are willing to treat workers' compensation patients at the low-multiple RBRVS rates. Another 5% will accept injured workers only for fees above the official state fee schedule.

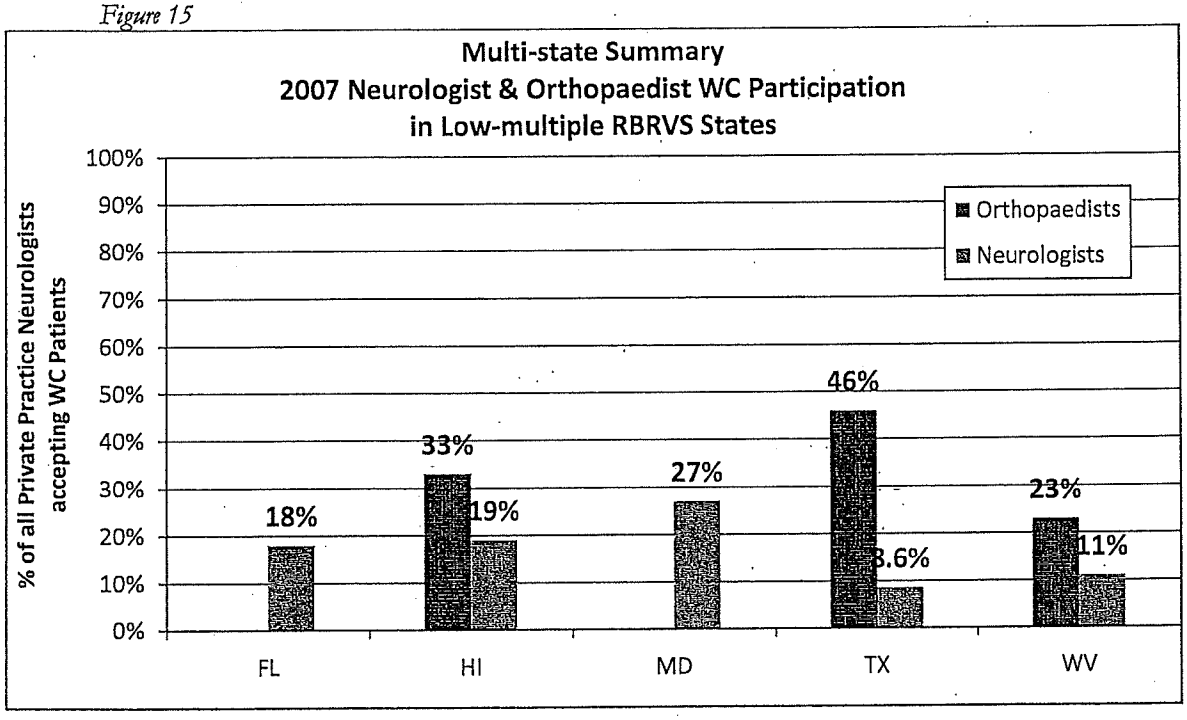
Figure 14


Maryland Neurologists Accepting
Workers' Compensation Patients, 2007
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
5%
27%
Only Above Fee Schedule
At Fee Schedule

SUMMARY – ALL LOW-MULTIPLE RBRVS STATES

When all five study states are taken into consideration, the prospects for maintaining substantial access for injured workers under a low-multiple RBRVS fee scale are not promising. The chart below illustrates the current neurologist and orthopaedist participation levels in all states that have adopted a low-multiple RBRVS-based fee schedule. In every one of the low-multiple states, less than half of the private practice orthopaedist offices and fewer than a third of the neurologist offices are willing to treat workers' compensation patients at the mandated fee schedule amount. Conversely, over half of orthopaedists and over 70% of neurologists are unwilling to accept workers' compensation in these states.

Figure 15



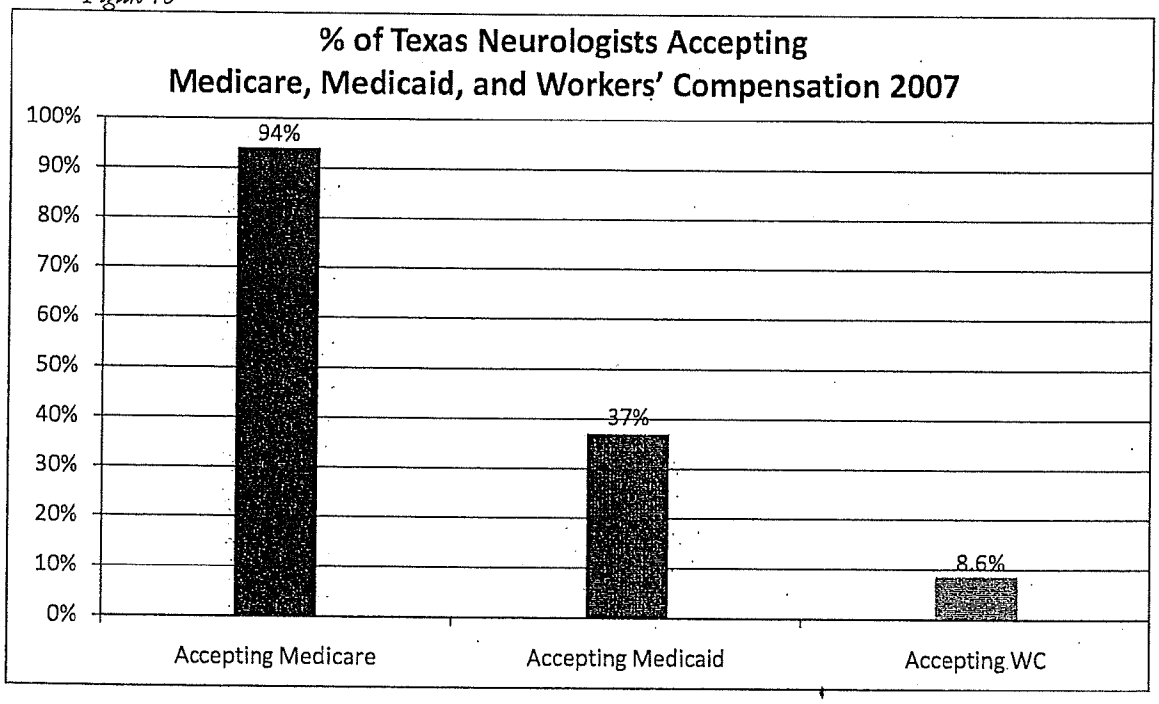
As seen in Texas and Florida, physician participation declines significantly within the first 2-3 years after a low-multiple fee schedule has been put in place. As Hawaii and West Virginia demonstrate, physician participation remains low even ten years after a low-multiple fee schedule has been in place. This suggests that once providers give up on the workers' compensation system, they are not motivated to find ways to adjust their practices or treatment patterns in an effort to rejoin the system. In fact, as Hawaii illustrates, participation continues to drop even once fees begin to rise again, as providers prove extremely reluctant to rejoin the workers' compensation system once they have found other sources of patients and revenues.

COMPARISON OF MEDICARE, MEDICAID & WORKERS' COMPENSATION

In an attempt to determine whether the barrier to physician participation in the workers' compensation systems of states with low-multiple RBRVS fee schedules was just the reimbursement levels, a secondary survey was conducted of the number of neurologists in the survey groups that accepted Medicare and Medicaid patients. The unit cost reimbursement rates for Medicare and Medicaid patients was lower than for workers' compensation patients and yet, as the charts below illustrate, participation in both the Medicare and Medicaid systems was strikingly higher than in the workers' compensation system.

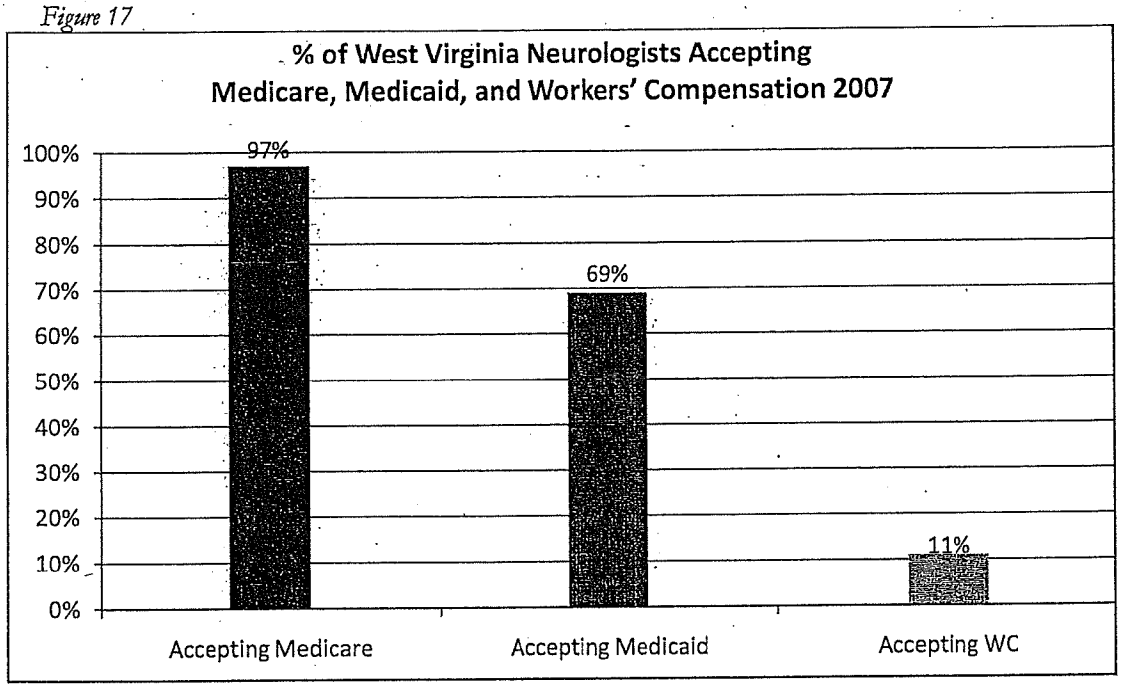
For example, in Texas the neurologist participation rate in Medicare was more than ten times higher than the workers' compensation rate, with 94% of all Texas neurologists accepting Medicare patients. While significantly fewer neurologists accepted Medicaid patients, participation levels were still four times the workers' compensation rate despite Medicaid fees that were only 52% of Medicare fees and 42% of workers' compensation fees.

Figure 16



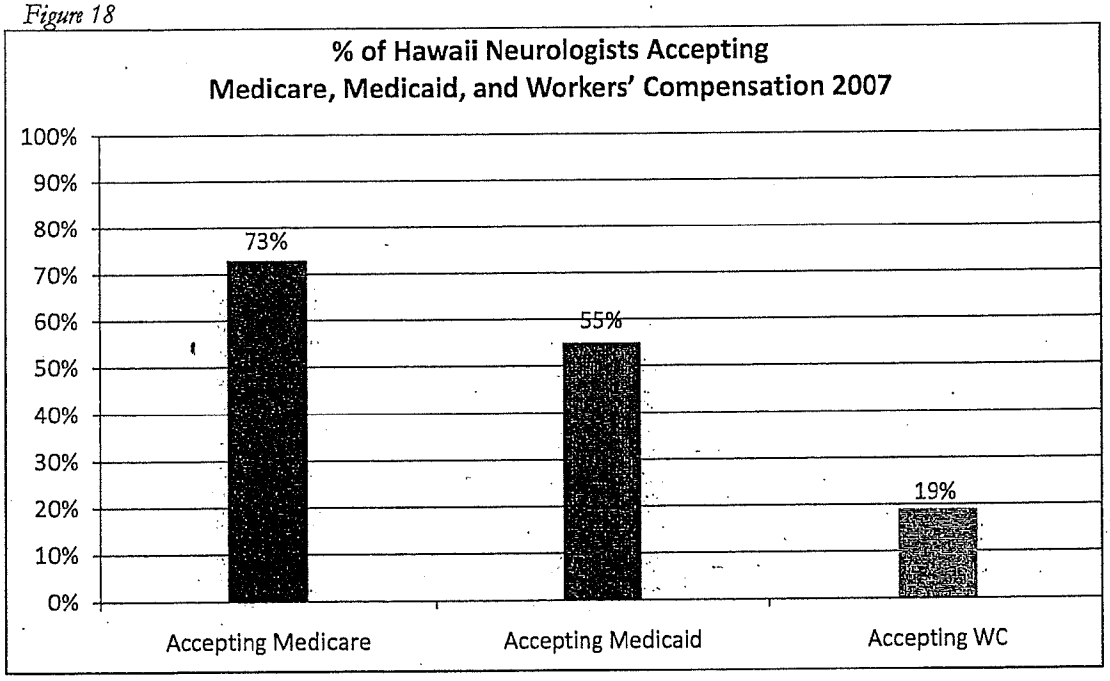
Similarly, in West Virginia, nearly all neurologists surveyed (97%) accepted Medicare patients and more than two-thirds (69%) accepted Medicaid. And yet only 11% reported they were willing to accept workers' compensation patients with higher unit cost reimbursement levels.

Figure 17



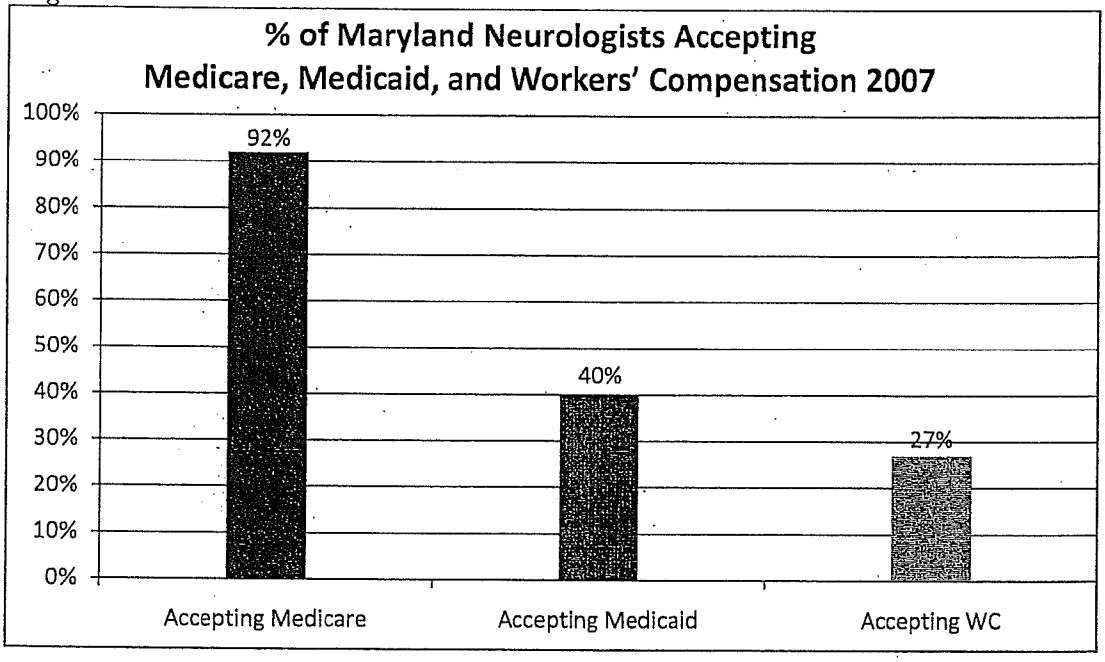
The same pattern was found in Hawaii. Although overall participation levels in Medicare and Medicaid were not as high as in West Virginia, they were still 3-4 times higher than the workers' compensation participation levels in the state.

Figure 18



Results from the Maryland surveys complete the picture. In every state with a low-multiple RBRVS fee schedule for workers' compensation, neurologists were much more likely to accept Medicare or Medicaid patients than injured workers covered by higher workers' compensation rates.

Figure 19



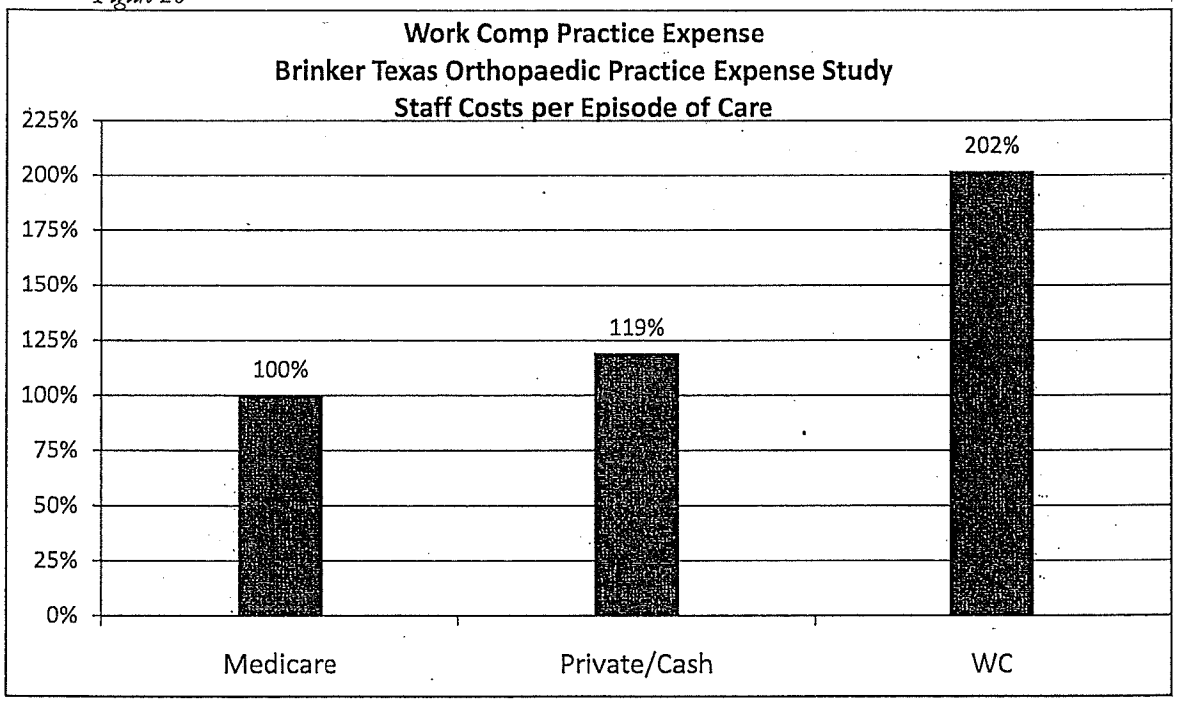
Since the procedure-level reimbursement rates for workers' compensation patients were higher than the rates for either Medicare or Medicaid in each of the study states, it is clear that fees alone are not the determining factor in a physician's willingness to participate in that state's workers' compensation system.

On the basis of comments from physicians and office staff during the survey process, it appears that additional administrative burdens or "hidden costs" which are not sufficiently offset by low-multiple RBRVS fee schedules are embedded in the workers' compensation system. It seems that the combination of these additional workers' compensation-specific administrative burdens, coupled with what are perceived as an insufficient increment in fees to pay for the added overhead drives the significant differences between physicians' willingness to accept Medicare, Medicare and workers' compensation patients.

COMPARISON OF PHYSICIAN PRACTICE EXPENSE

The evaluation of incremental expenses associated with operating a medical practice that accepts workers' compensation patients has been the subject of previous research. A study of the effect of payer type on orthopaedic practice expense was completed in Texas in 2002.[11] The results, published in the American Journal of Bone and Joint Surgery (Brinker, 2002), demonstrated that the staff costs per episode of care for a single type of injury (knee pain) were twice as high for workers' compensation patients compared to Medicare patients.

Figure 20



The Brinker study, along with provider feedback from the telephonic surveys conducted in the low-multiple RBRVS states, suggested that the physician work component (typically the focus of RBRVS-driven fee scales) may not adequately reflect additional administrative burdens embedded in the workers' compensation system. These additional administrative requirements typically encountered in workers' compensation claims include:

- Obtaining PPO and/or MPN network certification,
- Interfacing with Nurse Case Managers,
- Seeking approval for treatment from Utilization Review,
- Transcribing dictated medical reports and,
- Reconciling medical invoices that have been reduced to state fee schedules

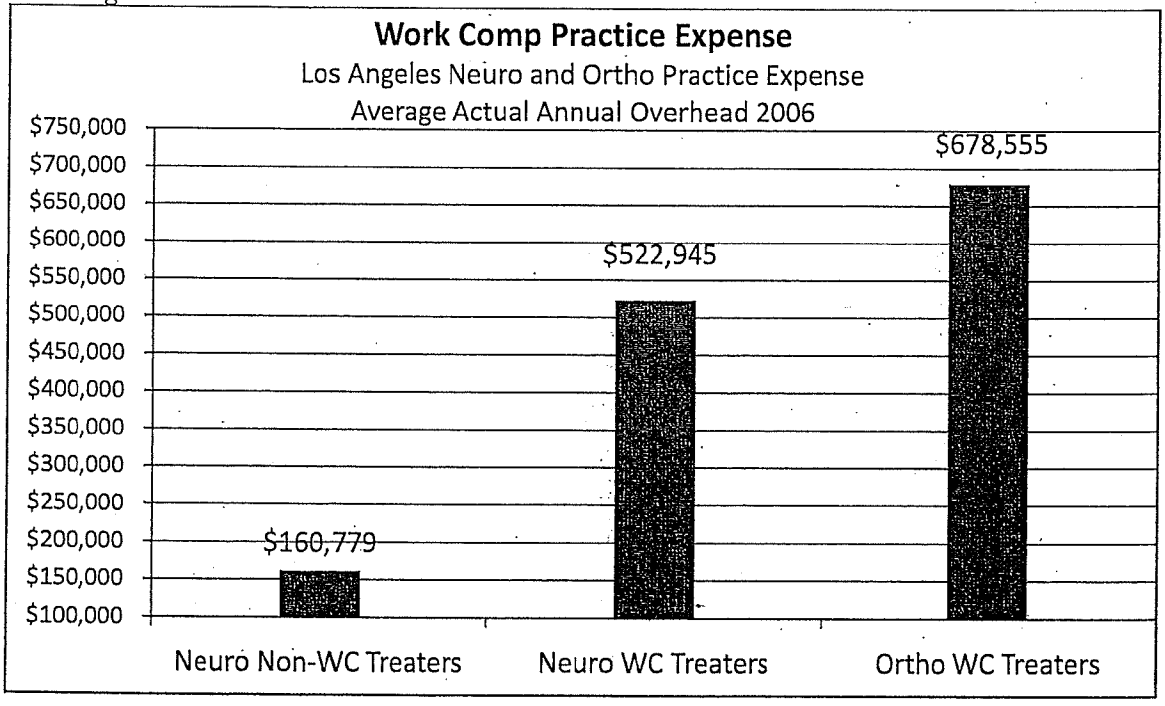
In addition to requiring some additional physician time for workers' compensation claims, these factors are much more likely to require additional staff resources that increase offices' overall practice expense.

With this in mind, a more detailed analysis of the practice expenses of neurologist and orthopaedist practices in the Los Angeles metropolitan area was conducted. Eleven neurologists and six orthopaedists in fifteen private practices agreed to confidentially share with the authors their practice expenses for the calendar year 2006. Practice expenses included all business expenditures but did not include physician income and retirement contributions. Data was self-reported by the physicians. Neurologists were classified as either accepting or not accepting workers' compensation patients without major limitation. All orthopaedists in the survey accepted workers' compensation patients. Several orthopaedists who do not accept workers' compensation patients agreed to participate, but were eliminated because they practiced with partners who did, and their practice expense data could not be segregated.

Practice expense per hour was calculated as annual overhead divided by 2,200 hours, per the U.S. Department of Health and Human Services Health Resources and Services Administration. Medicare 2007 practice expense data per hour was multiplied by the Los Angeles County GPCI practice expense factor of 1.156, yielding Medicare practice expense of $80.57 per hour for neurologists and $124.85 for orthopaedists.

The actual average practice overhead expenses for calendar year 2006 were calculated for each group (shown below). The average overhead practice expense for neurologists who did accept workers' compensation patients was more than 3 times the overhead expense of those neurologists who did not treat injured workers.

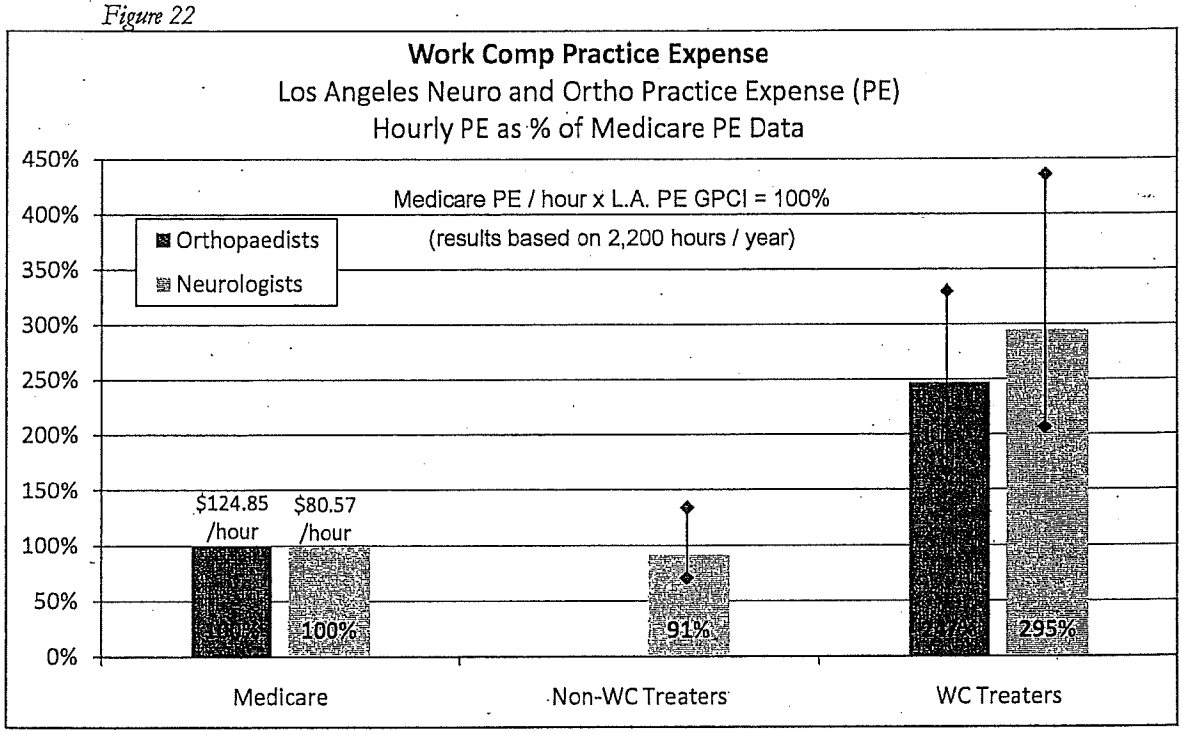
Figure 21



Data from the Medicare GPCI for Los Angeles County was then incorporated to provide a relative comparison of the hourly practice expense of three distinct groups of providers: 1) Medicare

providers; 2) neurologists/orthopaedists who treat workers' compensation patients and; 3) neurologists who do not treat workers' compensation patients.

Figure 22



The hourly practice expense for physicians who accepted workers' compensation patients was determined to be 2.5 to 3 times the hourly Medicare practice expense. This significant gap between the Medicare hourly cost and the practice expense of offices that treat workers' compensation patients helps explain why the Medicare participation rates were so much higher than workers' compensation acceptance rates across all study states despite the fact that procedure reimbursement rates were higher for workers' compensation. If practice expenses associated with treating workers' compensation patients are 247-295% of Medicare for neurologists and orthopaedists, fee scales set at 100-125% of Medicare fees simply do not provide enough financial incentive to maintain high physician participation levels.

Based on the actual 2006 practice expense data from the Los Angeles area offices, the ratio of practice expenses by specific category for those neurologists who treat workers' compensation patients was compared to those who do not. As the following table illustrates, practice expenses were found to be significantly higher for workers' compensation treaters across all categories – including both fixed and variable expenses.

Table 2

CATEGORY	WC TREATERS VS. NON-TREATERS PE RATIO
Rent	289%
Staff	392%
Office Expense	378%
Equipment	412%
Outside Services	326%
Health Plan	136%
Insurance	215%
Non-Income Taxes	453%

QUALIFICATIONS OF PHYSICIANS ACCEPTING WORKERS' COMPENSATION

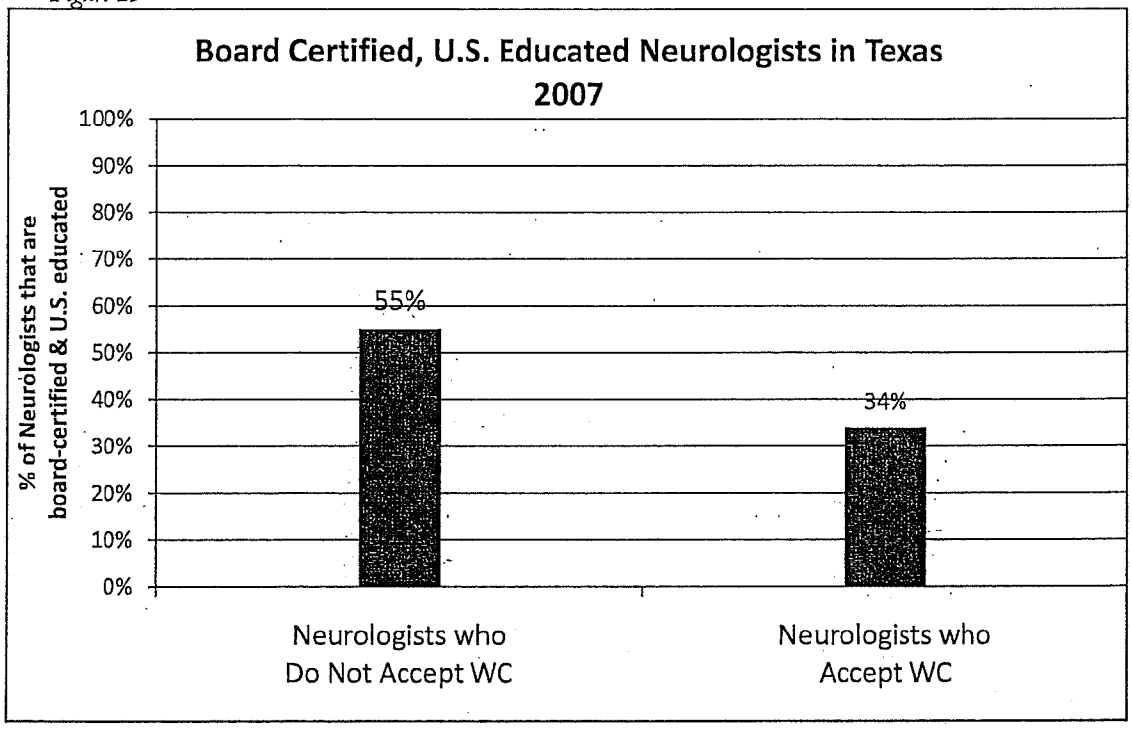
In states with low-multiple RBRVS workers' compensation fee schedules, the telephonic surveys also uncovered interesting differences in the qualifications of neurologists who continued to treat injured workers.

Searches were performed using the Texas Medical Board website (http://reg.tsbme.state.tx.us/OnLineVerif/Phys_SearchVerif.asp), the West Virginia Board of Medicine website (http://www.wvdhhr.org/wvbom/licensesearch.asp), and the website of the American Board of Medical Specialties (http://www.abms.org/) to determine the educational and certification status of each survey respondent as listed on the websites. The educational status results for all physicians in the survey population were categorized as (1) graduated from a U.S. or Canadian Medical School (U.S.-educated) or not; and (2) and certified in adult neurology by the American Board of Psychiatry & Neurology or not.

The 2005 ACN study found that in Texas, neurologists who stopped treating injured workers in the period immediately following the implementation of the 125% of Medicare fee scale were nearly two times more likely to be board-certified graduates of U.S. medical schools than those physicians who continued to participate in the workers' compensation system.

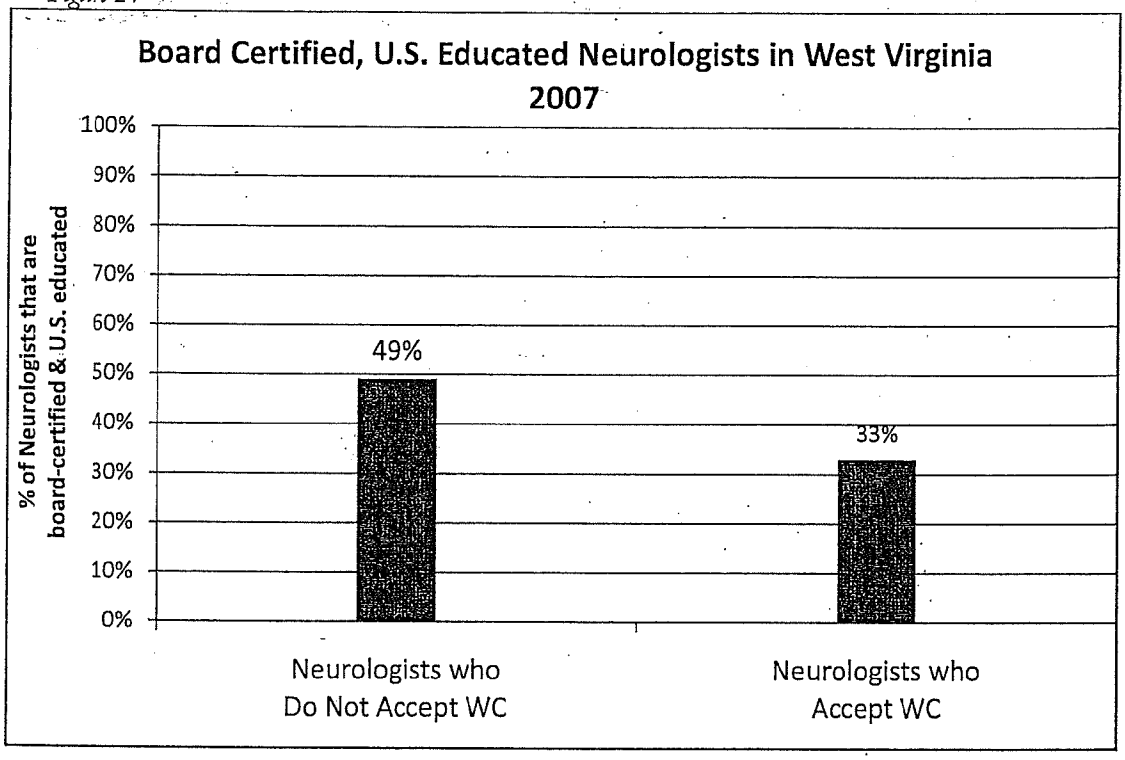
The current study found that among Texas neurologists who do not accept injured workers the proportion of those who are board-certified graduates of U.S. medical schools is far higher than among those who do accept injured workers.

Figure 23



This same trend was found in West Virginia where only one-third of all neurologists who still accept workers' compensation patients were board-certified and U.S. educated compared to nearly half of all neurologists who do not treat injured workers.

Figure 24

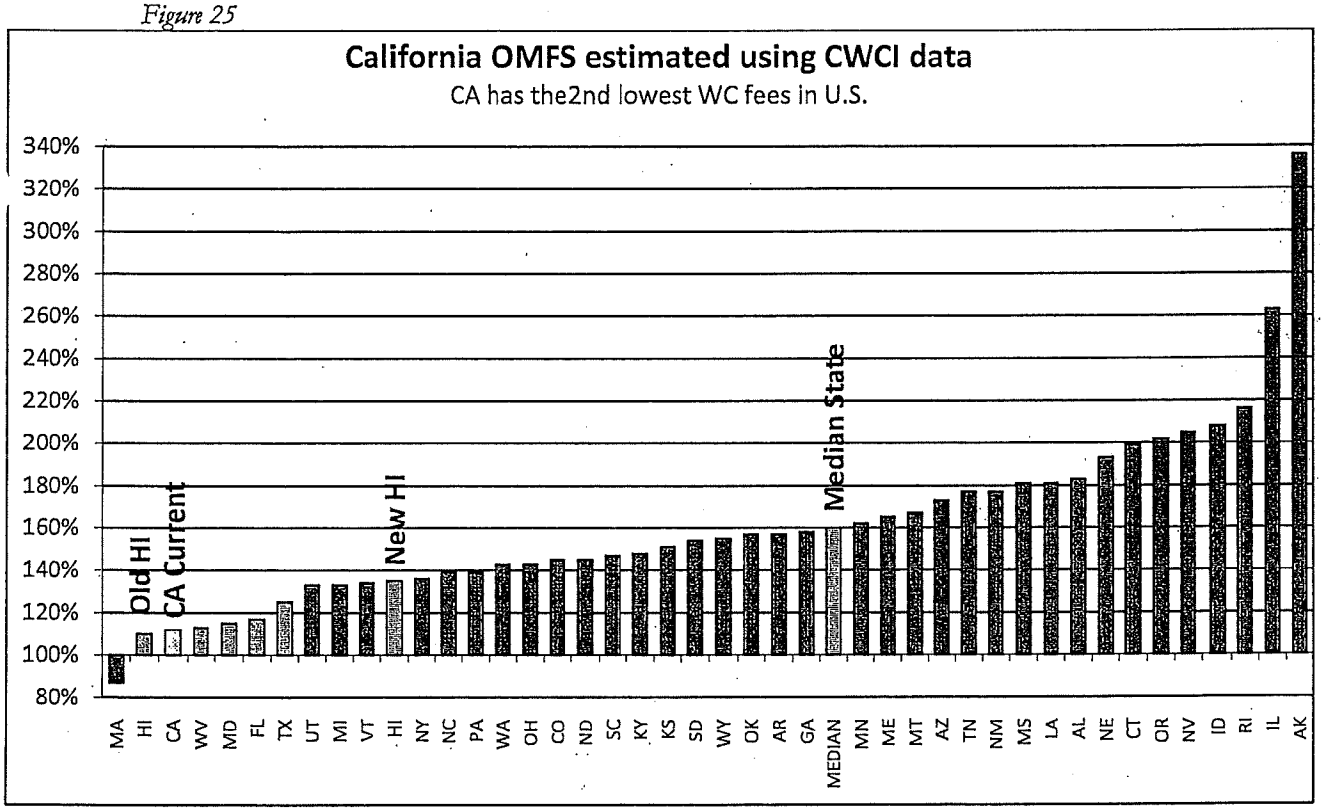

Board Certified, U.S. Educated Neurologists in West Virginia
2007
% of Neurologists that are board-certified & U.S. educated
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
49%
33%
Neurologists who Do Not Accept WC
Neurologists who Accept WC

CALIFORNIA UPDATE

California's current workers' compensation regulations provide for a charge-based Official Medical Fee Schedule (OMFS) that averages between 112% - 121% of the state Medicare rates. Under the current OMFS system, California medical fees are generally in a range very comparable to the study states of Hawaii, West Virginia, Texas and Florida.

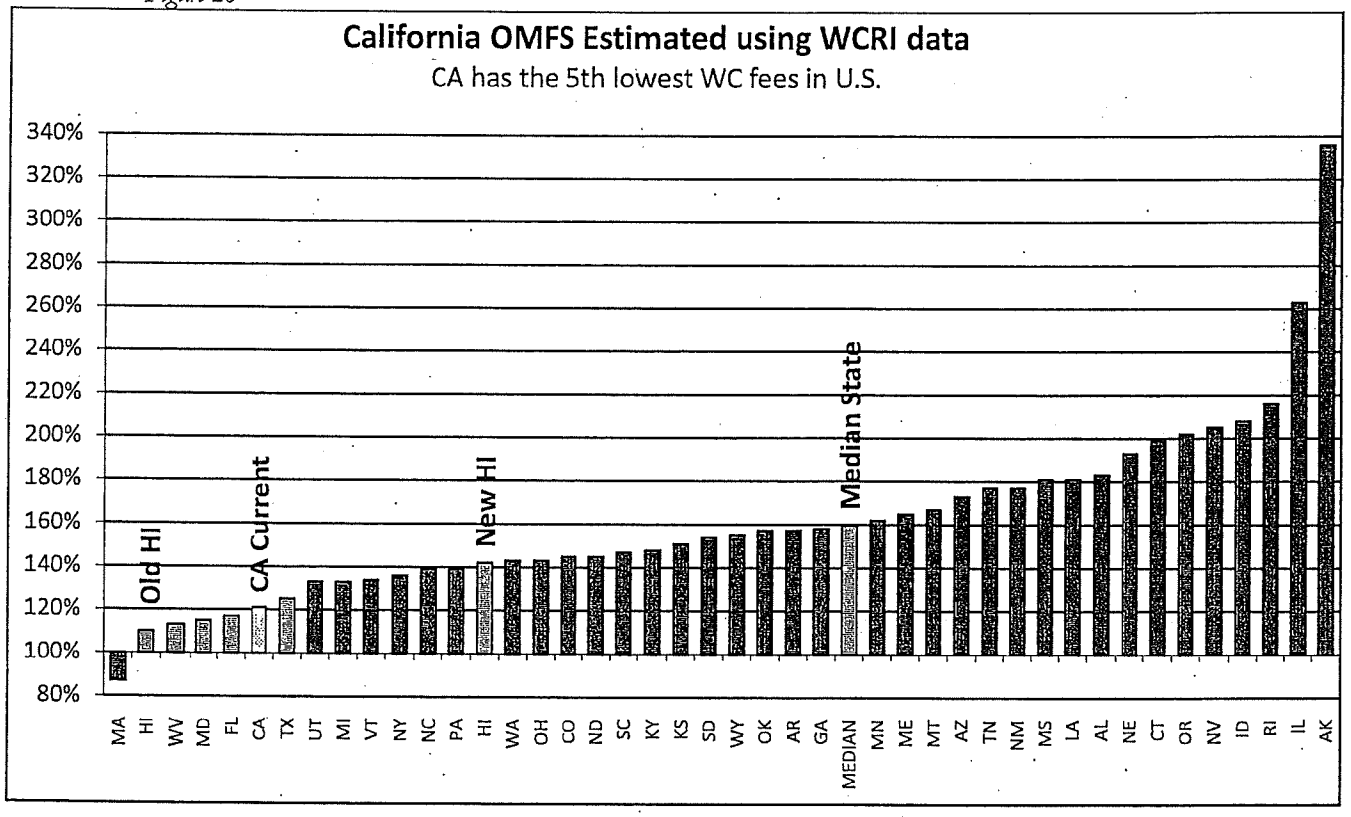
Historical procedure utilization data from CWCI would suggest that California (at 111.9% of Medicare) had the third lowest workers' compensation unit cost fees in the country, with only Massachusetts and Hawaii offering lower fees to workers' compensation providers. However, in 2006 as a result of continued concerns over injured worker access to specialty providers, the Hawaii state legislature increased their fee schedule to an average of approximately 135% of Medicare. Interestingly, rather than simply increase the Medicare multiple from 110% to a flat 135% across all procedure groups, Hawaii implemented a system which allocated higher fees to surgery and other specialty care in an effort to retain those providers engaged in the system and attract those who had deserted the system over the previous decade. As a result, California now has the second lowest workers' compensation fee schedule in the country according to the CWCI data.

Figure 25



Alternatively, if the historical distribution of medical charges from WCRI is used; California is currently the fifth lowest unit cost state in the nation at an average of 121% of Medicare.

Figure 26



Both CWCI and WCRI agree that the greatest medical cost drivers in California have been unregulated charges from outpatient surgery centers and over-utilization of specific procedure groups such as physical medicine, rather than high fee levels. Recent California reforms would appear to have successfully controlled both of these cost driver issues as billing for outpatient surgical centers is now capped at 120% of Medicare and the introduction of utilization review with hard limits on both physical therapy and chiropractic care has dramatically reduced over-utilization concerns.

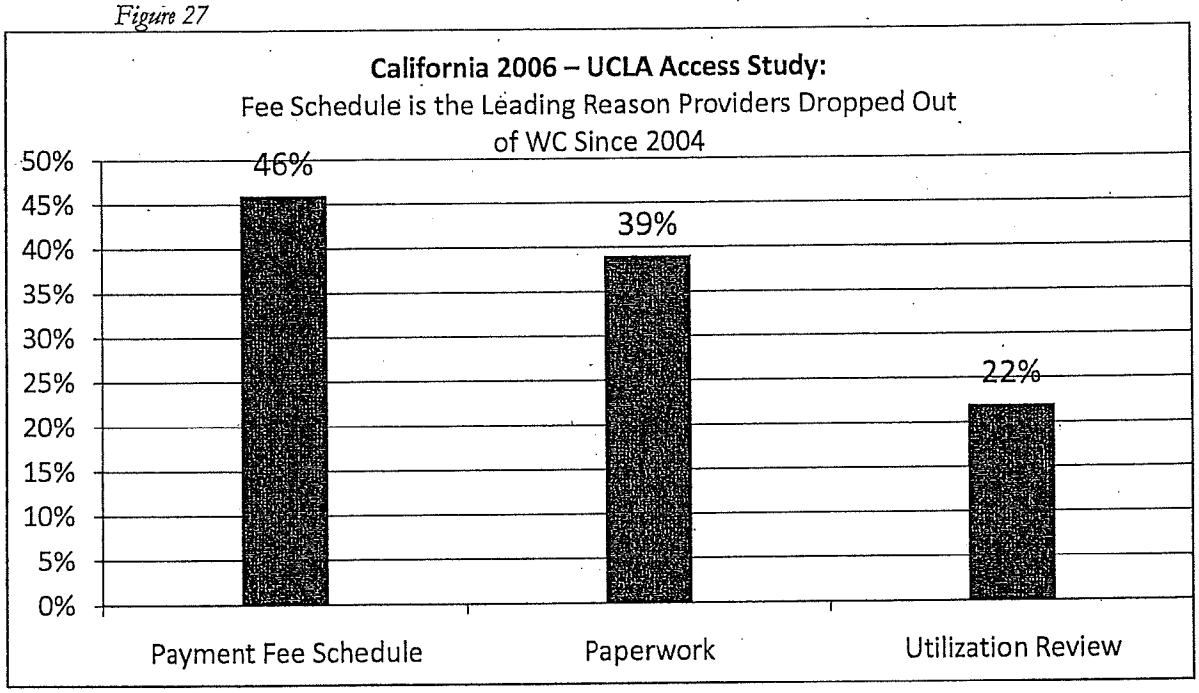
However, it must be noted that no data whatsoever is publicly available (from CWCI or WCRI) regarding code frequencies or even code group weightings in the post-reform era, during which a vigorous regime of pre-authorization/utilization review affecting expensive procedures has been applied. Given the likely shifts in code use since the reforms were implemented, it is difficult to accurately determine the current rank of California's fee schedule compared to other states and it is virtually impossible to precisely predict the impact of implementing an entirely new fee schedule methodology. Nonetheless, it is clear that California's fee schedule is among the lowest in the nation.

While the rates for the most common Evaluation and Management procedure codes were recently increased to approximately 100% of California Medicare values, major specialty care fees were cut 5% on January 1, 2004. This fee reduction coupled with the increase in the perceived administrative burdens of recent California reforms (utilization review, medical provider networks, etc.) and increase in practice expenses with inflation has apparently weakened the incentives for

physicians, particularly specialty physicians, to continue participating in the workers' compensation system.

A provider access study conducted by UCLA in 2006 identified the top three reasons physicians have dropped out of the workers' compensation system as involving the existing payment fee schedule, additional paperwork required and the introduction of utilization review.[12]

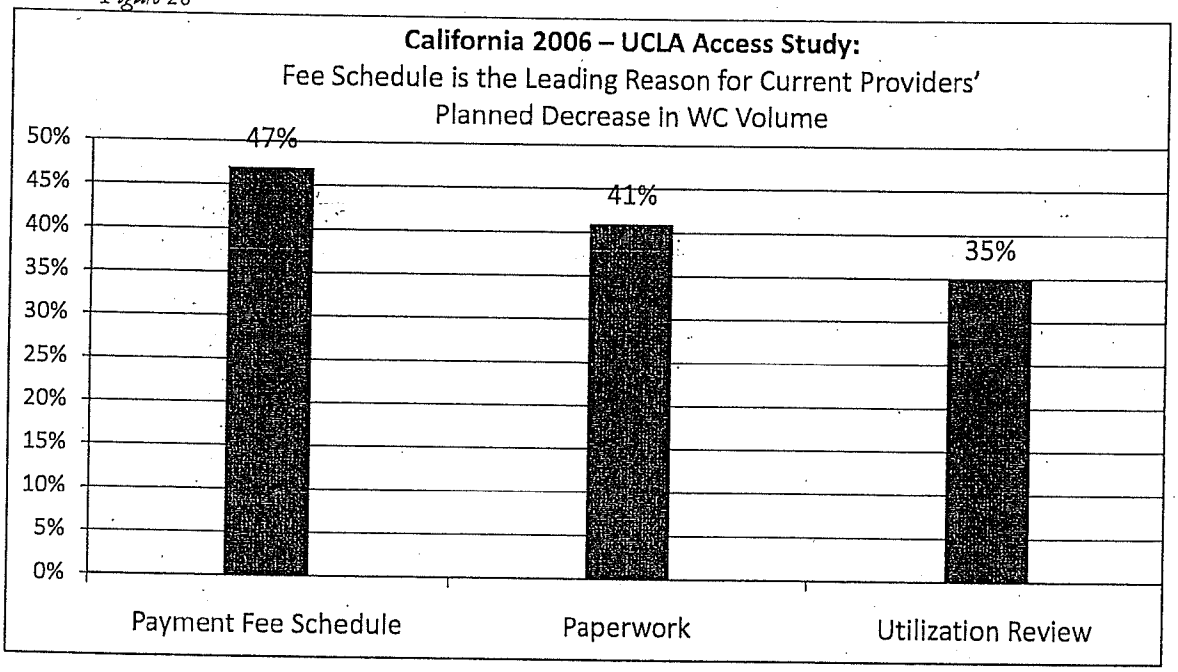
Figure 27



Providers noted that the combination of growing regulatory burdens and increased overhead required to service workers' compensation patients coupled with fees for procedures that are already considered low and will likely decrease prompted their decisions to exit the market.

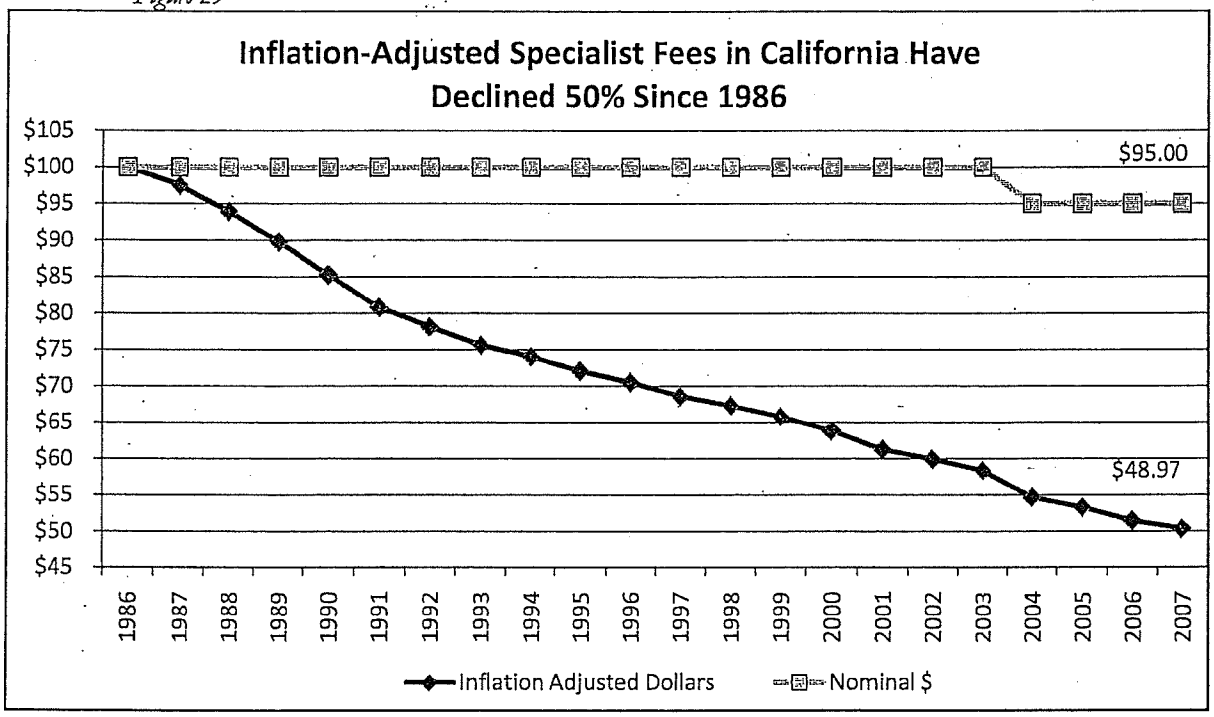
Similarly, those providers who were still accepting workers' compensation patients at the time of the survey cited the same three issues as the major reason they were planning to decrease the volume of workers' compensation patients they accepted going forward.

Figure 28



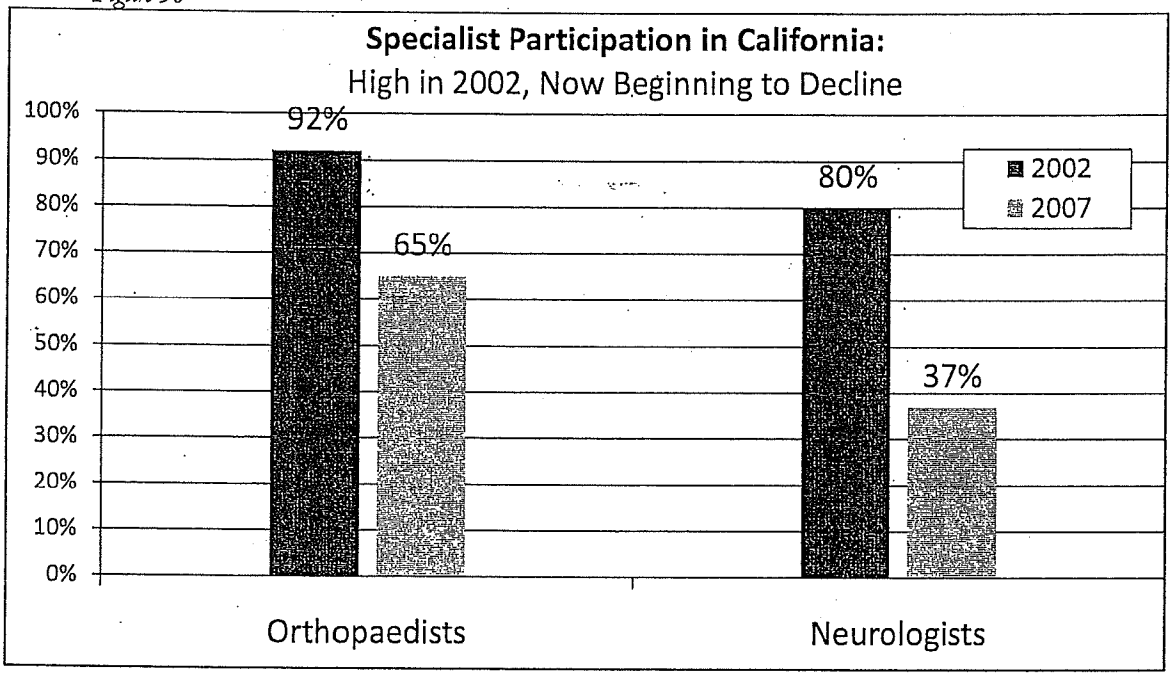
The issue of fees that are no longer sufficient to offset growing administrative and regulatory burdens is even clearer when workers' compensation specialist fees in California are adjusted for inflation. As the following chart illustrates, the California fee schedule for specialists has not changed between 1986 and 2003, but inflation adjusted fees have actually declined by 50%. At the same time, the number and complexity of the additional administrative burdens associated with treating workers' compensation patients has increased dramatically.

Figure 29



Interestingly, over that same time period specialist participation in the California workers' compensation system remained high. As recently as 2002, more than 80% of all neurologists and 92% of orthopaedists reported they still accepted workers' compensation patients without significant restrictions.[13] The current survey shows that participation has recently begun to change, with only 37% of neurologists and 65% of orthopaedists still accepting workers' compensation patients in 2007.

Figure 30



This change appears to be largely driven by changes (and proposed changes) in the fee structure coupled with the growing administrative burdens of reform. In 2002, the California fee schedule averaged 112% of Medicare, but specialty care was priced at 140-180% of Medicare while common Evaluation & Management (E&M) procedures were priced at 90% of Medicare. With the recent 5% cut in specialty fees and the threat of additional fee shifts away from specialty care towards primary care E&M visits, many specialists have already begun to exit the workers' compensation system.

A similar pattern emerged in Texas after the 2003 fee schedule reform. Even though E&M fees rose a full 36% in the conversion to RBRVS and the overall payment level only fell from 138% of Medicare to 125%, specialist participation in the workers' compensation system plummeted.

Although California workers' compensation patients still have reasonable access to specialists, participation has already begun to decline and the conversion to a low-multiple RBRVS schedule threatens to create the same result as Texas, where less than 10% of all neurologists and less than 50% of all orthopaedists still accept injured workers.

CONCLUSIONS

Ultimately the present research points to several major conclusions. First and foremost, low-multiple, unmodified RBRVS fee scales do not maintain specialist participation. Every state that has adopted a low-multiple RBRVS workers' compensation fee schedule has experienced a subsequent rapid and dramatic drop in neurologist and orthopaedist participation levels. In each of the study states, specialist participation levels were reduced by half or more within two years of the adoption of the low-multiple RBRVS fee schedule. Specialist participation levels continued to decline in Hawaii and West Virginia more than a decade after the low-multiple fee schedules were first adopted.

In addition, the workers' compensation system is far less attractive to specialists than lower-paying alternatives such as Medicare or Medicaid. This appears largely due to the additional administrative and regulatory burdens associated with workers' compensation, which apparently are not sufficiently compensated by the slightly higher fees paid per procedure. Overhead costs are far higher for workers' compensation practices than is generally recognized, driven by common system-specific requirements such as utilization review, case management and medical provider networks.

There are also clear demographic and professional qualification differences between providers who choose to leave the workers' compensation system and those who continue to treat injured workers under low-multiple RBRVS fee schedules. Physicians who choose to exit the workers' compensation system are much more likely to be board-certified and to have been educated at an American medical school.

It is worth noting that none of the three most recently adopted workers' compensation state fee schedules elected to employ an unmodified RBRVS system. Hawaii abandoned 110% of Medicare RBRVS after 11 years, and increased specialist fees in an attempt to restore access, raising average fees to about 135% of Medicare. Tennessee adopted a multiple conversion factor RBRVS fee scale with higher fees for specialty codes that average 177% of Medicare (slightly above the median state average of 160% of Medicare). Finally, Illinois adopted a charge-based scale with higher relative fees for specialty procedures as it's first ever workers' compensation fee schedule.

This trend away from unmodified RBRVS fee schedules may be driven by evidence which suggests that once specialists choose to leave the workers' compensation system they are slow to return even when reimbursement rates increase. States that have been down this path and ultimately decided to increase fees in an attempt to lure specialists back to workers' compensation demonstrate that it is far easier to maintain physician participation than to rebuild it.

The dramatic departure of physicians from workers' compensation systems in states with low-multiple RBRVS fee scales appears to have been precipitated in all cases by decreases in specialist procedure fees.

There are a variety of ways to mitigate the impact of a low-multiple RBRVS fee schedule on medical access in California: 1) Initially maintain existing specialist fees, allowing gradual decreases due to inflation, while access is monitored; 2) Use an RBRVS base, but with higher fees for specialty codes reflecting other fee data, as was done recently in Hawaii; or 3) Use multiple RBRVS conversion factors, higher for specialty areas, as has been done in Tennessee, Oregon and many other states.

Regardless of the particular approach, modification of the low-multiple RBRVS fee structure would appear prudent. The approaches suggested would potentially allow implementation of a low-cost RBRVS-based fee scale for California, while reducing the likelihood of substantial declines in medical access.

APPENDIX A: REFERENCES

1. Workers' Compensation Special Report – 2004 Survey of Texas Physicians. Texas Medical Association. 2004. http://www.texmed.org/uploadedfiles/Global_Media/wcn_04surveytxphysicians.pdf

2. Adoption of New Proposed §134.202 Medical Fee Guideline, Texas Register, 2002.

3. Ibid.

4. Impact of Medicare-based Workers' Compensation Fee Schedules on Injured Worker Access to Neurological Care in Texas & Hawaii. Association of California Neurologists – Workers' Compensation Committee. 2005. p 2.

5. Ibid.

6. Martin P. The Medical Fee Schedule Under the Workers' Compensation Law. Hawaii Legislative Reference Bureau, Report No. 8. 1998. p 11-13.

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8. Ibid.

9. Workers' Compensation Special Report – 2004 Survey of Texas Physicians. Texas Medical Association. 2004. p 1.

10. Johnson C, Huth D, Bush R. RBRVS-Based Fee Schedules in Workers' Compensation: Implications for California. HJH Group Inc. 2002. p 4-5.

11. Brinker MR, et al. The Effect of Payer Type on Orthopaedic Practice Expense. J Bone Joint Surgery (Amer.). 2002 Oct; 84: 8116-22.

12. Kominski GF, et al. Access to Medical Treatment in the California Workers' Compensation System, 2006. UCLA Center for Health Policy Research. December 2006. p xxv-xxvi, 84, 102, 122.

13. Johnson C, Huth D, Bush R. RBRVS-Based Fee Schedules in Workers' Compensation: Implications for California. HJH Group Inc. 2002.

14. Levine SE, Kent RN. New Findings and Recent Events in Workers' Compensation Fee Scales: Implications for California. March 2007.

APPENDIX B: METHODOLOGY

PART 1, SECTION 1: PHYSICIAN WORKERS' COMPENSATION PARTICIPATION IN LOW-MULTIPLE RBRVS STATES

TIMING OF SURVEYS

All telephone surveys were conducted between December 2006 and March 2007, except for Hawaii and West Virginia orthopaedists, who were surveyed in June 2007.

TELEPHONE SURVEY OF TEXAS NEUROLOGISTS

The Texas Board of Medical Examiners maintains a searchable database of physicians by specialty (http://reg.tsbme.state.tx.us/OnLineVerif/Phys_SearchVerif.asp).

A search was performed using this website to all licensed, active physicians who listed neurology as their specialty. The initial search found 1622 physician names.

In order to capture Texas Neurologists in private practice open to the public, physicians were excluded if they did not have a Texas practice address, did not hold an active license, were deceased or retired, were pediatric neurologists, or were practicing in hospitals (VA included), the military, universities, or HMO's. 1,180 listings were excluded for the following reasons:

- 44%: Out of state practice addresses
- 26%: Could not be located using 411.com, Yellow.com, or the American Academy of Neurology membership directory, or whose listed phone number was not answered on three attempts in two different weeks.
- 14%: Practicing in hospitals, the military, universities, or specialized in pediatric neurology
- 12%: Inactive licenses, not in practice, or were not physicians
- 4%: Retired or deceased

After the above exclusions, the final survey population consisted of 442 identifiable adult neurologists in private practice open to the public, which is believed to be the entire population of such neurologists in Texas. Thus, the survey was not a sample, but a full census population study.

All 442 neurologists' offices were contacted by telephone between 12/1/06 and 2/1/07. The receptionist answering the phone was asked if the doctor is accepting new WC patients. The responses were categorized as accepting WC patients for treatment without significant limitations or not accepting WC patients. All but 18 neurologists clearly fell into the accepting or not accepting categories. These 18 (4%) were accepting WC patients, but with significant limitations (only accepting employees from a single employer; only accepting from out of state insurance carriers; or accepting only on a limited, case-by-case basis after review of all files). For the present analysis, these neurologists were categorized as not accepting WC patients, since they are not generally available to treat injured workers. This assignment conforms to the methodology of the 2002 HJH study[1], the 2005 ACN WC Committee study[2], and the 2002 and 2004 Texas Medical Association Surveys[3]. Responses were obtained from all 442 offices in the census population. The same assignment methodology was followed for orthopaedists and neurologists in all states surveyed. The percentage of physicians who accepted WC patients only with significant limitations ranged from 0% to 13% in the other surveys, with the average being 4%.

TELEPHONE SURVEY OF TEXAS ORTHOPAEDISTS

The Texas Board of Medical Examiners website was searched for orthopaedists. All active, practicing, Texas orthopaedists whose office phone numbers ended with the digits 6, 7, 8 or 9 were included, according to the same criteria as Texas neurologists. The resulting sample consisted of 278 orthopaedists. All offices of the orthopaedists were contacted in the same fashion as the Texas neurologists, and were categorized as accepting or not accepting WC patients. Responses were obtained from all 278 offices in the survey sample.

TELEPHONE SURVEY OF WEST VIRGINIA NEUROLOGISTS

The West Virginia Board of Medicine maintains a searchable database of physicians by specialty (http://www.wvdhhr.org/wvbom/licensesearch.asp). A search was performed using this website, which returned 100 names of neurologists with active licenses.

The initial search returned 100 neurologists for the state. Using identical filtering methods and criteria as the Texas survey, the resulting survey population was 45 adult neurologists. Exclusions were for the same reasons as for Texas, with the majority of the 55 exclusions involving an out of state practice address.

The resulting population consisted of 45 identifiable adult neurologists in private practices open to the public, believed to be all such neurologists in West Virginia. Thus, the survey was not a sample, but a full census population study.

All 45 offices were contacted by telephone and asked if they are accepting new WC patients for evaluation and treatment. The results were categorized into the same groups as Texas. Responses were obtained from all 45 neurology offices in the census population.

TELEPHONE SURVEY OF WEST VIRGINIA ORTHOPAEDISTS

The West Virginia Board of Medicine maintains a searchable database of physicians by specialty (http://www.wvdhhr.org/wvbom/licensesearch.asp). A search was performed using this website, which returned 52 names of orthopaedists with active licenses.

All 52 offices were contacted by telephone and asked if they are accepting new WC patients for evaluation and treatment. The results were categorized into the same groups as Texas. Responses were obtained from all 52 neurology offices in the census population.

TELEPHONE SURVEY OF HAWAII NEUROLOGISTS

The Hawaii Board of Medical Examiners does not maintain a searchable database of physicians. Consequently, a search was performed using (1) the American Academy of Neurology 2006-7 membership directory; (2) and the websites 411.com and Yellow.com. It is believed that all adult neurologists practicing in the state of Hawaii were located, with the possible exception of a few practicing in several multi-specialty groups, none of which accepted WC patients. Thus, the results may overstate the proportion of private practice neurologists who accept WC patients.

Using identical inclusion criteria as the Texas and West Virginia surveys, the resulting survey population was 27 adult neurologists. Responses were obtained from all 27 neurology offices.

TELEPHONE SURVEY OF HAWAII ORTHOPAEDISTS

The Hawaii Board of Medical Examiners does not maintain a searchable database of physicians. Consequently, a search was performed using (1) the American Academy of Orthopaedic Surgeons 2006-7 membership directory; (2) and the website 411.com.

A total of 54 orthopaedists were found. All 54 offices were contacted by telephone and asked if they are accepting new WC patients for evaluation and treatment. Responses were obtained from all 54 offices.

TELEPHONE SURVEY OF CALIFORNIA NEUROLOGISTS

The Medical Board of California does not maintain a searchable database of physicians. Consequently, a search was performed using (1) the American Academy of Neurology 2006-7 membership directory, and (2) the directory websites 411.com and Yellow.com, to find all neurologists in private practice in the state of California. The same filtering methods and criteria were applied as in other states, but to achieve a manageable sample size, an additional filter was added, to exclude telephone numbers with last digits other than 6, 7, 8, or 9 (as did the 2005 ACN WC Committee Survey). After all filters were applied, the resulting sample comprised 106 adult neurologists. Responses were obtained from all 106 neurology offices.

TELEPHONE SURVEY OF CALIFORNIA ORTHOPAEDISTS

Since California does not maintain a searchable database of physicians, the membership directory of the American Association of Orthopaedic Surgery was searched for California orthopaedists whose phone numbers end in the digits 6, 7, 8 or 9. Orthopaedists were included using the same criteria as Texas neurologists. The resulting sample consisted of 224 orthopaedists. Responses were obtained from all 224 orthopaedic offices.

TELEPHONE SURVEY OF FLORIDA NEUROLOGISTS

The Florida Department of Health maintains a listing of licensed physicians by specialty, but not a searchable database. Consequently, a search was performed using (1) the American Academy of Neurology membership directory, and (2) the directory websites 411.com and Yellow.com to find all neurologists practicing in the state of Florida. The same filtering criteria applied as in California, with the final phone number digits 2 and 8 chosen to obtain a sample size under 100. Using the same inclusion criteria as in Texas, the final sample consisted of 88 adult neurologists. Responses were obtained from all 88 neurology offices.

SECONDARY TELEPHONE SURVEY OF PROVIDERS IN FLORIDA FOR ACCEPTANCE AT FEE SCALE

Since the 2002 HJH study[1] indicated that some Florida providers regularly negotiated fees above the Florida WC Fee Schedule, all 20 Neurologists' offices which responded that they accept WC patients for treatment were surveyed a second time to determine if the physician accepted such patients at fee scale. This often required speaking to an office manager or billing representative to acquire the most informed answer. Responses were obtained from all 20 neurology offices.

TELEPHONE SURVEY OF MARYLAND NEUROLOGISTS

Maryland does not maintain a searchable database of physicians. Hence, the membership directory of the American Academy of Neurology 2006-7 membership directory was searched to find all Maryland neurologists in private practice. The resulting sample consisted of 82 adult neurologists in private practice. All offices were contacted in the same fashion as the other surveys, but were not only asked if they were accepting WC patients for treatment and evaluation, but also if they accept those patients at Florida WC fee scale. Responses were obtained from all 82 neurology offices.

PART I, SECTION 2: COMPARISON OF MEDICARE, MEDICAID AND WORKERS' COMPENSATION PHYSICIAN PARTICIPATION IN LOW-MULTIPLE RBRVS STATES

SECONDARY TELEPHONE SURVEY OF PROVIDERS FOR MEDICARE AND MEDICAID ACCEPTANCE IN TEXAS, WEST VIRGINIA, MARYLAND, HAWAII AND FLORIDA

A secondary survey was conducted separately to determine the number of physicians in the survey groups who are accepting Medicare and Medicaid patients.

Texas

From the original Texas neurologist survey group, selecting neurology offices whose phone number final digit was 0 (zero) produced a sample of 100 neurologists. These offices were called a second time, and were asked if the physician is accepting new Medicare patients for evaluation and treatment. Clear accepting or not accepting responses were obtained for all 100 neurologists.

Additionally, selecting offices whose phone number final digit was 4, 5, or 6 produced another random sample of 100 neurologists who are accepting or not accepting Medicaid patients for evaluation and treatment. Clear accepting or not accepting responses were obtained for all 100 neurologists.

Medicare fees were considered 100% of Medicare by definition. Medicaid fees as a percentage of Medicare for Texas neurologists was determined for the General Medicine and Evaluation and Management codes. Medicaid was 52% of Medicare using code frequencies weighted per California work comp (see Part IV methodology below) and was 51% using direct average of fees without frequency weighting.

http://www.tmhp.com/File%20Library/File%20Library/Fee%20Schedules/Texas%20Medicaid%20Fee%20Schedule%20PRCR400C%20-%202006.xls

West Virginia

All 45 neurology offices were called two weeks after the original survey and asked if they are accepting Medicare patients for evaluation and treatment. All 45 offices were called one week after the Medicare survey and were asked if they are accepting Medicaid patients for evaluation and treatment. Clear accepting or not accepting responses were obtained for all 45 neurologists on both occasions.

Medicaid fees as a percentage of Medicare for West Virginia were determined as follows: West Virginia Medicaid pays straight RBRVS at a conversion factor of $29.53 (http://www.wvdhhr.org/BMS/). The national Medicare conversion factor is $37.8975. The West Virginia average Medicare conversion factor was calculated to be $36.15, based on a weighting of 55% physician work, 40% practice overhead, and 5% malpractice expense, and applying the West Virginia GPCI's for each of these factors. This yielded an estimate of Medicaid fees in West Virginia at 82% of West Virginia Medicare fees.

California

All 106 neurology offices were called and asked if they are accepting Medicare patients for evaluation and treatment. All 106 offices were called two weeks later and were asked if they are accepting Medi-Cal (California's version of the Medicaid program) patients for evaluation and treatment. Clear accepting or not accepting responses were obtained for 85 neurologists for Medicare, and 97 neurologists for Medi-Cal.

Medi-Cal fees as a percentage of California Medicare were determined as follows: California Medi-Cal rates were determined for each code from the Medi-Cal link on the state of California's website:

http://files.medi-cal.ca.gov/pubsdoco/pubsframe.asp?hURL=/pubsdoco/Rates/rates_range_display.asp

Once these rates were determined and compared to California's Medicare rate (straight RBRVS using 1.063 GPCI and $37.985 conversion factor), each was multiplied by the frequency per code, returning the overall cost of Medicare and Medicaid for our code set. Comparing the total cost of Medi-Cal to the total cost of Medicare returned Medi-Cal as 53% of California Medicare.

Maryland

All 82 neurology offices were called after the original survey and asked if they are accepting Medicare patients for evaluation and treatment. All 82 offices were called after the Medicare survey and were asked if they are accepting Medicaid patients for evaluation and treatment.

Medicaid fees as a percentage of Medicare for Maryland were determined as follows: Maryland Medicaid RVU's were obtained

http://www.dhmh.state.md.us/mma/providerinfo/pdf/2007physfeemanual.pdf

and the national conversion factor of $37.8975 was applied. Based on frequency weighting per California WC, and further weighting of 70% Evaluation and Management and 30% General Medicine (neurodiagnostics), Maryland Medicaid fees were estimated to be at 58% of Maryland Medicare.

Hawaii

All 27 neurology offices were called after the original survey and asked if they are accepting Medicare patients for evaluation and treatment. All 27 offices were called after the Medicare survey and were asked if they are accepting Medicaid patients for evaluation and treatment.

Medicaid fees as a percentage of Medicare for Hawaii were determined as follows: Hawaii Medicaid fees were obtained

http://www.med-quest.us/PDFs/Provider%20Memos/2005%20Medicaid%20Fee%20Schedule.pdf

Based on frequency weighting per California WC, Hawaii Medicaid fees were estimated to be at 58% of Maryland Medicare.

Florida

All 88 neurology offices were called after the original survey and asked if they are accepting Medicare patients for evaluation and treatment, then were called and asked if they are accepting Medicaid patients for evaluation and treatment.

Medicaid fees as a percentage of Medicare for Florida were determined as follows: Florida Medicaid fees were obtained (http://files.medi-cal.ca.gov/pubsdoco/rates/rates_information.asp). Florida Medicaid fees were estimated to be at 46% of Maryland Medicare.

PART I, SECTION 3: COMPARISON OF PHYSICIAN PRACTICE EXPENSE WITH WORKERS' COMPENSATION, MEDICARE AND PRIVATE PATIENTS

LOS ANGELES NEURO AND ORTHO PRACTICE EXPENSE

Eleven neurologists and six orthopaedists in fifteen private practices agreed to confidentially share with the author practice expenses for the calendar year 2006. Practice expenses included were all business expenditures except physician income and retirement contributions. Data was self-reported by the physicians. Neurologists were classified as accepting or not accepting WC patients without major limitation. All orthopaedists in the survey accepted WC patients. Several orthopaedists who do not accept WC agreed to participate, but were eliminated because they practiced with partners who did, and their expense data was inseparable.

Practice expense per hour was calculated as annual overhead divided by 2,200 hours, per U.S. Department of Health and Human Services Health Resources and Services Administration.

(http://bhpr.hrsa.gov/healthworkforce/reports/physiciansupplydemand/trendsinphysicianproductivity.htm).

Medicare 2007 practice expense data per hour was multiplied by the Los Angeles County GPCI practice expense factor of 1.156, yielding Medicare practice expense of $80.57 per hour for neurologists and $124.85 for orthopaedists.

(http://www.cms.hhs.gov/apps/ama/license.asp?file=/physicianfeesched/downloads/pehrtable.zip)

Comparison of the major expense categories for WC treaters' practice expense as a percentage of non-treaters' practice expense was calculated based on actual expense without regard to Medicare data.

PART I, SECTION 4: QUALIFICATIONS OF PHYSICIANS ACCEPTING WORKERS' COMPENSATION IN LOW-MULTIPLE RBRVS STATES

Searches were performed using the Texas Medical Board website (http://reg.tsbme.state.tx.us/OnLineVerif/Phys_SearchVerif.asp), the West Virginia Board of Medicine website (http://www.wvdhhr.org/wvbom/licensesearch.asp), and the website of the American Board of Medical Specialties (http://www.abms.org/) to determine the educational and certification status of each survey respondent as listed on the websites. The educational status results for all physicians in the survey population were categorized as (1) graduated from a U.S. or Canadian Medical School (U.S.-educated) or not; and (2) and certified in adult neurology by the American Board of Psychiatry & Neurology or not.

PART II: CALIFORNIA UPDATE

INFLATION-ADJUSTED SPECIALIST FEES IN CALIFORNIA

The effects of inflation on specialist fees under OMFS 1986–2007 were calculated by annual deflation from $100 in 1986. This was accomplished by applying the annual CPI for western urban regions maintained by the U.S. Bureau of Labor Statistics website (http://data.bls.gov/PDQ/servlet/SurveyOutputServlet). The 5% cut imposed by SB 228 at the end of 2003 was included in the calculations.

PART III: STRATEGIES EMPLOYED BY STATES TO MAINTAIN AND/OR IMPROVE SPECIALIST WORKERS' COMPENSATION PARTICIPATION RATES

CALCULATED COST OF 2007 HAWAII WC FEE SCHEDULES

(Appendix C- spreadsheet titled 'Calculated Cost of HI WC')

Due to the unavailability of frequency data for Hawaii, the adjusted frequency data for California (based on 2004/2006 CWCI statistics) was used to determine the cost of the new 2007 Hawaii WC Fee Schedule. This was done in order to create a meaningful comparison of Hawaii and California fee scale costs.

The new 2007 Hawaii workers' compensation medical fee scale pays 110% of Hawaii Medicare for all codes except those listed in the supplemental fee scale effective January 1, 2007 (http://hawaii.gov/labor/dcd/pdf/wc/approved_mfs_eff_01-01-07.pdf). The 2007 Hawaii Medicare fee was determined from the Hawaii Department of Industrial Labor website (http://www.hawaii.gov/labor/dcd/pdf/MFS_1-2-07.pdf). If a code appears on the supplemental fee schedule, the supplemental unit value (multiplied by a conversion factor of $33.54) supersedes the HI Medicare fee. An Excel formula was applied to return for each CPT code in the CA code frequency table used in the present analysis either the HI supplemental if one exists, or 110% of the HI Medicare fee. The resulting fee is the new 2007 HI WC fee. These were multiplied by the CA frequency to determine the cost per code and these costs were summed across all codes to determine the total cost of the new 2007 HI WC Fee Schedule overall and by code group.

ADJUSTING YEAR 2000 CODE FREQUENCIES TO REFLECT 2004 CODE GROUP WEIGHTING

Top 100 Codes from year 2000, released in May, 2003 by the California Workers' Compensation Institute, along with accompanying tables for several code groups, yielded frequencies for about 170 codes. After deleting codes which never did or no longer appear in the Medicare RBRVS, 152 codes remain. These were separated into the following five major fee schedule sections (code groups): Surgery, Medicine, Radiology, Physical Therapy, and Evaluation and Management (E/M). These codes and their frequency data from year 2000 are shown in Appendix C (Excel spreadsheet titled 'Adjustments to Code Frequencies'). Code groups not included in the present analysis are those for which the Medicare main RBRVS methodology does not apply (chiropractic, acupuncture, anesthesia, pathology, special services [P&S reports, etc.]). CWCI has released a list of Top 200 Codes for 2004 data, but has refused to make these available to non-members.

Due to the unavailability of more recent code frequency data, a formula for updating the 2000 claim frequency data was applied using the most current statistics available to the general public. The CWCI report "ICIS SAYS: Early Returns on Workers' Comp Medical Reforms: Part 3," table 1, shows 2004 physician payment distribution by fee schedule section. The percentage of payment distribution (i.e., percentage of spending per code group) from Table 1 was applied for each of the five subject code groups. According to Table 1 of the ICIS study, these five code groups represented 76.5% of total physician payments in 2004.

Recently, CWCI released a brief analysis of the effects of the increase in fees for the ten most common E/M codes. In that analysis, it was revealed that E/M payments had risen from 19.7% of physician payments in 2004 (the ICIS Table 1 referred to above) to 21.17% in 2005. This latter amount was used instead of the 19.7% in the 2004 Table 1, and the difference distributed proportionately among the remaining four code groups.

The 76.5% represented by the new code group percentages was adjusted to represent 100% of spending for the current analysis. In order to achieve this, each code group target percentage was multiplied by the ratio of 100% over 76.5% (1.307) to achieve a normalized percentage for each group. This became the new target percentage of total spending per code group.

Using 2006 OMFS fees, the spending for each code group in the sample was determined. To correct to target weighting, all frequencies within each code group were multiplied by a single factor that would result in the spending for each code group matching the target weight for the code group per Table 1 ICIS. By this method, the 2000 frequency data now matched the code group weighting of spending as reported for 2004 by CWCI in the ICIS study, adjusted for the recent revelation about the increase in 2005 for the weight of the E/M code group.

Relative frequencies of codes within code groups was unaffected by these adjustments – only the weightings of the code groups were changed from the 2000 data to reflect the 2004 ICIS Table 1 weightings.

It must be noted that no data whatsoever is publicly available (CWCI or WCRI) that addresses code frequencies or even code group weightings in the post-reform era, during which a vigorous regime of pre-authorization/utilization review affecting expensive procedures has been applied.

CALCULATED COST OF CURRENT CA AND CA WITH MEDICARE MINIMUM & HOLD HARMLESS

(Appendix C- spreadsheet titled 'Calculated Cost CA with Medicare Minimum & Hold Harmless')

With the new code frequency data equivalent to 2004 code group spending, the cost of current OMFS and Medicare, and any other variation of the fee schedule, could be determined (as of 2004).

COST OF 2007 OMFS

For each code, the new (adjusted) frequency was multiplied by the 2007 OMFS fee to determine the cost of 2007 OMFS per code, and these costs were summed across all codes to determine the total cost of 2007 OMFS.

COST OF 2007 CALIFORNIA MEDICARE

For each code, the new (adjusted) frequency was multiplied by the 2007 California Medicare Fee (national RVU x CF $37.8975 x 1.063, the geographical factor used by DWC to implement SB228), to determine the cost of 2007 Medicare per code, and these costs were summed across all codes to determine the overall cost of 2007 California Medicare.

COST OF 2007 OMFS AS % OF CA MEDICARE

The total cost of 2007 OMFS was divided by the total cost of 2007 Medicare and multiplied by 100 to determine the percentage of Medicare to which the current OMFS spending is equivalent.

VIRGINIA AFL-CIO

5400 Glenside Drive, Suite E ♦ Richmond, Virginia 23228
Phone: (804) 755-8001 ♦ FAX: (804) 755-8005 ♦ E-Mail: info@va-aflcio.org

DORIS CROUSE-MAYS, *President* ♦ C. RAY DAVENPORT, *Secretary-Treasurer*

A Voice for Virginia's Working Families

November 22, 2010

The Honorable William Dudley, Chair
Virginia Workers' Compensation Commission
1000 DMV Drive
Richmond, VA 23220

Dear Commissioner Dudley:

The Virginia AFL-CIO would like to thank you for your invitation to consider comments from our organization regarding Senator Saslaw's letter on workers' compensation with regards to SB 367 and HB 1326 and addressing the four issues: multiple surgery discounts; cost of surgical assistants, prompt payment to medical providers; and payments to out-of-state doctors.

It is important to place the issue of medical costs under Virginia workers' compensation in perspective.

First, Virginia workers' compensation costs are consistently lower than at least 46 other states. According to the 2010 Oregon Workers' Compensation Rate Survey, Virginia ranks 47 in cost. All of the neighboring states studied by the Commission are more costly to employers.

Any attempt to portray payments to Virginia doctors as contributing to a crisis in workers' compensation costs is inconsistent with this fundamental reality. It is misleading to focus solely on relative proportions of indemnity and medical payments given the restrictiveness of the Virginia system.

Second, attempts to lower payments to Virginia physicians who treat workers' compensation patients will result in a decrease in the number of physicians willing to treat injured workers. The additional paperwork and reports required by the workers' compensation system already deter some physicians from treating injured workers.

Third, to reduce health care costs, the legislature might consider allowing injured workers to be treated with their primary care physician. A 1994 study (in which data was used from NCCI) of 32,000 claims for 17 states indicates that restricting employee choice of physician can actually result in higher health care costs (Pozzebon, Silvana. ILR Review Vol. 48, No. 1).

With respect to the specific issues raised by Senator Saslaw's letter, our view is that the existing law under which payments to physicians must be consistent with the prevailing community rate seems to be effective in retaining doctors in the workers' compensation system.

Thank you for allowing us to address our concerns.

Sincerely,

Doris Crouse-Mays

Doris Crouse-Mays
President

DCM:csj
OPEIU 334, AFL-CIO

SECTION FOUR

DISCUSSION AND RECOMMENDATIONS

Discussion and Recommendations

Medical cost containment is the subject of many studies and reports, and efforts to contain medical costs in workers' compensation are underway in most states. Many states utilize fee schedules to regulate and control workers' compensation medical costs.[1]

Virginia's statutory scheme uses the prevailing community rate to reimburse medical providers.[2] When this standard was first enacted, medical providers varied their charges based upon the patients' social class and ability to pay. This standard was enacted to prevent medical providers from charging an employer an amount in excess of what would have been charged to a self-paying injured person.[3]

Today, medical providers normally do not vary their charges based on the social status of the patient or the identity of the payer. On the other hand, their charges often exceed the amount that they expect to receive in payment.[4] Reimbursement rates under PPO contracts or under Medicare may be but a small fraction of the medical provider's charges. Because of the presumption that a self-paying injured person would pay the medical provider's full charges, the "prevailing community rate" standard has become a standard based upon charges, and not based upon the amount that the medical provider would actually expect to receive from a private insurance company or from Medicare (or,

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[1] *See* Section Two (Methods of Reimbursement) for a detailed analysis of fee schedules in workers' compensation.

[2] Va. Code § 65.2-605.

[3] *See* the discussion on pages 4-7 of this report.

[4] In the United States today, "the charges for medical services bears little resemblance to the actual cost to deliver services." Cost v. Charge, Pacific Medical International, at http://pacmedi.com/cost-vs-charge.html, citing John Carreyrou, *As Medical Costs Soar, The Insured Face Huge Tab*, Wall St. J., Nov. 29, 2007, at http://pacmedi.com/cost-vs-charge.html (In this example, a hospital admitted to charging in excess of three times its actual costs "to account for the fact that it only collects on average a third of what it bills in any given year.").

for that matter, from a self-paying uninsured injured person). Thus, under this statutory standard, medical providers often receive larger reimbursements from an injured worker's employer or workers' compensation insurance carrier than they otherwise would receive had Medicare or a private health insurer been the payer.[5]

[5] *See* John Robertson & Dan Corro, *Making Workers Compensation Medical Fee Schedules More Effective* (NCCI Dec. 2007).

Multiple Surgical Procedures and Assistants at Surgery

The disparity between the prevailing community rate standard and the expected reimbursement under a PPO contract or Medicare is particularly apparent in the case of multiple surgical procedures and assistants at surgery. Some medical providers do not discount their charges in these situations. Rather, they often bill the same amount for an assistant at surgery as for the primary surgeon, and bill the same amount for a successive surgical procedure as for the initial or primary procedure. Thus, while the reimbursement for such services typically is discounted under PPO contracts or under Medicare, the determination of the prevailing community rate may be skewed by inclusion of these non-discounted charges in any database used in this determination.[6] Again, this standard is based upon charges, and not based upon actual or expected reimbursements. In short, if one compares reimbursements under private health insurance contracts or Medicare with reimbursements under Virginia's "prevailing community rate" standard, medical providers may receive a larger amount when the payer is the injured worker's employer or its workers' compensation insurance carrier.

In years past, this disparity was minimized or justified by a number of factors. First, one may assert that the "hassle factor" of dealing with the workers' compensation system justifies greater reimbursement. For example, medical providers may be required to furnish medical records, fill out forms, write reports, give opinions regarding issues such as work capacity, permanent impairment, or causation, and testify in depositions or in hearings. Moreover, the provider risks nonpayment should the employee's accident be found not to be compensable under the Act. Second, in many workers' compensation

[6] The Commission has seen a steady increase of applications from medical providers challenging databases used by carriers in making reimbursement decisions.

cases, reimbursement of medical charges is governed by a PPO contract. These contracts often contain provisions discounting reimbursement of charges related to multiple procedures and assistant surgeons. Third, the Act provides the employer some rights regarding the choice of the treating physician. Thus, employers may be able to direct injured employees to medical providers who contractually have agreed to limited reimbursements, and who might, in turn, make any necessary referrals to other "in network" specialists. Finally, in years past, many medical providers simply accepted whatever discounted amounts the employer offered in payment of their charges. The providers were accustomed to receiving discounted amounts under Medicare, Medicaid, private health insurers, and HMOs, and thus saw no reason to complain so long as the employer's payments on behalf of the injured worker were equal to or above the accustomed amounts from these other payers.

In more recent years, some medical providers have become more knowledgeable regarding their rights under the Act and more aggressive in contesting discounted reimbursements. Some have opted out of the workers' compensation coverage of PPO contracts and have filed more claims with the Commission seeking full payment of their charges. They frequently are successful in recovering sums which exceed the employer's voluntary payments or what they would have received had the payer been a PPO or Medicare, particularly regarding charges for multiple procedures or assistant surgeons.[7]

[7] For example, in Williams v. Hampton Newport News Community Srvs. Bd., VWC File No. 146-64-21 (July 2, 2010), a medical provider was awarded $125,426.16 . An inspection of the underlying claims in this file reveals that for one surgical procedure the primary surgeon and the non-physician assistant each charged (and were awarded) $43,377.00.

A continuation of this trend may impact the Commission's judicial resources as the number of contested claims increases.[8] It may also perpetuate disparities in reimbursements to medical providers who adopt PPO contracts and passively accept discounted reimbursements as compared with medical providers who avoid PPO contracts and aggressively pursue increased payment through claims filed with the Commission.

Some states have addressed the issues of multiple procedure and assistants at surgery discounts within their fee schedules, providing specific instructions and using modifiers for charges based on these situations.[9]

The Commission has restricted authority to address these issues. Since the standard for medical reimbursement is set by statute, any significant changes would require legislation. The Commission's recommendation is that the legislature, in considering any statutory changes, (1) balance the need for controlling medical costs related to multiple procedures and assistants at surgery against the need for sufficient reimbursement levels to insure the ready availability of excellent medical care for injured workers, and (2) consider the approaches that have been taken by Medicare and by our adjoining states in addressing these issues.

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[8] *See* Introduction of this report where we note that the number of applications from medical providers has increased from 236 applications in 2000 to 1298 applications in 2009.

[9] *See* Section One, Subsections 1 and 2, for detailed analysis of the methods used by other states in handling multiple procedure and assistants at surgery issues.

A Word about Fee Schedules

NCCI and WCRI have extensively studied fee schedules and their impact on cost containment in workers' compensation. The Commission would suggest careful review of these studies before a decision is made to promulgate a fee schedule (and any method employed to do so) as there are many issues to consider. Determining the basis for a fee schedule is very important. Some states use Medicare as a benchmark, but there are vast differences among states. Research shows the potential for over utilization of more invasive procedures and concerns that fee schedules are not effective at containing prices for specialty care. Moreover, stakeholders express concern over access to quality medical care if a fee schedule were to be adopted in Virginia.

Prompt Payment of Medical Bills

Many states have prompt payment standards in workers' compensation cases including time frames for medical providers to submit their bills and time frames for payers to make payment or dispute the bills. Some states penalize medical providers who do not make timely submission of bills by denying their right to reimbursement. States also penalize employers and insurers who fail to timely pay or dispute medical bills by charging interest, imposing fines, or limiting the payer's right to deny reimbursement.

The Commission has limited authority to address these issues. The law allows the Commission to assess costs and attorney's fees against employers or carriers who bring, prosecute, or defend proceedings or delay payment without reasonable grounds. Va. Code

§ 65.2-713.[10] Any significant change would require legislation. On the other hand, the Commission has received relatively few complaints regarding tardy pre-trial payments. In most of these instances, the delay in payment has been found justified, mostly due to the lack of supporting documentation.

The Commission's recommendation is that the legislature, in considering any statutory changes, would need to address several issues including:

1) whether the current system needs changing;

2) whether the benefits of any changes would outweigh any increase in litigation caused by such changes;

3) defining a "clean" bill subject to payment -- providing clear directions as to the information necessary for a provider to include with the bill for the payer to make a payment decision;

4) setting forth when the time period for submission of a bill begins to run, i.e. a certain number of days after treatment is rendered;

5) setting forth when the time period for payment or dispute of a bill begins to run, i.e. the number of days after the bill and supporting documentation are received by the payer;

6) setting forth provisions for the tolling of these time periods based on specific situations;

7) consideration of underlying issues in workers' compensation regarding payment of medical benefits;

[10] If the Commission has ordered the defendant to pay a sum certain for medical treatment, the Commission might also use its contempt powers to enforce prompt payment. *See* Va. Code § 65.2-202.

8) a mechanism for handling disputes over these issues and disputes over the definitions contained in any new legislation;

9) any penalty or repercussion for failing to submit a bill (such as waiver or forfeiture) within the timeframes articulated in the statute; and

10) any penalty or repercussion for failing to pay or respond to a bill (such as a fine, interest, waiver) within the timeframes articulated in the statute and how that penalty would be assessed.

The legislature should be mindful of various issues that arise on a regular basis in contested workers' compensation cases. An employer or carrier is only responsible for payment of medical treatment for a compensable injury. Therefore, the legislature should consider whether a final decision on compensability must be made before a prompt payment statute would apply or before any statutory time period would begin to run. The legislature should also take into account that an employer or carrier generally is only responsible for payment of medical treatment that is authorized, reasonable, necessary, and causally related to the compensable injury. Oftentimes, an employer or carrier may stipulate to the compensability of a claim and an initial period of causally related medical treatment but deny that treatment is related to the injury beyond a certain date based on medical documentation. Employers and carriers are not always required to pay medical bills where an injured employee has refused to undergo an independent medical evaluation or otherwise refused medical treatment. Therefore, the legislature should consider whether these issues must be resolved before any prompt payment statute would apply or statutory time periods would begin to run.

Charges for Medical Services Provided Outside of Virginia

Statutory workers' compensation law in Virginia does not explicitly address the determination of charges for medical services rendered to injured workers by out of state health care providers. By case law, Virginia applies the terms of Va. Code § 65.2-605 to out of state medical services. If an applicable medical services contract, such as a PPO contract, exists the parties are bound by its terms. However, in the absence of such a contract, a prevailing community rate standard is applied.

Other states are not defined by communities like Virginia. However, under Rule 14 of the Virginia Workers' Compensation Act, the Commission can designate a community. Rule 14 provides: "Whenever an employee receives treatment outside of the Commonwealth, the Commission will determine the appropriate community in the state or territory where the treatment is rendered upon application of either the employee, employer (or its representative), or medical provider." Thus, the Commission can designate a Virginia community or an out-of-sate community as the appropriate community under Rule 14. The problem in designating an out-of-state area as a community is the reliability of the data used to determine the prevailing community rate. However, there have been very few, if any, disputes brought to the Commission regarding the reliability of this data.

The question of the amount of payment for out of state medical services is addressed by other states in various ways:

1) Some states apply their own fee schedules to out of state services.

2) Some states require that payment amounts be determined in a manner consistent with the law of the state where the service is rendered.

3) Washington, D. C. provides for payment at a percentage of the Medicare reimbursement rate.

There are very few cases brought to the Commission that raise the issue of application of law for charges for medical services rendered to injured workers by out of state health care providers. The vast majority of cases involving this question come from southwest Virginia.

The Commission notes that any changes to the law in this area would be dependent on any other changes – i.e. the enactment of a fee schedule or statutory language changes. Furthermore, since this is a limited problem in Virginia, no action may be necessary.

APPENDIX A

COMMONWEALTH OF VIRGINIA

RICHARD L. SASLAW
SENATE MAJORITY LEADER
35TH SENATORIAL DISTRICT
PART OF FAIRFAX COUNTY; AND
PART OF THE CITY OF ALEXANDRIA
POST OFFICE BOX 1856
SPRINGFIELD, VIRGINIA 22151

COMMITTEE ASSIGNMENTS:
COMMERCE AND LABOR, CHAIR
COURTS OF JUSTICE
EDUCATION AND HEALTH
FINANCE
RULES

SENATE

March 12, 2010

The Honorable Virginia R. Diamond
The Honorable William L. Dudley, Jr.
The Honorable Roger L. Williams
Virginia Worker's Compensation Commission
Second Floor
1000 DMV Drive
Richmond, VA 23220

RE: SB367 AND HB1326

Dear Commissioners Diamond, Dudley, and Williams:

Pursuant to action taken in the Senate Commerce and Labor Committee on February 15, 2010 with regards to SB367 and again on March 8, 2010 with regards to HB1326, as Chairman of the Senate Commerce and Labor Committee I am writing to you to request that the Virginia Workers' Compensation Commission review the following issues: (1) the extent to which reductions and discounts are allowed for multiple surgical procedures performed during a single operative session; (2) the extent to which an employer is liable for the costs of assistants at surgery; (3) the extent to which prompt payment to medical providers should be required; and (4), how charges for medical services provided for treatment to Virginia claimants in foreign jurisdictions are determined to be appropriate under Virginia law.

Please report your recommendations regarding these issues to my office prior to the 2011 session of the General Assembly or as soon thereafter as you are able to make findings with regards to these issues.

Thank you for your attention and consideration of this request.

Sincerely,

Richard L. Saslaw

Richard L. Saslaw, Chairman
Senate Commerce and Labor Committee

2010 SESSION

INTRODUCED

10101326D

SENATE BILL NO. 367
Offered January 13, 2010
Prefiled January 12, 2010

A BILL to amend and reenact § 65.2-605 of the Code of Virginia, relating to workers' compensation; employer liability for medical services.

Patron—Puckett

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That § 65.2-605 of the Code of Virginia is amended and reenacted as follows:

§ 65.2-605. Liability of employer for medical services ordered by Commission; malpractice.

A. The pecuniary liability of the employer for medical, surgical, and hospital service herein required when ordered by the Commission shall be limited to such charges as prevail in the same community for similar treatment ~~when such treatment is paid for by the injured person and the~~. *However, if more than one covered surgical procedure is performed during an operative session, the pecuniary liability of the employer shall be based on (i) 100 percent of the applicable prevailing community rate for the procedure performed during an operative session that has the highest prevailing community rate and (ii) 50 percent of the prevailing community rate for all other covered surgical procedures performed. If in the performance of a covered surgical procedure:*

1. A physician serves as an assistant-at-surgery and such service is necessary, the pecuniary liability of the employer for such service shall not exceed 20 percent of the prevailing community rate payable to the primary surgeon; and

2. An individual who is not a physician serves as an assistant-at-surgery and is licensed to provide such service, the pecuniary liability of the employer for such service shall not exceed 10 percent of the prevailing community rate payable to the primary surgeon.

B. A health care provider who renders, in a state outside of the Commonwealth that has in effect a workers' compensation fee schedule, medical services to an injured worker whose claim and injuries have been as compensable under this title shall be reimbursed for authorized, reasonable, and necessary medical treatment in the amount that is provided therefor in accordance with that state's fee schedule. A health care provider who renders, in a state outside of the Commonwealth that does not have in effect a workers' compensation fee schedule, medical services to an injured worker whose claim and injuries have been as compensable under this title shall be reimbursed for authorized, reasonable, and necessary medical treatment at the prevailing community rate.

C. An employer shall not be liable in damages for malpractice by a physician or surgeon furnished by him pursuant to the provisions of § 65.2-603, but the consequences of any such malpractice shall be deemed part of the injury resulting from the accident and shall be compensated for as such.

ENGROSSED

10105306D

HOUSE BILL NO. 1326

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the House Committee on Commerce and Labor)

(Patron Prior to Substitute—Delegate Merricks)

House Amendments in [ ] - February 15, 2010

A BILL to amend and reenact § 65.2-605 of the Code of Virginia, relating to workers' compensation; liability of employer for medical services.

Be it enacted by the General Assembly of Virginia:

1. That § 65.2-605 of the Code of Virginia is amended and reenacted as follows:

§ 65.2-605. Liability of employer for medical services ordered by Commission; malpractice.

A. The pecuniary liability of the employer for medical, surgical, and hospital service herein required when ordered by the Commission shall be limited to such charges as prevail in the same community for similar treatment [when such treatment is paid for by the injured person] and the employer shall not be liable in damages for malpractice by a physician or surgeon furnished by him pursuant to the provisions of § 65.2-603, but the consequences of any such malpractice shall be deemed part of the injury resulting from the accident and shall be compensated for as such.

B. A health care provider rendering medical services in a state other than the Commonwealth to an injured worker whose claim and injuries have been accepted as compensable under this title shall be reimbursed for authorized, reasonable, and necessary medical treatment in an amount equal to the workers' compensation fee schedule, if any, adopted by the state where the services were rendered. If the state has not adopted a fee schedule, the health care provider shall be reimbursed consistent with subsection A.

2. That the Workers' Compensation Commission shall appoint a task force to review and make recommendations exclusively on the following subjects: (i) whether and the extent to which reductions and discounts shall be allowed for multiple surgical procedures performed during a single operative session; (ii) whether and the extent to which an employer shall be liable for the costs of assistants-at-surgery; and (iii) whether and the extent to which prompt payment to medical providers should be required. The Workers' Compensation Commission shall appoint as members of the task force individuals recommended by interested parties, including but not limited to the Virginia Manufacturers Association, the Business Coalition on Workers' Compensation, the Virginia Hospital and Healthcare Association, the Medical Society of Virginia, the Virginia Trial Lawyers Association, and the Virginia Association of Defense Attorneys. The task force shall gather information and receive testimony from interested parties and shall deliver its recommendations to the Workers' Compensation Commission by September 15, 2010. Upon receiving such recommendations, the Workers' Compensation Commission, pursuant to the Administrative Process Act, Chapter 40 (§ 2.2-4000 et seq.) of Title 2.2 of the Code of Virginia, shall develop regulations, if any, it deems appropriate to address the issues described in clauses (i) through (iii), with such regulations to be effective by November 30, 2011.

ENGROSSED

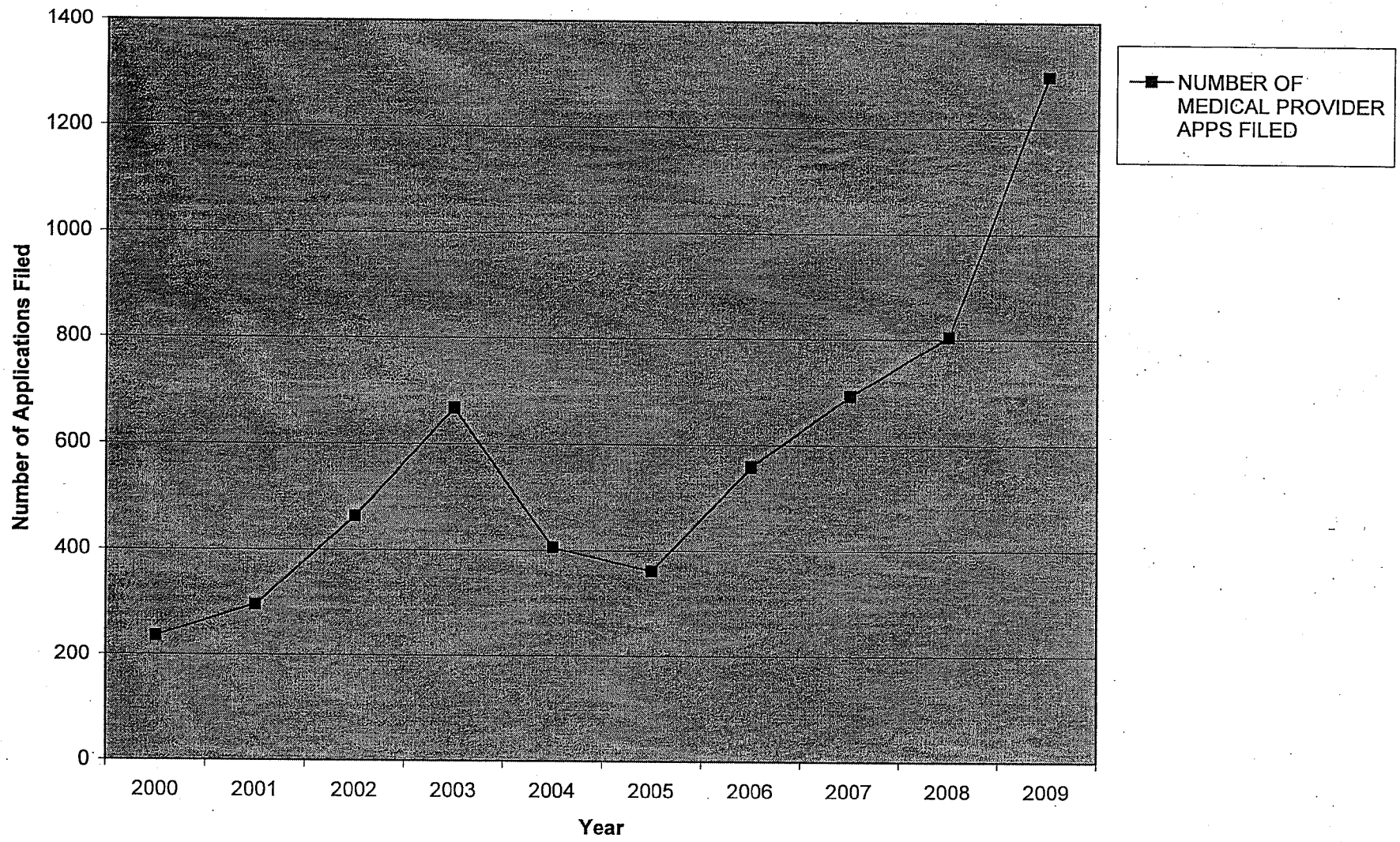
APPENDIX B

Virginia Workers' Compensation Commission
Number of Applications Filed by Medical Providers
2000-2010

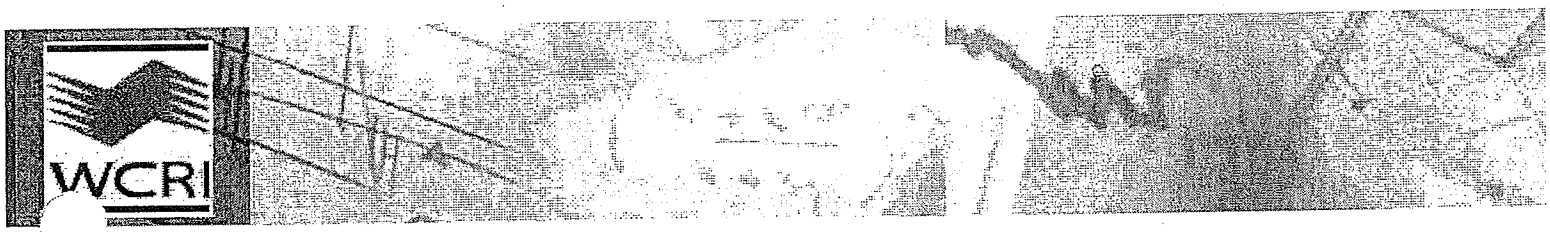
YEAR	NUMBER OF MEDICAL PROVIDER APPLICATIONS FILED
2000	236
2001	295
2002	463
2003	667
2004	405
2005	361
2006	558
2007	692
2008	805
2009	1298
2010	656*

*Data current as of 5/18/2010.

NUMBER OF MEDICAL PROVIDER APPLICATIONS FILED



APPENDIX C



BENCHMARKS FOR DESIGNING WORKERS' COMPENSATION MEDICAL FEE SCHEDULES: 2009

Nicole M. Coomer
Te-Chun Liu

WC-10-32

June 2010

WORKERS COMPENSATION RESEARCH INSTITUTE
CAMBRIDGE, MASSACHUSETTS

Note to Reader: While we do our best to ensure that the product is fully functional for all users, there may be rare cases where user computer settings reduce the functionality. We would appreciate these instances being brought to our attention.

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EXECUTIVE SUMMARY

This report helps to ground the debates about fee schedules in analytic facts, rather than anecdotes or partisan claims. The study provides an important benchmark for the design of fee schedules in workers' compensation. This is especially important as the development or update of a fee schedule is often subject to considerable political pressure from payors and providers. The goal of this study is to give policymakers useful benchmarks so they can compare their state workers' compensation fee schedule rates with measures of the relative costs of providing services and with fee schedules in other states.

In this study each state's workers' compensation fee schedule is compared to a benchmark that establishes relative differences in provider expenses of delivering different services across geographic areas. Conceptually many potential benchmarks exist including state level group health rates, Medicare fee schedule rates, and Medicaid fee schedule rates, among others. The availability of data greatly limits the choice of a benchmark. The benchmark used in this study is the state Medicare fee schedule. It is recognized that there are many concerns surrounding the Medicare system, particularly in regard to the final fee schedule rates that are established. These rates are often criticized as being low. In this study it is acknowledged that there is no reason to expect that the ideal workers' compensation fee schedule rate is equal to Medicare.

This study utilizes the relative differences in provider expenses across geographic areas established by Medicare through the design of the Resource-Based Relative Value System (RBRVS). There are three aspects of Medicare that are important to discuss when using Medicare as a benchmark: the conversion factor (i.e., level), the relative values of services, and the geographic variation in rates. The Medicare rates are established by multiplying geographically adjusted service specific relative value units (RVUs) by a federally established conversion factor that is constant across all services. Each of the three aspects is discussed below in turn.

The Medicare conversion factor is established annually and is the same for all states (or parts of states) and services. For individual procedure codes, the Medicare rates resulting from the chosen conversion factor are not recognized as optimal levels of workers' compensation fee schedule rates in this study. The conversion factor is determined each year partially dependent on the federal budget, therefore introducing a bias that is not related to provider expenses of delivering care.

The Medicare RBRVS ranks services according to the relative costs required to produce them. These costs are defined in terms of units, with more complex, time-consuming services, say a shoulder arthroscopy, having higher unit values than less complex, less time-consuming services, perhaps an office visit. The components of the RBRVS reflect several aspects of provider expenses for delivering care, such as the cost of the physician's time and skill (physician work or work value), rent, office staff, supplies, and equipment (physician expense or PE value), as well as malpractice insurance. The Medicare RBRVS, (not the rates themselves, but the relative values), provides a good benchmark for evaluating the relationship between fee schedule rates and the provider expenses of delivering care across different services.

The third aspect of Medicare, pertinent to benchmarking medical fee schedules, is geographic variation in rates. Each of the components above, work value, PE value, and malpractice insurance, are adjusted before determining the Medicare payment value in a state (or part of a state). This adjustment occurs as costs vary according to geographic area. The Centers for Medicare & Medicaid Services (CMS) establishes

geographic practice cost indices (GPCIs) for each of the three RBRVS components in each state (several states have more than one GPCI in the state). Use of the GPCIs explicitly measures area differences in provider expenses of delivering care from state to state.

Using the Medicare fee schedules as a benchmark allows evaluation of the relationship between fee schedule rates and the provider expenses of delivering care among different services and across states. This study presents the comparisons of workers' compensation medical fee schedules (nonhospital/nonfacility) to state Medicare fee schedules as of December 2009. In 2009, 43 states had workers' compensation nonhospital fee schedules. In addition to the overall workers' compensation premium over Medicare, the premium over Medicare is reported for eight major service groups: emergency services, evaluation and management, major radiology, minor radiology, physical medicine, neurological testing, major surgery, and surgical treatment. This study does not directly analyze the differences in the statistics presented in this study compared to the previous version, *Benchmarks for Designing Workers' Compensation Medical Fee Schedules: 2006.* The reader should be aware that some definitional and methodological differences exist between the two studies.

PRINCIPAL FINDINGS

- There are significant differences in workers' compensation fee schedule levels compared to Medicare fee schedule levels across the states. The premium over Medicare varied widely from 8 percent above Medicare in Massachusetts to 215 percent above Medicare in Alaska.
- Three states, California, Florida, and Massachusetts, set workers' compensation fee schedule rates, on average across all nonhospital service groups, to be within 20 percent of Medicare rates in those states.
- Just over half of the states set the workers' compensation fee schedule rates between 50 and 100 percent above Medicare at the state level.
- Six states, Alaska, Delaware, Idaho, Illinois, Nevada, and Oregon, set the workers' compensation fee schedule rates at levels more than double Medicare at the state level.
- Nine states, Maryland, Michigan, Montana, North Dakota, South Carolina, Texas, Utah, Washington, and West Virginia, set rates that result in the premium over Medicare being relatively the same for each of the service groups, which may neutralize incentives for over-utilization of specialty and invasive care.[1, 2]
- Nine states, Alabama, Alaska, Arizona, Connecticut, Delaware, Idaho, Illinois, Nevada, and Rhode Island, set fee schedule reimbursement rates where the difference between the highest premium over Medicare and the lowest for the eight service groups was more than 200 percentage points, which may result in distorted utilization incentives.
- Higher workers' compensation rates are not necessarily correlated with higher provider expenses of delivering medical services.
- In 2009 more than half of the 43 states, 25, based their workers' compensation fee schedule on the Medicare RBRVS system in some way. Seven states used some other form of relative value units and 25 of these 32 states with relative value systems used more than one conversion factor across service

[1] The percentage point difference between the service group with the highest premium over Medicare and the service group with the lowest premium over Medicare in these nine states is less than or equal to 45.

[2] In Washington workers' compensation regulations impose a daily maximum of $118.07 for physical medicine reimbursement. This limit may affect incentives for the use of specialty and invasive care.

groups.

- Thirty-three of the 43 states, well over one-half, had premiums of 100 percent above Medicare or greater for at least one service group.
- Nine of the 43 states, Alabama, California, Florida, Hawaii, Massachusetts, New York, North Carolina, Pennsylvania, and South Dakota, had workers' compensation fee schedule rates within 10 percent of Medicare for at least one service group.
- Four of the 43 states, California, Florida, Massachusetts, and New York, had workers' compensation fee schedule rates more than 10 percent below Medicare for at least one service group.

INTRODUCTION

Medical costs have been the subject of much concern amid rapid growth in several state workers' compensation systems. Policymakers in many states have considered various means of cost containment in the workers' compensation arena. Often included are updates to or implementation of workers' compensation fee schedules. These fee schedules vary greatly across the nation in all aspects, including development, updating, structure, and basis used for setting rates (WCRI, 2009). Not surprisingly, these different methods yield very different results in the level of reimbursement rates set, overall and for different groups of providers and services. The construction of a medical fee schedule in workers' compensation involves a delicate balance. If rates are set too high, savings will be negligible and the fee schedule will not achieve its cost containment goal. Conversely, setting rates too low makes treating injured workers uneconomical for providers and jeopardizes workers' access to quality care.

PURPOSE

The purpose of this report is to help provide a foundation for the debates about fee schedules that is grounded in analytic facts. The methods used in this study provide a benchmark for the design of fee schedules in workers' compensation. In this study, as with its predecessors, each state's Medicare fee schedule is used as a benchmark, recognizing that the optimal level of fee schedule rates is likely not the same as Medicare.

The Medicare Resource-Based Relative Value System (RBRVS) (not the rates themselves but the relative values) provides a good benchmark for evaluating the relationship between fee schedule rates and the costs of providing services. The Medicare RBRVS is based on extensive research on the relative resource costs of providing particular services in specific areas as they apply to a general population. Provider practice expenses differ from state to state based on differing malpractice expenses, office rent, staffing costs, etc. It stands to reason, then, that the cost of delivering health care differs across states. The Medicare RBRVS is designed specifically to take these practice expense factors into account. A balanced workers' compensation fee schedule design would mean that higher workers' compensation fee schedules are found in states with higher provider practice expenses. The resource-based relative value scale allows an opportunity to quantify those differences in practice expenses and serves as a standardization mechanism across states and services within a state. Thus, this report focuses on the relative comparisons between workers' compensation fee schedules and Medicare fee schedules.

SCOPE

The goal of this study is to give policymakers useful benchmarks so they can compare their state workers' compensation fee schedule rates with measures of the relative costs of providing services and with fee schedules in other states. This study presents the comparisons of workers' compensation medical fee schedules to state Medicare fee schedules as of December 2009. It does not directly analyze the differences in the statistics presented in this study compared to the previous version, *Benchmarks for Designing Workers' Compensation Medical Fee Schedules: 2006.*

It is important to note that this study covers only nonhospital fee schedules. In most states, payments made to hospitals account for between 28 percent and 57 percent of total workers' compensation medical expenditures (Radeva et al., 2009). The analysis in this report covers the remaining 43 percent to 72 percent of total medical expenditures.[3] Hospital price regulation in workers' compensation is the subject of other WCRI studies.[4]

The analysis in this report does not attempt to define the appropriate fee schedule rates in each state. Rather, it provides a benchmark for comparison. Other questions of policy interest, such as negotiation of prices paid, the effect of changes in fee schedule rates on access to quality care, and changing patterns of utilization are also outside of the scope of this study.[5]

[3] The reader should note that the 43 to 72 percent of total medical expenditures for nonhospital services includes spending on pharmaceuticals. Pharmaceuticals are often not covered under the fee schedules examined in this report. A study by the National Council on Compensation Insurance, Inc. (NCCI) shows that the developed costs of prescriptions may be as much as 20 percent of total medical costs (Stevens, Brown, and Laws, 2008).

[4] Coomer, N. 2010. *Fee Schedules for Hospitals and Ambulatory Surgical Centers: A Guide for Policymakers.* Cambridge, MA: Workers Compensation Research Institute; Coomer, N. 2010. *National Inventory of Workers' Compensation Fee Schedules for Hospitals and Ambulatory Surgical Centers.*

[5] For information on price and utilization patterns in workers' compensation systems, see the WCRI CompScope™ Medical benchmarking studies. The most recent, 9th edition, was published in 2009. For information regarding worker outcomes in workers' compensation systems, see the WCRI Worker Outcomes Series. The most recent report for Wisconsin was published in 2010.

eight major service groups: emergency services, evaluation and management, major radiology, minor radiology, physical medicine, neurological testing, major surgery, and surgical treatment. Evaluation and management services are office visits. Major radiology includes services such as computed tomography (CT) scans and magnetic resonance imaging (MRIs) while minor radiology includes services such as X rays and ultrasounds. Neurological testing includes neuromuscular testing and services such as F-wave studies. Physical medicine includes physical and occupational therapies and chiropractic care. Major surgery is typically invasive surgical procedures such as arthroscopic surgeries and laminotomies while surgical treatment is defined as less invasive treatment under the surgical section of the Current Procedural Terminology (CPT) manual, such as sutures and debridements. Table TA.1 lists the CPT codes included in the marketbasket with a brief description by service group.

BACKGROUND

The methodology used in this study is similar to that in a prior fee schedule benchmarking study in 2006. However, the numbers in the studies are not directly comparable due to several major differences mentioned briefly below. The technical appendix further discusses the differences in more detail and includes a section on the comparability to the 2006 fee schedule benchmarking study. The major differences between the 2006 and 2009 studies are:

- The fee schedules for workers' compensation and for Medicare in this study are as of December 2009. The 2006 study used similar information as of July 2006. Many states have changed their fee schedules over that period. Some states change their fee schedule rates annually, while others do so periodically.
- One state has joined the ranks of fee schedule states since the earlier WCRI study. Delaware published a medical fee schedule on May 23, 2008 and implementation of the fee schedule by system participants occurred over time.
- Rhode Island is no longer compared at the state level but is compared at the service group level. See the technical appendix for further details.
- The marketbasket used in this study is smaller than that used in 2006. The new marketbasket was selected to be representative of the expenditures across the states in this study. It is also consistent with the marketbasket in the Medical Price Index for Workers' Compensation (MPI-WC) and the CompScope™ Medical benchmarking studies.[6] For a discussion of the marketbasket procedure see the technical appendix.
- This study has eight service groups compared to five in the 2006 study. Comparing states using more detailed service groups consisting of similar procedures allows for better analysis of the different fee schedule structures and incentives within and/or across states. The use of eight service groups is also consistent with the MPI-WC and CompScope™ Medical studies.
- This study uses frequency weights at the state level rather than expenditure weights, which were used in the 2006 study. The use of frequency weights allows aggregation to the state level to occur without an intermediate step of creating service group indices relative to the median state. This method is also consistent with the MPI-WC study. For a discussion of the weighting procedures see the technical appendix.

The overall state rankings for many states are relatively similar for the reports. For states whose rankings have changed significantly, there are typically two reasons. First, some states made major changes to their fee schedules. Second, Medicare began to phase in changes to the full RBRVS after 2006. (The values will be fully phased-in in 2010.) Thus, even states that made no substantive changes to their workers' compensation fee schedules from 2006 to 2009, such as Louisiana, may still have changes in their relative ranking among states as the RBRVS RVUs continued to adjust over the period.

This study presents the comparisons of workers' compensation medical fee schedules to state Medicare fee schedules as of December 2009. It does not analyze how the states have changed over time. In addition to the overall workers' compensation premium over Medicare, the premium over Medicare is reported for

[6] The MPI-WC is an annual report published by WCRI.

RESULTS

Each state's workers' compensation fee schedule rate is compared to the Medicare fee schedule in the state. This comparison is referred to as the premium over Medicare. The range in premiums seen across states is large. To illustrate this, the premium over Medicare for each state is listed in Table 1 and illustrated in Figure 1.

As Figure 1 shows, the premium over Medicare varied from 8 percent above Medicare in Massachusetts to 215 percent above Medicare in Alaska. Three states, California, Florida, and Massachusetts, set workers' compensation fee schedule rates, on average across all nonhospital service groups, to be within 20 percent of Medicare rates in those states. Just over half of the states set the workers' compensation fee schedule rates between 50 and 100 percent above Medicare at the state level. Lastly, six states, Alaska, Delaware, Idaho, Illinois, Nevada, and Oregon, set the workers' compensation fee schedule rates at levels more than double Medicare at the state level.

Table 1 also shows the premium over Medicare for each state for the eight service groups. These premiums are further illustrated in Figures 2–9. Nine states, Maryland, Michigan, Montana, North Dakota, South Carolina, Texas, Utah, Washington, and West Virginia, set rates that result in the premium over Medicare being relatively the same for each of the service groups.[7,8] However, this is the exception. Take for instance Massachusetts, where the premium over Medicare for all service groups except major surgery was within 20 percent of Medicare. The premium over Medicare for major surgery in Massachusetts was 151 percent as Massachusetts enacted fee schedule changes that focused on increasing the surgical fee schedule rates to amounts that were actually paid in the market. In nearly every other state the premium over Medicare varied substantially across service groups. Nine states set fee schedule rates where the difference between the highest premium over Medicare and the lowest for the eight service groups was more than 200 percentage points. In 19 other states the difference lies between 100 and 200 percentage points.

Illustrations of actual fee schedule amounts are provided in Table 2, state by state, for several medical procedures often utilized in workers' compensation. One selected procedure is shown for each of the eight service groups. The rates for each of these procedures varied greatly among the states. For a moderate severity emergency department visit (CPT code 99283) the lowest fee schedule rate in Massachusetts was four times less than the highest fee schedule rate in Alaska. Similarly, looking at the fee schedule rates for a low complexity established patient office visit (CPT code 99213) the highest fee schedule rate in Alaska was 204 percent greater than the lowest fee schedule rates in Massachusetts and New York (Region 4). For a lumbar MRI (CPT code 72148) the fee schedule rate in the highest state, Alaska, was 5.5 times higher than the lowest fee schedule rate in Florida (Dade and Monroe Counties). The lowest state fee schedule rate for a complete radiological exam with a minimum of two views (CPT code 73030) was $35 in Massachusetts and West Virginia compared to the highest rate of $228 in Alaska. For sensory nerve conduction on any site (CPT code 95904) the range from the highest per nerve fee schedule rate ($257 in Alaska) to the lowest per nerve fee schedule rate ($46 in North Carolina) was $211. For a therapeutic procedure on one or more areas

[7] The percentage point difference between the service group with the highest premium over Medicare and the service group with the lowest premium over Medicare in these nine states is less than or equal to 45.

[8] In Washington workers' compensation regulations impose a daily maximum of $118.07 for physical medicine reimbursement. This limit may affect incentives for the use of specialty and invasive care.

(CPT code 97110) the lowest fee schedule rate in Massachusetts was more than four times less than the highest fee schedule rate in Alaska. Fee schedule rates for an arthroscopic shoulder surgery (CPT 29826) ranged from a low of $799 in West Virginia to a high of $4,747 in Alaska. The range from the second lowest rate of $919 in Hawaii to the second highest rate of $4,214 in Illinois (Chicago geozip) was also large. Likewise, for an arthrocentesis of a major joint or bursa (CPT code 20610) the highest fee schedule rate in Alaska was 561 percent greater than the lowest fee schedule rate in California.

Table 1 Workers' Compensation Premium Over Medicare, December 2009

State	Overall	ER Services	E&M	Major Radiology	Minor Radiology	Neuro. Testing	Physical Medicine	Major Surgery	Surgical Treatment
Alabama	82	28	8	74	205	59	67	313	33
Alaska	215	164	92	318	408	369	158	488	272
Arizona	84	102	30	99	133	140	61	240	58
Arkansas	62	29	34	131	129	35	34	115	103
California	15	26	-7	8	27	18	20	77	-27
Colorado	52	119	34	79	58	69	23	139	29
Connecticut	89	72	42	118	127	142	26	314	92
Delaware[a]	131	168	41	156	246	132	95	362	176
Florida[a]	9	4	6	-14	10	14	1	37	49
Georgia	75	37	38	134	138	55	36	194	85
Hawaii	26	106	16	-2	45	58	17	82	33
Idaho	121	91	97	181	175	114	37	323	157
Illinois[a]	180	219	54	214	280	259	125	504	213
Kansas	59	21	24	86	83	74	29	143	166
Kentucky	50	24	24	44	41	44	38	133	95
Louisiana	68	75	28	103	105	67	74	116	29
Maine	68	51	52	74	70	91	66	81	107
Maryland	23	17	17	19	19	18	17	55	22
Massachusetts	8	-4	-20	6	3	7	-20	151	10
Michigan	45	44	44	49	50	42	44	46	36
Minnesota	71	105	53	114	112	75	53	122	34
Mississippi	79	34	40	96	89	87	73	168	85
Montana	98	88	95	112	108	103	94	99	102
Nebraska	91	34	32	165	164	70	50	232	164
Nevada	119	107	28	224	186	85	80	345	66
New Mexico	66	57	25	107	116	79	48	148	85
New York[a]	24	46	-27	36	104	94	1	169	-5
North Carolina	34	32	4	71	75	20	4	143	68
North Dakota	83	79	84	60	97	91	83	91	91
Ohio[b]	52	n/c	40	41	41	41	40	119	69
Oklahoma	52	42	15	90	64	82	23	145	113
Oregon	101	85	84	98	98	116	88	156	149
Pennsylvania[a]	45	24	8	69	72	42	38	129	35
Rhode Island[c]	n/c	54	13	87	140	57	n/c	289	54
South Carolina	46	31	34	50	48	30	45	71	64
South Dakota	64	100	27	118	89	57	46	173	1
Tennessee	78	111	69	71	111	69	29	186	174
Texas[d]	54	49	49	49	49	49	49	86	49
Utah	43	29	33	60	58	35	33	66	61
Vermont	54	51	21	39	98	86	37	166	71
Washington	67	70	70	70	71	71	59	70	70
West Virginia[e]	35	35	36	36	37	31	36	34	27
Wyoming	81	110	35	157	122	94	45	221	24

Note: Positive numbers in this table reflect a percentage above the Medicare fee schedule levels for a state and negative numbers in this table reflect a percentage below the Medicare fee schedule levels for a state.

[a] Delaware, Florida, Illinois, New York, Pennsylvania, and Texas have distinct fee schedules for different parts of the state. For each, a single statewide rate was created by averaging the different sub-state fee schedules using the percentage of employed persons in each sub-state region as weights. Medicare establishes distinct sub-state fee schedules in 14 states. For each, a single statewide rate was created using the same procedure.

[b] Ohio does not establish rates for the emergency services included in the marketbasket. For Ohio the overall rate is based on the fee schedule levels for the other seven service groups. For more detail see the technical appendix.

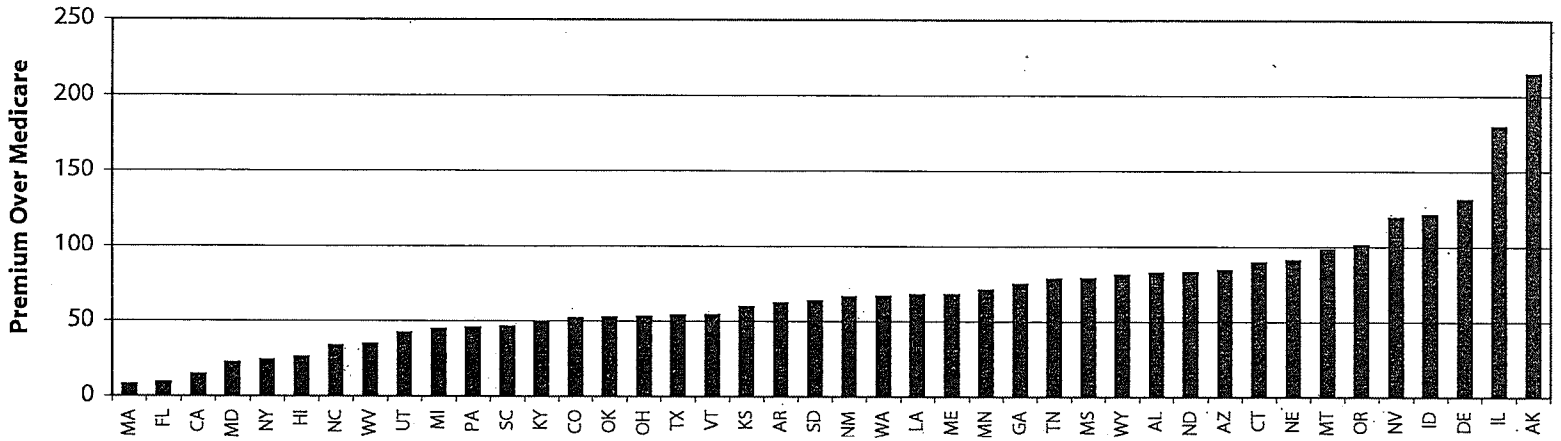
[c] Rhode Island has different billing codes for physical medicine and does not establish rates for the majority of the codes. An overall rate is not established for Rhode Island as physical medicine is the largest component of the marketbasket and excluding it significantly biases the results. For more detail see the technical appendix.

[d] Texas sets a unique conversion factor for surgery in a facility setting. Surgeries in a facility setting are likely to be a more invasive procedures similar to those in the major surgery service group, thus the unique "surgery in a facility setting" conversion factor was applied to the major surgery service group. The "surgery in an office setting" conversion factor was applied to the surgical treatment service group.

[e] West Virginia sets the workers' compensation fee schedule to be 135 percent of Medicare using rounded fully implemented RVUs. In 2009 Medicare was still using transitional RVUs, and Medicare does not round during the calculation. The result of these differences is that the 2009 workers' compensation premium over Medicare in West Virginia is not exactly 35 percent.

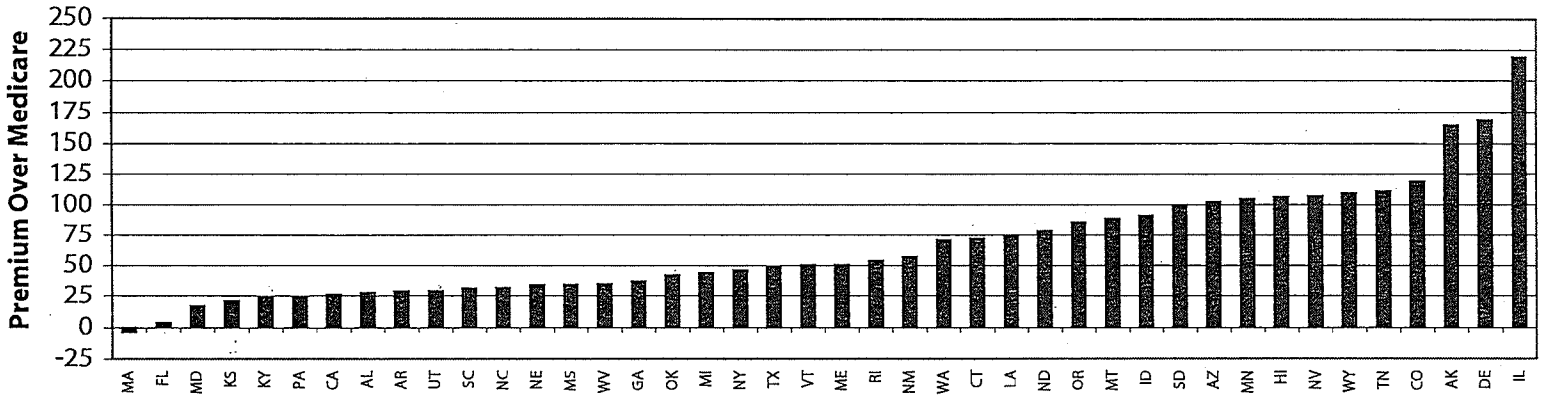
Key: E&M: evaluation and management; ER: emergency; n/c: not comparable; Neuro.: neurological; RVU: relative value unit.

Figure 1 Workers' Compensation Premium Over Medicare, December 2009



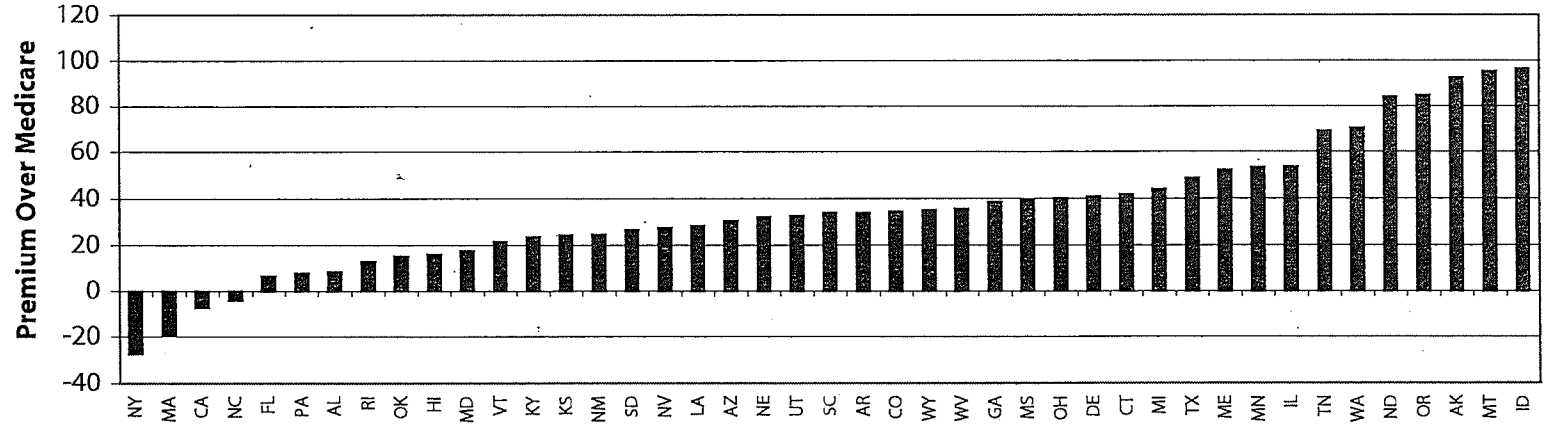
Notes: Delaware, Florida, Illinois, New York, Pennsylvania, and Texas have distinct fee schedules for different parts of the state. For each, a single statewide rate was created by averaging the different sub-state fee schedules using the percentage of employed persons in each sub-state region as weights. Medicare establishes distinct sub-state fee schedules in 14 states. For each, a single statewide rate was created using the same procedure. Texas sets a unique conversion factor for surgery in a facility setting. The unique "surgery in a facility setting" conversion factor was applied to the major surgery service group while the "surgery in an office setting" conversion factor was applied to the surgical treatment service group. Ohio does not establish rates for the emergency services included in the marketbasket. For Ohio the overall rate is based on the fee schedule levels for the other seven service groups. Rhode Island has different billing codes for physical medicine and does not establish rates for the majority of the codes. An overall rate is not established for Rhode Island as physical medicine is the largest component of the marketbasket and excluding it significantly biases the results. For more detail see the technical appendix. West Virginia sets the workers' compensation fee schedule to be 135 percent of Medicare using rounded fully implemented relative value units (RVUs). In 2009 Medicare was still using transitional RVUs, and Medicare does not round during the calculation. The result of these differences is that the 2009 workers' compensation premium over Medicare in West Virginia is not exactly 35 percent.

Figure 2 Workers' Compensation Premium Over Medicare, Emergency Services, December 2009



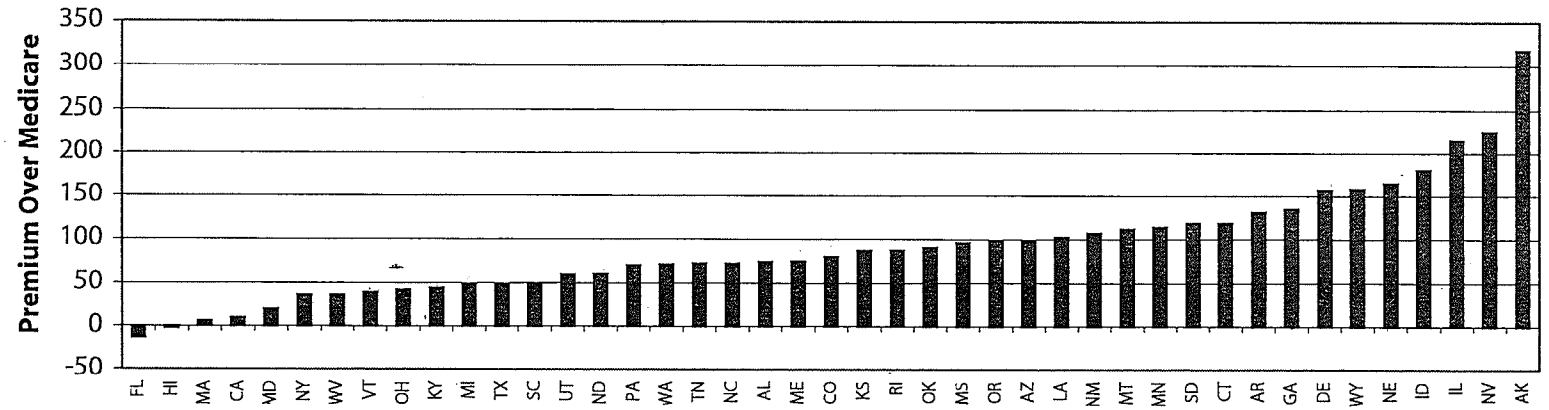
Notes: Delaware, Florida, Illinois, New York, Pennsylvania, and Texas have distinct fee schedules for different parts of the state. For each, a single statewide rate was created by averaging the different sub-state fee schedules using the percentage of employed persons in each sub-state region as weights. Medicare establishes distinct sub-state fee schedules in 14 states. For each, a single statewide rate was created using the same procedure. Ohio does not establish rates for the emergency services included in the marketbasket, thus Ohio is not shown on this chart. West Virginia sets the workers' compensation fee schedule to be 135 percent of Medicare using rounded fully implemented relative value units (RVUs). In 2009 Medicare was still using transitional RVUs, and Medicare does not round during the calculation. The result of these differences is that the 2009 workers' compensation premium over Medicare in West Virginia is not exactly 35 percent.

Figure 3 Workers' Compensation Premium Over Medicare, Evaluation & Management, December 2009



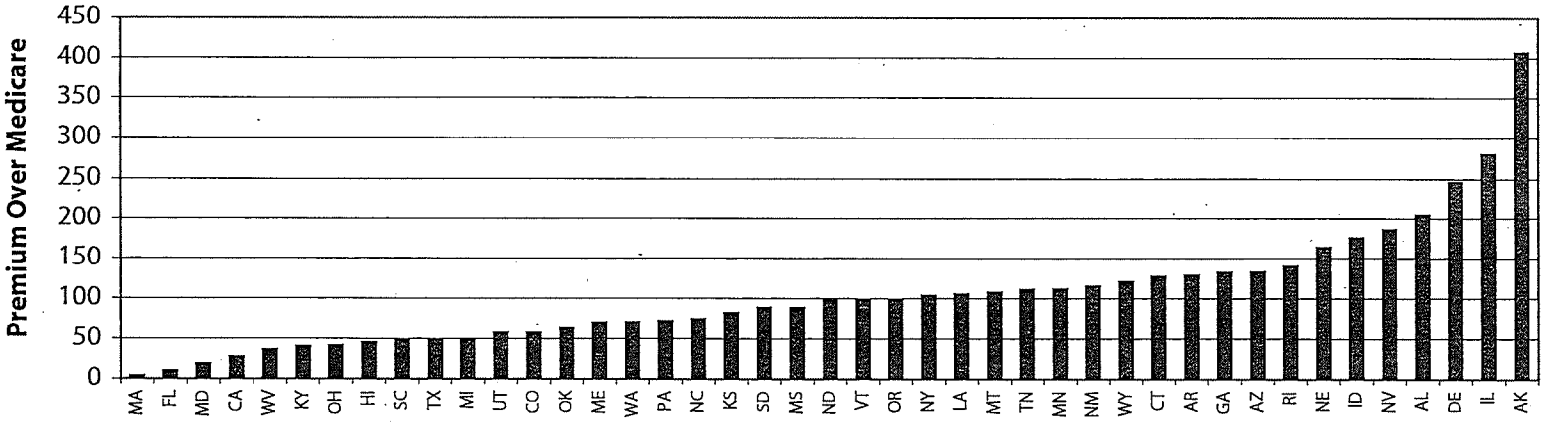
Notes: Delaware, Florida, Illinois, New York, Pennsylvania, and Texas have distinct fee schedules for different parts of the state. For each, a single statewide rate was created by averaging the different sub-state fee schedules using the percentage of employed persons in each sub-state region as weights. Medicare establishes distinct sub-state fee schedules in 14 states. For each, a single statewide rate was created using the same procedure. West Virginia sets the workers' compensation fee schedule to be 135 percent of Medicare using rounded fully implemented relative value units (RVUs). In 2009 Medicare was still using transitional RVUs, and Medicare does not round during the calculation. The result of these differences is that the 2009 workers' compensation premium over Medicare in West Virginia is not exactly 35 percent.

Figure 4 Workers' Compensation Premium Over Medicare, Major Radiology, December 2009



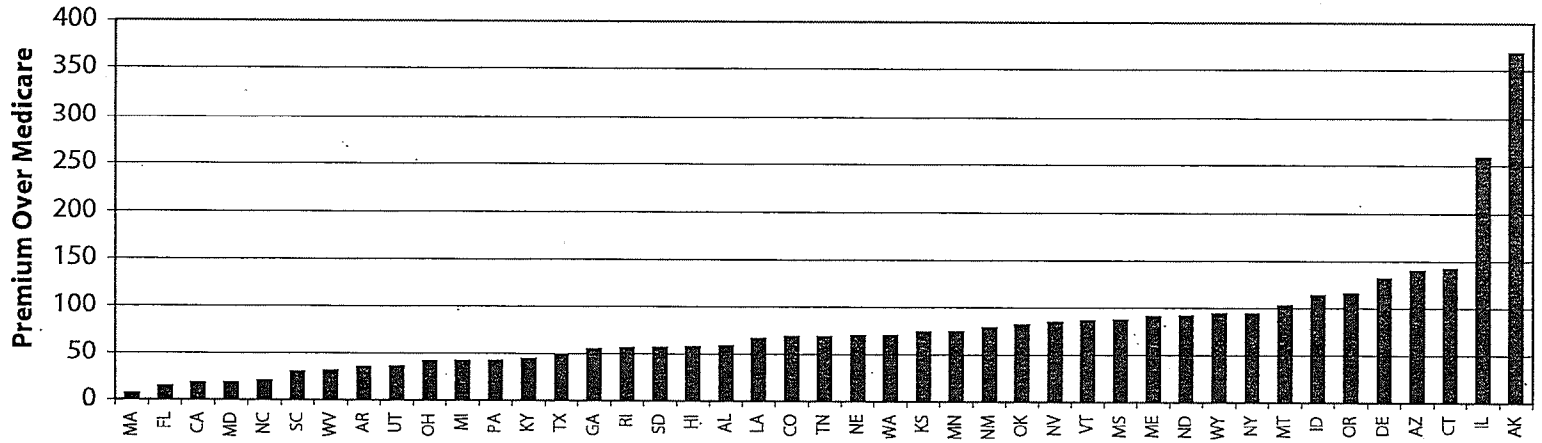
Notes: Delaware, Florida, Illinois, New York, Pennsylvania, and Texas have distinct fee schedules for different parts of the state. For each, a single statewide rate was created by averaging the different sub-state fee schedules using the percentage of employed persons in each sub-state region as weights. Medicare establishes distinct sub-state fee schedules in 14 states. For each, a single statewide rate was created using the same procedure. West Virginia sets the workers' compensation fee schedule to be 135 percent of Medicare using rounded fully implemented relative value units (RVUs). In 2009 Medicare was still using transitional RVUs, and Medicare does not round during the calculation. The result of these differences is that the 2009 workers' compensation premium over Medicare in West Virginia is not exactly 35 percent.

Figure 5 Workers' Compensation Premium Over Medicare, Minor Radiology, December 2009



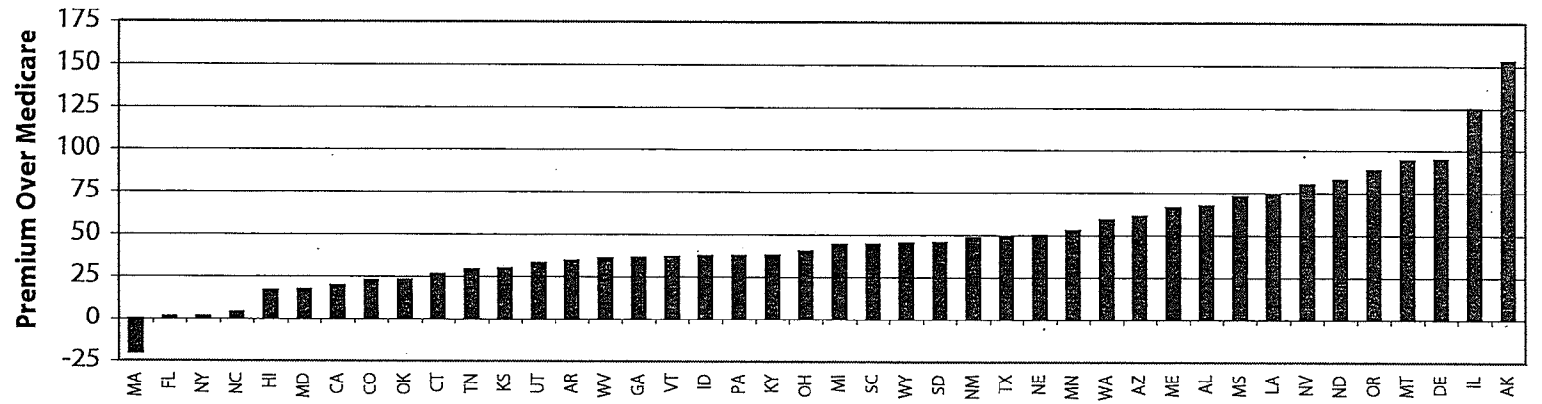
Notes: Delaware, Florida, Illinois, New York, Pennsylvania, and Texas have distinct fee schedules for different parts of the state. For each, a single statewide rate was created by averaging the different sub-state fee schedules using the percentage of employed persons in each sub-state region as weights. Medicare establishes distinct sub-state fee schedules in 14 states. For each, a single statewide rate was created using the same procedure. West Virginia sets the workers' compensation fee schedule to be 135 percent of Medicare using rounded fully implemented relative value units (RVUs). In 2009 Medicare was still using transitional RVUs, and Medicare does not round during the calculation. The result of these differences is that the 2009 workers' compensation premium over Medicare in West Virginia is not exactly 35 percent.

Figure 6 Workers' Compensation Premium Over Medicare, Neurological Testing, December 2009

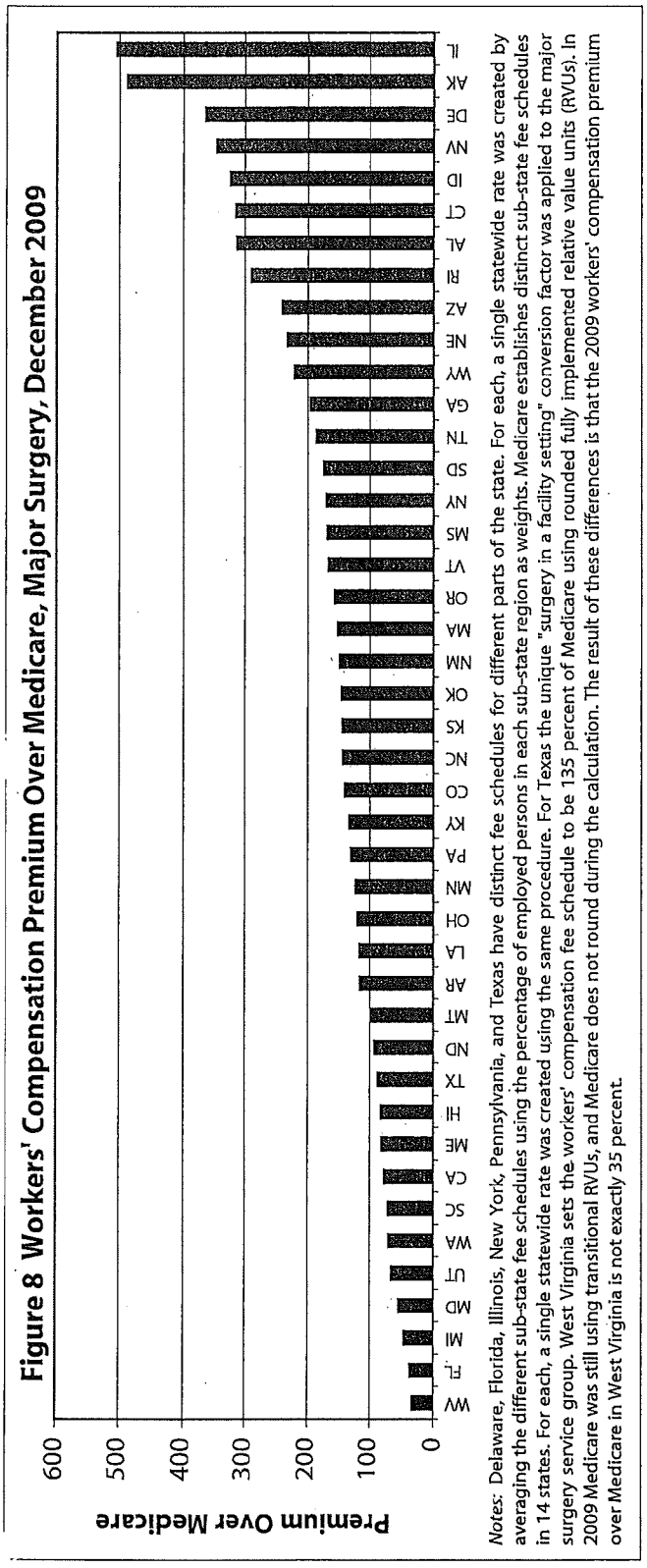


Notes: Delaware, Florida, Illinois, New York, Pennsylvania, and Texas have distinct fee schedules for different parts of the state. For each, a single statewide rate was created by averaging the different sub-state fee schedules using the percentage of employed persons in each sub-state region as weights. Medicare establishes distinct sub-state fee schedules in 14 states. For each, a single statewide rate was created using the same procedure. West Virginia sets the workers' compensation fee schedule to be 135 percent of Medicare using rounded fully implemented relative value units (RVUs). In 2009 Medicare was still using transitional RVUs, and Medicare does not round during the calculation. The result of these differences is that the 2009 workers' compensation premium over Medicare in West Virginia is not exactly 35 percent.

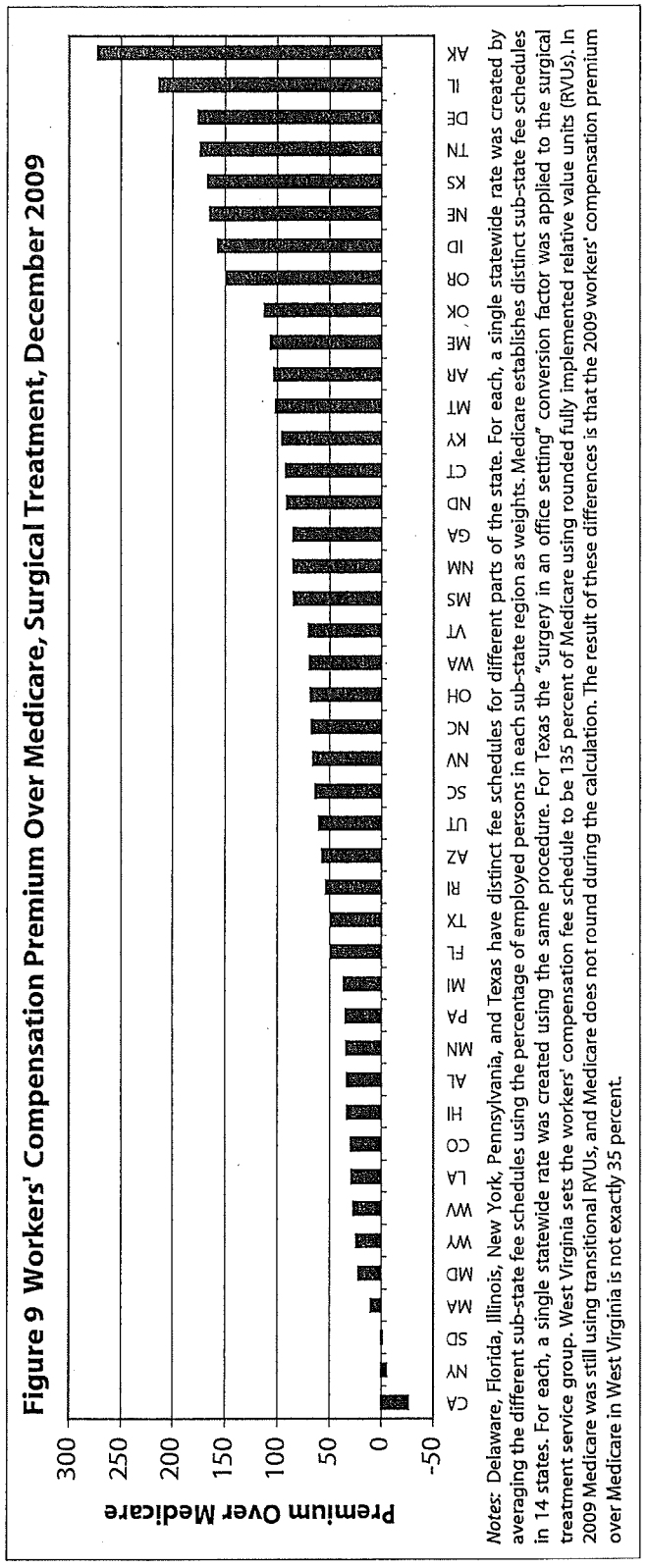
Figure 7 Workers' Compensation Premium Over Medicare, Physical Medicine, December 2009



Notes: Delaware, Florida, Illinois, New York, Pennsylvania, and Texas have distinct fee schedules for different parts of the state. For each, a single statewide rate was created by averaging the different sub-state fee schedules using the percentage of employed persons in each sub-state region as weights. Medicare establishes distinct sub-state fee schedules in 14 states. For each, a single statewide rate was created using the same procedure. Rhode Island has different billing codes for physical medicine and does not establish rates for the majority of the codes, thus Rhode Island is not shown on this chart. West Virginia sets the workers' compensation fee schedule to be 135 percent of Medicare using rounded fully implemented relative value units (RVUs). In 2009 Medicare was still using transitional RVUs, and Medicare does not round during the calculation. The result of these differences is that the 2009 workers' compensation premium over Medicare in West Virginia is not exactly 35 percent.



Notes: Delaware, Florida, Illinois, New York, Pennsylvania, and Texas have distinct fee schedules for different parts of the state. For each, a single statewide rate was created by averaging the different sub-state fee schedules using the percentage of employed persons in each sub-state region as weights. Medicare establishes distinct sub-state fee schedules in 14 states. For each, a single statewide rate was created using the same procedure. For Texas the unique "surgery in a facility setting" conversion factor was applied to the major surgery service group. West Virginia sets the workers' compensation fee schedule to be 135 percent of Medicare using rounded fully implemented relative value units (RVUs). In 2009 Medicare was still using transitional RVUs, and Medicare does not round during the calculation. The result of these differences is that the 2009 workers' compensation premium over Medicare in West Virginia is not exactly 35 percent.



Notes: Delaware, Florida, Illinois, New York, Pennsylvania, and Texas have distinct fee schedules for different parts of the state. For each, a single statewide rate was created by averaging the different sub-state fee schedules using the percentage of employed persons in each sub-state region as weights. Medicare establishes distinct sub-state fee schedules in 14 states. For each, a single statewide rate was created using the same procedure. For Texas the "surgery in an office setting" conversion factor was applied to the surgical treatment service group. West Virginia sets the workers' compensation fee schedule to be 135 percent of Medicare using rounded fully implemented relative value units (RVUs). In 2009 Medicare was still using transitional RVUs, and Medicare does not round during the calculation. The result of these differences is that the 2009 workers' compensation premium over Medicare in West Virginia is not exactly 35 percent.

Table 2 Workers' Compensation Fee Schedule Rates for Eight Commonly Billed Procedures, December 2009

State	ER Services	E&M	Major Radiology	Minor Radiology	Neuro. Testing	Physical Medicine	Major Surgery	Surgical Treatment
	CPT 99283	CPT 99213	CPT 72148	CPT 73030	CPT 95904	CPT 97110	CPT 29826	CPT 20610
Alabama	$87	$61	$805	$84	$50	$44	$2669	$62
Alaska	$249	$149	$2846	$228	$257	$97	$4747	$304
Arizona	$137	$76	$1127	$70	$106	$41	$2448	$101
Arkansas	$74	$76	$1012	$56	$54	$35	$1188	$137
California	$87	$57	$640	$53	$65	$33	$1483	$46
Colorado	$145	$79	$959	$47	$76	$28	$1429	$56
Connecticut	$119	$96	$1363	$90	$125	$35	$2946	$139
Delaware: New Castle County[a]	$189	$79	$1688	$139	$88	$50	$3709	$183
Florida: Dade & Monroe Counties[a]	$72	$70	$516	$39	$60	$32	$1036	$110
Georgia	$89	$83	$1177	$66	$69	$38	$1797	$105
Hawaii	$154	$74	$778	$50	$81	$37	$919	$97
Idaho	$112	$114	$1282	$70	$88	$37	$2424	$173
Illinois: Chicago[a]	$211	$102	$1626	$148	$184	$68	$4214	$227
Kansas	$78	$66	$901	$51	$76	$34	$1390	$147
Kentucky	$76	$69	$671	$39	$61	$36	$1209	$149
Louisiana	$114	$68	$1051	$61	$64	$43	$1687	$92
Maine	$98	$83	$907	$52	$88	$44	$1083	$110
Maryland	$72	$73	$639	$36	$55	$33	$978	$84
Massachusetts	$61	$49	$655	$35	$57	$23	$2131	$77
Michigan	$91	$89	$773	$43	$64	$42	$930	$105
Minnesota	$132	$85	$1135	$64	$71	$39	$1550	$96
Mississippi	$81	$79	$933	$52	$81	$45	$1606	$91
Montana	$111	$111	$957	$54	$84	$51	$1127	$127
Nebraska	$78	$76	$1242	$70	$72	$39	$1895	$141
Nevada	$142	$77	$1818	$89	$86	$43	$2811	$110
New Mexico	$107	$67	$1015	$65	$75	$36	$1611	$111
New York: Manhattan, Bronx, & Queens[a]	$113	$49	$912	$95	$106	$34	$2448	$57
North Carolina	$86	$51	$894	$52	$46	$25	$1608	$86
North Dakota	$104	$104	$701	$50	$78	$48	$1053	$118
Ohio[b]	n/c	$84	$710	$40	$62	$39	$1356	$96
Oklahoma	$92	$63	$890	$44	$78	$30	$1843	$76
Oregon	$110	$110	$997	$56	$96	$51	$1493	$168
Pennsylvania: Philadelphia[a]	$90	$65	$988	$57	$57	$34	$1792	$85
Rhode Island[c]	$110	$75	$945	$89	$65	n/c	$3189	$123
South Carolina	$85	$72	$750	$43	$53	$38	$1087	$95
South Dakota	$129	$70	$1023	$50	$64	$32	$1513	$59
Tennessee	$125	$98	$796	$56	$71	$37	$1668	$187
Texas: Dallas[a,d]	$92	$92	$793	$44	$69	$42	$1181	$105
Utah	$78	$78	$777	$43	$59	$36	$1002	$113
Vermont	$99	$67	$722	$63	$88	$46	$1955	$122
Washington	$103	$105	$895	$50	$79	$48	$1039	$118
West Virginia	$81	$78	$613	$35	$53	$36	$799	$89
Wyoming	$138	$75	$1208	$59	$79	$32	$1851	$72
Range: Lowest to Highest	$61–$249	$49–$149	$516–$2846	$35–$228	$46–$257	$23–$97	$799–$4747	$46–$304
Range: Second Lowest to Second Highest	$72–$211	$49–$114	$613–$1818	$35–$148	$50–$184	$25–$68	$919–$4214	$56–$227

[a] Delaware, Florida, Illinois, New York, Pennsylvania, and Texas have distinct fee schedules for different parts of the state. For each, the fee schedule amount for only one sub-state region is shown.

[b] Ohio does not establish rates for the emergency services included in the marketbasket. Therefore a rate for 99283 is not listed in the Ohio workers' compensation fee schedule.

[c] Rhode Island has different billing codes for physical medicine and does not establish rates for the majority of the codes. Therefore a rate for 97110 is not listed in the Rhode Island workers' compensation fee schedule.

[d] Texas sets a unique conversion factor for surgery in a facility setting. Surgeries in a facility setting are likely to be a more invasive procedures similar to those in the major surgery service group, thus the unique "surgery in a facility setting" conversion factor was applied to the major surgery service group. The "surgery in an office setting" conversion factor was applied to the surgical treatment service group.

Key: CPT: Current Procedural Terminology; E&M: evaluation and management; ER: emergency; MRI: magnetic resonance imaging; n/c: not comparable; Neuro.: neurological; 99283: Emergency department visit, moderate severity; 99213: Established patient office visit, low-moderate severity, 15 min; 72148: MRI, spinal canal & contents, lumbar, without contrast material; 73030: Radiologic exam, complete, minimum of two views; 95904: Nerve conduction, each nerve—any/all sites, sensory; 97110: Therapeutic procedure, one or more areas, 15 min exercises each; 29826: Arthroscopy shoulder surgery, decompression of subcromial space; 20610: Arthrocentesis, major joint or bursa.

DISCUSSION

In light of the large range in premiums over Medicare at both the state and service group levels and the large variation in actual fee schedule rates, it is unlikely that every state has struck an optimal balance between savings to employers and good access to quality care for injured workers. Indeed there are several possible lessons that may be derived from the results shown previously. Below, lessons regarding the relation of fee schedules to incurred provider expenses, financial incentives for invasive care, and optimal relative fee schedule values including higher than necessary fees and potential concerns for access to care are discussed in turn.

FEE SCHEDULES AND INCURRED PROVIDER EXPENSES

If interstate differences in workers' compensation fee schedule levels were related to the level of provider expenses one would expect to see higher workers' compensation fee schedule rates in states with higher Medicare rates. This is because state to state differences in physician expenses are explicitly reflected in the Medicare fee schedule rates (practice expenses, malpractice insurance, etc.).

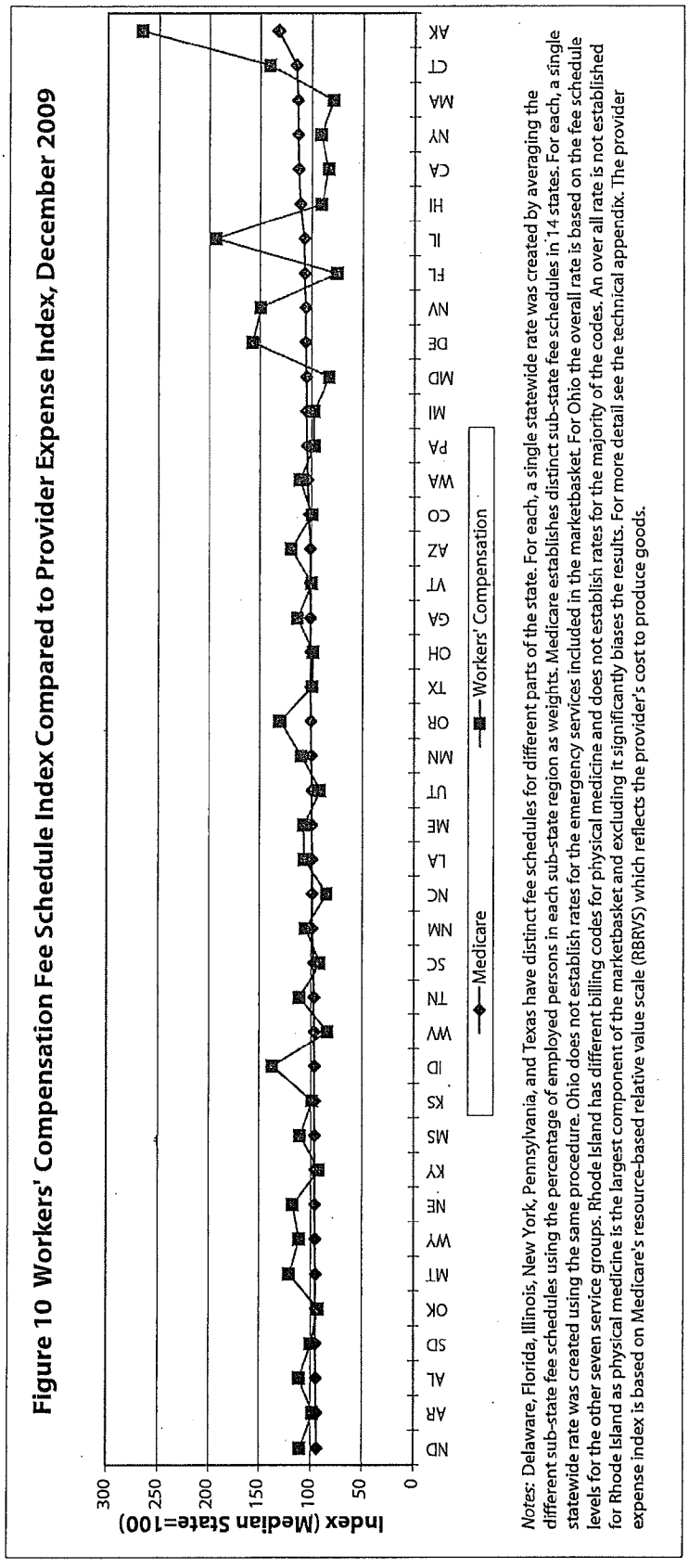
Figure 10 shows a comparison of a Medicare fee index and a workers' compensation fee index. Each index is relative to the median state. For example in North Dakota, the Medicare rates were on average 6 percent below the median state while the workers' compensation fees were on average 10 percent higher than the median state. In Figure 10 it is shown that higher workers' compensation rates are not necessarily correlated with higher Medicare rates. For example in New York, the Medicare fee schedule rate was 13 percent above the median whereas the workers' compensation fee schedule was 9 percent below the median. The lowest workers' compensation fee schedule was 25 percent below the median in Florida while the Medicare fee schedule was 7 percent above the median. The interstate differences in workers' compensation fee schedule levels are thus not likely closely related to the expenses incurred by health care providers as shown in Figure 10.

FINANCIAL INCENTIVES FOR INVASIVE CARE

The RBRVS system that underlies Medicare and several state workers' compensation fee schedules was designed to provide appropriate incentives for utilization of both primary care and specialty care to a general population. If all services were reimbursed at the same premium over Medicare then utilization incentives would be neutral, that is a provider would not be rewarded more for the use of certain services than others. Table 1 shows that only nine states, Maryland, Michigan, Montana, North Dakota, Texas, Utah, Washington, and West Virginia, set rates that result in the premium over Medicare being relatively the same for each of the service groups, which may neutralize some utilization incentives.[9, 10] However, this is uncommon among state workers' compensation fee schedules. As seen in Table 1, 28 states set fee

[9] The percentage point difference between the service group with the highest premium over Medicare and the service group with the lowest premium over Medicare in these nine states is less than or equal to 45.

[10] In Washington workers' compensation regulations impose a daily maximum of $118.07 for physical medicine reimbursement. This limit may affect incentives for the use of specialty and invasive care.



Notes: Delaware, Florida, Illinois, New York, Pennsylvania, and Texas have distinct fee schedules for different parts of the state. For each, a single statewide rate was created by averaging the different sub-state fee schedules using the percentage of employed persons in each sub-state region as weights. Medicare establishes distinct sub-state fee schedules in 14 states. For each, a single statewide rate was created using the same procedure. Ohio does not establish rates for the emergency services included in the marketbasket. For Ohio the overall rate is based on the fee schedule levels for the other seven service groups. Rhode Island has different billing codes for physical medicine and does not establish rates for the majority of the codes. An over all rate is not established for Rhode Island as physical medicine is the largest component of the marketbasket and excluding it significantly biases the results. For more detail see the technical appendix. The provider expense index is based on Medicare's resource-based relative value scale (RBRVS) which reflects the provider's cost to produce goods.

schedule rates where the difference between the highest premium over Medicare and the lowest for the eight service groups was more than 100 percentage points. Typically more invasive and specialty care is reimbursed at a higher premium over Medicare in workers' compensation fee schedules, which may result in distorted utilization incentives toward more invasive specialty care.

In comparing the premium over Medicare for major surgery (a type of invasive specialty care) to that of treatment considered to be a substitute for such modalities in many cases such as evaluation and management and physical medicine services (less invasive care), only five states, Michigan, Montana, North Dakota, Washington, and West Virginia, had premiums within 11 percentage points of one another. On the opposite end of the spectrum, seven states, Alabama, Alaska, Connecticut, Delaware, Idaho, Illinois, and Nevada, set both evaluation and management and physical medicine services rates at premiums over Medicare that were more than 200 percentage points less than the premium over Medicare for major surgery.

Optimal Relative Fee Schedule Values

The RBRVS system that underlies Medicare is a good metric of the optimal relative fee schedule rates. That is, the fee schedule rate for one medical procedure compared to a different procedure. The optimal fee schedule rates are likely to be those that provide access to quality care in the most cost-efficient manner.[11] As previously discussed the Medicare RBRVS system was designed to neutralize incentives for utilization between primary care and specialty care to a general population. It therefore provides a good measure of the relative differences in costs across states and across service types.

In 2009 more than half of the states based their workers' compensation fee schedules on the RBRVS system in some part. A few states set their fee schedule to an explicit percent above Medicare while the majority incorporated the Medicare relative value units (RVUs) with state-specific conversion factors. Of the 43 states, 25 used the RBRVS system, 7 states used some other form of relative value units, and 25 of these 32 states used more than one conversion factor across service groups. Most states that tie their fee schedules to Medicare adjust their fee schedules annually as Medicare rates change. A few states decoupled their Medicare-based fee schedules from the annual changes in Medicare rates. Pennsylvania, for example, ties annual changes to the change in the statewide average weekly wage. This is an important choice, since Medicare rates are adjusted annually based on some factors (e.g., the needs and politics of the federal budget) that have little relevance for public policy decisions in workers' compensation. Table 3 provides a brief summary of the characteristics of the 2009 workers' compensation fee schedules.

Fee Schedules in Excess of Optimal Amounts

It is not possible to definitively say if any state has set a fee schedule at an optimal rate without worker outcome measures in each state. However, one may conclude that several states have set workers' compensation fee schedule rates at levels that may be above the optimal level. Table 4 lists several states in which the workers' compensation fee schedule rates were more than double the Medicare fee schedule rates by service group. Thirty-three of the 43 states, well over one-half, had premiums over Medicare that were more than 100 percent for at least one service group.

[11] Absent multistate measures of workers' health outcomes and access to quality health care, it is difficult to say what the optimal absolute fee schedule rates are for a given state.

Table 3 Characteristics of Workers' Compensation Fee Schedules for Nonfacility Providers, December 2009

Jurisdiction	Relative Value Scale Used	Conversion Factors (single or multiple)[a]	Last Update of Fee Schedule and/or Conversion Factors
Alabama	n/a	n/a	July 15, 2009
Alaska	n/a	n/a	March 31, 2009
Arizona	n/a	n/a	October 1, 2009
Arkansas	RBRVS	Multiple	October 1, 2009
California	OMFS RVU	Multiple	February 15, 2007
Colorado	RVP	Multiple	January 1, 2009
Connecticut	RBRVS	Multiple	July 15, 2009
Delaware	n/a	n/a	January 1, 2009
Florida	RBRVS	Single	February 4, 2009
Georgia	RBRVS	Multiple	April 1, 2009
Hawaii	RBRVS	Single	January 1, 2008
Idaho	RBRVS	Multiple	May 8, 2009
Illinois	n/a	n/a	February 1, 2009
Kansas	RBRVS	Multiple	January 1, 2008
Kentucky	RBRVS	Multiple	July 31, 2008
Louisiana	n/a	n/a	December 2007
Maine	RBRVS	Single	November 5, 2006
Maryland	RBRVS	Multiple	January 1, 2009
Massachusetts	n/a	n/a	March 19, 2009
Michigan	RBRVS	Multiple	July 7, 2009
Minnesota	MN RVU	Multiple	September 16, 2009
Mississippi	RBRVS	Multiple	October 1, 2009
Montana	RBRVS	Multiple	January 1, 2009
Nebraska	RBRVS	Multiple	June 1, 2008
Nevada	RVP	Multiple	February 1, 2009
New Mexico	n/a	n/a	December 31, 2008
New York	NY RVU	Multiple	July 1, 2008
North Carolina	n/a	n/a	January 1, 2009
North Dakota	RBRVS	Multiple	January 1, 2009
Ohio	RBRVS	Multiple	November 1, 2009
Oklahoma	RBRVS	Multiple	March 10, 2008
Oregon	RBRVS	Multiple	July 1, 2009
Pennsylvania[b]	RBRVS	n/a	October 1, 2009
Rhode Island	n/a	n/a	November 6, 2008
South Carolina	RBRVS	Single	January 1, 2003
South Dakota	RVP	Multiple	June 19, 2008
Tennessee	RBRVS	Multiple	August 26, 2009
Texas	RBRVS	Multiple	January 1, 2009
Utah	RBRVS	Multiple	December 1, 2009
Vermont	n/a	n/a	January 1, 2008
Washington	RBRVS	Single	July 1, 2009
West Virginia	RBRVS	Single	July 1, 2009
Wyoming	RVP	Multiple	March 30, 2009

[a] The column for single or multiple conversion factors does not refer to anesthesia, laboratory, or pathology services.

[b] In Pennsylvania, prior to January 1, 1995, the medical fees were capped at 113 percent of Medicare. Medical fee updates on and after January 1, 1995, are calculated based on the percentage changes in the statewide average weekly wage annually. These updates are effective on January 1 of each year, and they are cumulative. The 2009 fee schedule was updated by the percentage change in the statewide average weekly wage, which was 3.6 percent. This percentage change applies to all services rendered on or after January 1, 2009.

Key: n/a: not applicable; OMFS: Official Medical Fee Schedule; RBRVS: Resource-Based Relative Value System (Medicare); RVP: Relative Values for Physicians; RVU: relative value unit.

Table 4 States with Workers' Compensation Fee Schedule Levels That Are Double Medicare Fee Schedule Levels or Greater, December 2009

ER Services	E&M	Major Radiology	Minor Radiology	Neurological Testing	Physical Medicine	Major Surgery	Surgical Treatment
Alaska (164)		Alaska (318)	Alabama (205)	Alaska (369)	Alaska (153)	Alabama (313)	Alaska (272)
Arizona (102)		Arkansas (131)	Alaska (408)	Arizona (140)	Illinois (125)	Alaska (488)	Arkansas (103)
Colorado (119)		Connecticut (118)	Arizona (133)	Connecticut (142)		Arizona (240)	Delaware (176)
Delaware (168)		Delaware (156)	Arkansas (129)	Delaware (132)		Arkansas (115)	Idaho (157)
Hawaii (106)		Georgia (134)	Connecticut (127)	Idaho (114)		Colorado (139)	Illinois (213)
Illinois (219)		Idaho (181)	Delaware (246)	Illinois (259)		Connecticut (314)	Kansas (166)
Minnesota (105)		Illinois (214)	Georgia (133)	Montana (103)		Delaware (362)	Maine (107)
Nevada (107)		Louisiana (103)	Idaho (175)	Oregon (116)		Georgia (194)	Montana (102)
South Dakota (100)		Minnesota (114)	Illinois (280)			Idaho (323)	Nebraska (164)
Tennessee (111)		Montana (112)	Louisiana (105)			Illinois (504)	Oklahoma (113)
Wyoming (110)		Nebraska (165)	Minnesota (112)			Kansas (143)	Oregon (149)
		Nevada (224)	Montana (108)			Kentucky (133)	Tennessee (174)
		New Mexico (107)	Nebraska (164)			Louisiana (116)	
		South Dakota (118)	Nevada (186)			Massachusetts (151)	
		Wyoming (157)	New Mexico (116)			Minnesota (122)	
			New York (104)			Mississippi (168)	
			Rhode Island (140)			Nebraska (232)	
			Tennessee (111)			Nevada (345)	
			Wyoming (122)			New Mexico (148)	
						New York (169)	
						North Carolina (143)	
						Ohio (119)	
						Oklahoma (145)	
						Oregon (156)	
						Pennsylvania (129)	
						Rhode Island (289)	
						South Dakota (173)	
						Tennessee (186)	
						Vermont (166)	
						Wyoming (221)	

Notes: The premium over Medicare is shown in parentheses for each state. Delaware, Florida, Illinois, New York, Pennsylvania, and Texas have distinct fee schedules for different parts of the state. For each, a single statewide rate was created by averaging the different sub-state fee schedules using the percentage of employed persons in each sub-state region as weights. Medicare establishes distinct sub-state fee schedules in 14 states. For each, a single statewide rate was created using the same procedure.

Key: E&M: evaluation and management; ER: emergency.

Two states (Illinois and Alaska) had fee schedule rates for major surgical procedures that were approximately six times the corresponding Medicare rates. For major radiology, the workers' compensation fee schedule rates were more than double Medicare in 15 states and for minor radiology, 19 states had fee schedule rates that were more than double Medicare. For physical medicine services only Illinois and Alaska had fee schedule rates that were more than double Medicare. Eleven states set emergency services fee schedule rates at levels double Medicare or greater, 8 did so for neurological testing, and 12 for surgical treatment.

FEE SCHEDULES BELOW OPTIMAL AMOUNTS: POTENTIAL ACCESS TO CARE ISSUES

While it is not possible, based on this study, to definitively say if any state has set a fee schedule at an optimal rate without worker outcome measures in each state, one may conclude that several states have set workers' compensation fee schedule rates at levels that may be below the optimal level for some service groups. It is often claimed that treating workers' compensation patients is more time consuming and intensive than treating other patients under group health or Medicare. It is likely that setting workers' compensation fee schedule rates at some premium over Medicare is appropriate. Indeed nearly every state, for every service group, sets rates at some premium over Medicare.

There may be concern about access to care in states where the workers' compensation fee schedule rates were set near to or below Medicare rates. Nine of the 43 states had workers' compensation fee schedule rates within 10 percent of Medicare as presented in Table 5a. Several states set rates for at least one service group where the premium was negative, meaning that the state's reimbursement rates were on average below Medicare. Four states, shown in Table 5b, set rates for at least one service group at levels that were more than 10 percent below Medicare. Four states set evaluation and management rates below Medicare, three set surgical treatment rates below Medicare, two set major radiology rates below Medicare, one set emergency services rates below Medicare, and one set physical medicine rates below Medicare. Florida and Massachusetts set the rates for nearly all service groups near to or below Medicare rates.

Table 5a States with Workers' Compensation Fee Schedule Levels That Are Within 10 Percent of Medicare Fee Schedule Levels, December 2009

Emergency Services	E&M	Major Radiology	Minor Radiology	Neurological Testing	Physical Medicine	Major Surgery	Surgical Treatment
Florida (4)	Alabama (8)	California (8)	Florida (10)	Massachusetts (7)	Florida (1)		Massachusetts (10)
Massachusetts (-4)	California (-7)	Hawaii (-2)	Massachusetts (3)		New York (1)		New York (-5)
Ohio (0)	Florida (6)	Massachusetts (6)			North Carolina (4)		South Dakota (-1)
	North Carolina (-4)				Rhode Island (0)		
	Pennsylvania (8)						

Table 5b States with Workers' Compensation Fee Schedule Levels That Are More Than 10 Percent Below Medicare Fee Schedule Levels, December 2009

Emergency Services	E&M	Major Radiology	Minor Radiology	Neurological Testing	Physical Medicine	Major Surgery	Surgical Treatment
	Massachusetts (-20)	Florida (-14)			Massachusetts (-20)		California (-27)
	New York (-27)						

Notes: The premium over or under Medicare is shown in parentheses for each state. Delaware, Florida, Illinois, New York, Pennsylvania, and Texas have distinct fee schedules for different parts of the state. For each, a single statewide rate was created by averaging the different sub-state fee schedules using the percentage of employed persons in each sub-state region as weights. Medicare establishes distinct sub-state fee schedules in 14 states. For each, a single statewide rate was created using the same procedure.

Key: E&M: evaluation and management.

CONCLUSION

This study provides an important benchmark for the design of fee schedules in workers' compensation by analyzing the relative levels of state workers' compensation medical fee schedules. While 43 states used medical fee schedules in 2009, there were significant differences in these fee schedule levels compared to the Medicare fee schedule levels across the states. The premium over Medicare varied widely from 8 percent above Medicare in Massachusetts to 215 percent above Medicare in Alaska. Nine states set rates that resulted in the premium over Medicare being relatively the same for each of the service groups, which may neutralize some utilization incentives for invasive and specialty care. Further, higher workers' compensation reimbursement rates were not necessarily correlated with higher Medicare rates.

In 2009 more than half of the 43 states, 25, based their workers' compensation fee schedules on the RBRVS system in some part. Seven states used some other form of relative value units and 25 of these 32 states used more than one conversion factor across service groups.

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TECHNICAL APPENDIX

RESEARCH APPROACH

The methodology in this report follows that in earlier WCRI studies of fee schedules. It compares workers' compensation fee schedules to Medicare fee schedules by creating an aggregate fee schedule rate, similar to the consumer price index and the Medical Price Index for Workers' Compensation (MPI-WC), for a representative collection of procedures and services. The WCRI aggregate fee schedule rate measures the relative fee schedule amounts of a representative collection of nonhospital medical procedures that are commonly provided to injured workers. The same representative group of medical services (in the same proportions) is used to create both the aggregate workers' compensation fee schedule rates and the aggregate Medicare fee schedule rates in all states. Further detail on methodology is provided below. Comparisons of workers' compensation fee schedule rates to the state's Medicare fee schedule rates are made and expressed in terms of the workers' compensation fee schedule percentage above (or in some cases below) Medicare.

DATA COLLECTION AND METHODOLOGY

The data in this study are from workers' compensation physician fee schedules for procedures in the marketbasket (described below). In some instances these fee schedule rates were requested and received from the various workers' compensation agencies and in other instances the data was purchased from Ingenix. Fee schedule rates in the analysis are current as of December 2009. Forty-three states had workers' compensation physician fee schedules in 2009.[12] Medicare fee schedules for each state with a workers' compensation fee schedule were also obtained from the Centers for Medicare & Medicaid Services.[13] The 2009 Medicare fee schedules were utilized.

The data for creating the marketbasket in this study are a subset of the detailed medical transaction data from WCRI's Detailed Benchmark/Evaluation (DBE) database. Expenditure data were used to establish the marketbasket. This data set includes the medical services paid on a subset of claims from 14 states over a 24-month period from 2005 and 2006 in the CompScope™ Medical benchmarks study.[14] In this data set the medical bill review data associated with claims that had relatively complete bill review were selected, as were data sources in which the claims with complete bill review data represented all claims from the same data sources. This allows a set of well-balanced detailed medical data supporting a marketbasket that adequately represents all procedures or services in a market, and avoids potential bias in service and expenditure distribution. To ensure accurate representation of the volume of services and payments within each service group, only the medical data associated with claims that had complete medical bills were selected. The DBE

[12] We were unable to obtain a fee schedule from the District of Columbia. In addition to the District of Columbia, we excluded Wisconsin from the analysis because that state uses certified databases based on charges, which is not considered a traditional workers' compensation fee schedule.

[13] Retrieved from http://www.cms.hhs.gov/PhysicianFeeSched/PFSCSF/list.asp#TopOfPage (accessed November 11, 2009).

[14] The 14 states in *CompScope™ Medical Benchmarks, 9th Edition* are California, Florida, Iowa, Illinois, Indiana, Louisiana, Massachusetts, Maryland, Michigan, North Carolina, Pennsylvania, Tennessee, Texas, and Wisconsin.

database includes approximately 42 to 78 percent of the workers' compensation claims in each of the 14 states, and the medical detailed data consists of roughly 30 percent of the claim population.

SELECTING A MARKETBASKET

The methodology for selecting the marketbasket follows directly from another WCRI study, the MPI-WC, Third Edition, which creates a price index or weighted average of prices paid for a collection of the most common medical services provided to injured workers. This collection is the marketbasket. Indeed the marketbasket used in this study is nearly identical to that used in the MPI-WC, Third Edition. There are nine Current Procedural Terminology (CPT) codes in the MPI-WC, Third Edition marketbasket for which Medicare does not establish rates. For two of these codes, 97010 (hot/cold packs) and 98943 (chiropractic manipulation treatment, extraspinal, one or more regions), Medicare does however establish relative value units (RVUs). The RVUs were utilized to establish a proxy Medicare rate for CPT codes 97010 and 98943 in each state. CPT code 97014 (electric stimulation, one or more areas) is reimbursed as G0283 under Medicare, thus established rates for G0283 were used. The remaining six codes were excluded from the marketbasket leaving 175 CPT codes.[15] See Table TA.1 for the list of CPT codes in the marketbasket.

A single marketbasket of procedure codes is used across all states for both workers' compensation and Medicare to provide more meaningful interstate comparisons. However, the marketbasket may represent a smaller percentage of the total expenditures in some states when state-specific codes are used. In the majority of cases, it was possible to map these unique codes to the standard codes in the marketbasket, though some state-specific codes do not have a standard alternative.

In selecting the marketbasket procedures, eight service groups were used to characterize the nonhospital services. Each of these groups represents an aggregate rate component. The top procedure codes ranked by frequency were reviewed for each of these groups. Then codes within each service group were sequentially chosen until approximately 80 percent or more of total expenditures in the group was reached, for most service groups. For surgical treatment and major surgery only 56 to 65 percent of total expenditures are represented by the marketbasket codes. This is because there is a broader list of codes in these groups and adding additional codes adds only a small percentage of payments each time. After the initial choice, the expenditures were broken down by state to see if any states were under-represented or had an overly large effect on the marketbasket. Table TA.2 describes the number of codes for each service group in the marketbasket, and the percentage of the service group expenditures captured by those codes. The third column in Table TA.2 shows the percentage of the total population of expenditures that each service group represents. Table TA.2 shows that the codes in the marketbasket capture the majority of expenditures in each of the service groups.

[15] The six excluded codes are 99058 (office services provided on an emergency basis), 97545 (work hardening/conditioning, initial two hours), 97546 (work hardening/conditioning, each additional hour), 97602 (Removal of devitalized tissue from wound, non-selective debridement w/o anesthesia, wound assessment and instructions, per session), 36415 (collection of venous blood by venipuncture), and 76375 (CT coronal, sagittal, multiplanar, oblique, and/or 3-d reconstruction).

Table TA.1 Marketbasket Procedures

Service Group	Procedure	CPT Code	Percentage Frequency[a]	Description
Emergency	1	99283	56.1%	Emergency department visit, moderate severity
	2	99284	21.6%	Emergency department visit, high severity, urgent evaluation
	3	99282	12.4%	Emergency department visit, low-moderate severity
	4	99285	7.4%	Emergency department visit, high severity, immediate significant threat
	5	99281	2.5%	Emergency department visit, self-limited/minor
Evaluation & Management	6	99213	37.9%	Established patient office visit, low-moderate severity, 15 min
	7	99214	23.4%	Established patient office visit, moderate-high severity, 25 min
	8	99212	9.9%	Established patient office visit, self limit/minor, 10 min
	9	99203	6.0%	New patient office visit, moderate severity, 30 min
	10	99215	5.7%	Established patient office visit, moderate-high severity, 40 min
	11	99204	4.9%	New patient office visit, moderate-high severity, 45 min
	12	99244	2.4%	Office consultation, new/established patient, moderate-high severity, 60 min
	13	99243	2.0%	Office consultation new/established patient moderate severity, 40 min
	14	99245	2.0%	Office consultation, new/established patient, moderate-high severity, 80 min
	15	99211	1.7%	Established patient visit, no physician necessary, 5 min
	16	99202	1.6%	New outpatient visit, low-moderate severity, 20 min
	17	99205	1.3%	New patient office visit, moderate-high severity, 60 min
	18	99232	1.2%	Subsequent hospital care, minor complication, 25 min
Major Radiology	19	72148	22.9%	MRI, spinal canal & contents, lumbar, without contrast material
	20	73221	20.6%	MRI, anterior joint, upper extremity
	21	73721	20.2%	MRI, anterior joint, lower extremity
	22	72141	10.3%	MRI, spinal canal & contents, cervical, without contrast material
	23	70450	7.1%	Cat scan, head or brain, with contrast material
	24	72158	3.7%	MRI, spinal canal, without then with contrast material, lumbar
	25	72125	3.1%	Computed tomography, cervical spine, without contrast material
	26	72131	2.8%	Cat scan, lumbar spine, without contrast material
	27	72193	2.5%	Computed tomography, pelvis, with contrast material
	28	72146	2.5%	MRI, spinal canal & contents, thoracic, without contrast material
	29	74160	2.4%	Computed tomography, abdomen, with contrast material
	30	73700	1.9%	Computed tomography, lower extremity, without contrast material
Minor Radiology	31	73030	8.7%	Radiologic exam, complete, minimum of 2 views
	32	72100	7.9%	Radiologic exam, spine, lumbosacral, anteroposterior & lateral
	33	73140	7.0%	Radiologic exam, finger(s), minimum of 2 views
	34	73110	6.9%	Radiologic exam, wrist, complete, minimum of 3 views
	35	73610	6.5%	Radiologic exam, ankle, complete, minimum of 3 views
	36	73130	6.0%	Radiologic exam, hand, minimum of 3 views
	37	73630	5.5%	Radiologic exam, foot, complete, minimum of 3 views

continued

Table TA.1 Marketbasket Procedures (continued)

Service Group	Procedure	CPT Code	Percentage Frequency[a]	Description
Minor Radiology (continued)	38	72110	5.0%	Radiologic exam, spine, lumbosacral, complete with oblique views
	39	71020	3.9%	Radiologic exam, chest, 2 views, frontal & lateral
	40	73560	3.9%	Radiologic exam, knee, anteroposterior & lateral views
	41	73562	3.7%	Radiologic exam, knee, anteroposterior & lateral with oblique, minimum of 3 views
	42	72040	3.4%	Radiologic exam, spine cervical, anteroposterior & lateral
	43	71010	3.0%	Radiologic exam, chest, frontal view
	44	73564	2.8%	Radiologic exam, knee, including oblique & tunnel and/or patellar
	45	73100	2.7%	Radiologic exam, wrist, anteroposterior & lateral views
	46	73080	2.6%	Radiologic exam, elbow, complete, minimum of 3 views
	47	72050	2.4%	Radiologic exam, spine cervical, minimum of 4 views
	48	73590	2.4%	Radiologic exam, tibia & fibula, anteroposterior & lateral views
	49	72070	1.9%	Radiologic exam, spine thoracic, anteroposterior & lateral
	50	72170	1.9%	Radiologic exam, pelvis, anteroposterior only
	51	73090	1.6%	Radiologic exam, forearm, anteroposterior & lateral views
	52	73600	1.4%	Radiologic exam, ankle, anteroposterior & lateral views
	53	73120	1.3%	Radiologic exam, hand, 2 views
	54	73620	1.1%	Radiologic exam, foot, anteroposterior & lateral views
	55	72052	1.1%	Radiologic exam, spine cervical, complete including oblique, flexion and/or extension studies
	56	73550	0.8%	Radiologic exam, femur, 2 views
	57	73060	0.8%	Radiologic exam, humerus, minimum 2 views
	58	73650	0.7%	Radiologic exam, calcaneus, minimum 2 views
	59	70030	0.6%	Radiologic exam, eye, for detection of foreign body
	60	73660	0.6%	Radiologic exam, toes, minimum 2 views
	61	71100	0.6%	Radiologic exam, ribs, unilateral, 2 views
	62	73565	0.6%	Radiologic exam, both knees, standing anteroposterior
	63	72072	0.4%	Radiologic exam, spine, thoracic, 3 views
Neurological Testing	64	95904	33.6%	Nerve conduction, each nerve—any/all sites, sensory
	65	95903	20.1%	Nerve conduction, each nerve, motor without f-wave study
	66	95900	15.6%	Nerve conduction, each nerve, motor with f-wave study
	67	95851	8.1%	ROM measurements and report, each, extremity or each trunk section
	68	95934	6.3%	H-reflex, amplitude & latency study, record gastrocnemius/soleus muscle
	69	95861	4.5%	Needle EMG, 2 extremities with or without related paraspinal areas
	70	95860	4.5%	Needle EMG, 1 extremity with or without related paraspinal areas
	71	95831	3.6%	Muscle test, manual, extremity/trunk
	72	95832	2.3%	Muscle test, manual, hand
	73	95852	1.4%	ROM measure, report (separate), hand, with or without comparing with normal

continued

Table TA.1 Marketbasket Procedures (continued)

Service Group	Procedure	CPT Code	Percentage Frequency[a]	Description
Physical Medicine	74	97110	38.4%	Therapeutic procedure, 1 or more areas, 15 min exercises each
	75	97140	15.5%	Manual therapy
	76	97014	9.6%	Electric stimulation, 1 or more areas
	77	97530	6.6%	Therapy activities, direct patient contact by the provider, each 15 min
	78	97035	5.0%	Ultrasound, 1 or more areas, each 15 min
	79	97010	3.5%	Hot/cold packs
	80	97112	3.5%	Therapeutic procedure, neuromuscular reeducation of movement
	81	98940	2.7%	Chiropractic manipulation treatment, spinal 1–2 regions
	82	97032	2.0%	Electric stimulation, 1 or more areas, each 15 min
	83	97012	1.9%	Traction, mechanical
	84	97001	1.8%	Physical therapy evaluation
	85	97124	1.7%	Massage
	86	98941	1.5%	Chiropractic manipulation treatment, spinal, 3–4 regions
	87	97026	0.9%	Application of modality to 1 or more areas, infrared
	88	97018	0.9%	Paraffin bath, 1 or more areas
	89	97033	0.9%	Iontophoresis, 1 or more areas, each 15 min
	90	97022	0.8%	Whirlpool
	91	97750	0.8%	Physical performance test or measurement, with written report, each 15 min
	92	97113	0.6%	Therapeutic procedure, aquatic therapy, 1 or more areas, each 15 min
	93	97016	0.5%	Application of modality to 1 or more areas, vasopneumatic devices
	94	97002	0.5%	Physical therapy re-evaluation
	95	98943	0.4%	Chiropractic manipulation treatment, extraspinal, 1 or more regions
Major Surgery	96	29826	12.3%	Arthroscopy shoulder surgery, decompression of subcromial space
	97	29881	11.0%	Arthroscopy knee surgery, with meniscectomy, medial or lateral
	98	64721	8.9%	Neuroplasty and/or transposition, median nerve at carpal tunnel
	99	29877	5.8%	Arthroscopy knee surgery, debridement/shaving of articular cartilage
	100	29823	4.2%	Arthroscopy shoulder surgery, debridement extensive
	101	49505	3.8%	Repair initial inguinal hernia, age 5 years or over, reducible
	102	29824	3.8%	Arthroscopy, shoulder
	103	29880	3.7%	Arthroscopy knee surgery, with meniscectomy, medial & lateral
	104	63030	3.6%	Laminotomy with decompression of nerve root, 1 interspace, lumbar
	105	22851	3.4%	Application of intervertebral biomechanical device to vertebral defect or interspace
	106	29827	3.2%	Arthroscopy, shoulder surgery, rotator cuff repair
	107	23120	2.8%	Claviculectomy, partial
	108	29888	2.6%	Arthroscopically aided ACL repair, augmentation, reconstruction
	109	23412	2.6%	Repaired ruptured musculotendinous cuff, chronic
	110	29822	2.6%	Arthroscopy, debridement, limited

continued

Table TA.1 Marketbasket Procedures (continued)

Service Group	Procedure	CPT Code	Percentage Frequency[a]	Description
Major Surgery (continued)	111	22612	2.5%	Arthrodesis, posterior or posterolateral, single level, lumbar
	112	22845	2.3%	Anterior instrumentation, 2 to 3 vertebral segments
	113	22554	2.2%	Arthrodesis-anterior interbody technique, with minimal diskectomy, cervical below C2
	114	63047	2.2%	Laminectomy, single vertebral segment, unilateral/bilateral, lumbar
	115	29876	2.0%	Arthroscopy, synovectomy, major
	116	64718	1.8%	Neuroplasty, ulnar nerve at elbow
	117	23420	1.7%	Complete repair, shoulder cuff, avulsion, chronic
	118	29807	1.7%	Repair of SLAP lesion
	119	29879	1.6%	Arthroscopy knee surgery, abrasion arthroplasty
	120	26418	1.5%	Repair, extensor tendon
	121	22630	1.4%	Arthrodesis, posterior interbody technique
	122	22585	1.4%	Arthrodesis, each additional interspace
	123	22614	1.3%	Arthrodesis, each additional vertebral segment
	124	29875	1.2%	Arthroscopy, synovectomy, limited
	125	22840	1.1%	Posterior nonsegmental instrumentation
Surgical Treatment	126	20610	14.7%	Arthrocentesis, major joint or bursa
	127	62311	7.3%	Injection, lumbar, sacral
	128	20550	6.7%	Injection(s), single tendon sheath or ligament, aponeurosis
	129	64483	4.9%	Injection, anesthesia agent or steroid, lumbar or sacral, single level
	130	12001	4.8%	Simple repair of superficial wounds of scalp, neck, axilae, external genitalia, trunk and/or extremities, 2.5/less
	131	20605	3.6%	Arthrocentesis, intermediate joint or bursa
	132	64475	3.3%	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve, lumbar or sacral, single level
	133	29125	3.1%	Application of short arm splint, static
	134	90471	3.1%	Immunization administration, 1 vaccine
	135	64476	3.0%	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; lumbar or sacral, each additional level
	136	12002	2.7%	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities, 2.6-7.5
	137	64415	2.1%	Injection, anesthetic agent, brachial plexus, single
	138	62310	2.1%	Injection, single, not including neurolytic substances, cervical or thoracic
	139	64484	2.0%	Injection, anesthetic agent and/or steroid, transforaminal epidural, lumbar or sacral, each additional level
	140	20552	1.9%	Injections, single or multiple trigger point(s), 1 or 2 muscle(s)
	141	20680	1.9%	Removal of implant, deep
	142	64450	1.8%	Injection, anesthetic agent, other peripheral nerve branch
	143	29075	1.6%	Application, cast, elbow to finger

continued

Table TA.1 Marketbasket Procedures (continued)

Service Group	Procedure	CPT Code	Percentage Frequency[a]	Description
Surgical Treatment (continued)	144	29130	1.4%	Application of finger splint; static
	145	62290	1.3%	Injection procedure for diskography, each level, lumbar
	146	27096	1.3%	Injection procedure, sacroiliac joint
	147	29220	1.3%	Strapping, low back
	148	62284	1.3%	Injection procedure for myelography and/or computed tomography, spinal
	149	23350	1.3%	Injection procedure, shoulder arthrography
	150	64550	1.2%	Application surface neurostimulator
	151	29515	1.2%	Application of short leg splint
	152	16020	1.2%	Dressings and/or debridement, initial or subsequent, without anesthesia, office or hospital, small
	153	20600	1.1%	Arthrocentesis, aspiration and/or injection, small joint or bursa
	154	29260	1.1%	Strapping, elbow or wrist
	155	97597	1.0%	Removal of devitalized tissue from wound, selective debridement without anesthesia, wound assessment, total wound surface area less than or equal 20 square cm
	156	29540	1.0%	Strapping, ankle and/or foot
	157	11042	1.0%	Debridement, skin and subcutaneous tissue
	158	64470	1.0%	Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve, cervical or thoracic, single level
	159	20553	1.0%	Injection(s), single or multiple trigger point(s), 3 or more muscle(s)
	160	29405	0.9%	Application of short leg cast
	161	65222	0.9%	Removal of foreign body, external eye, corneal, with slit lamp
	162	64472	0.9%	Injection, anesthesia agent or steroid, paravertebral facet joint or facet joint nerve, cervical or thoracic, each additional level
	163	29530	0.9%	Strapping, knee
	164	26055	0.8%	Tendon sheath incision
	165	11760	0.7%	Repair of nail bed
	166	64510	0.7%	Injection, anesthetic agent, stellate ganglion
	167	11012	0.7%	Debridement including removal of foreign matter, skin, subcutaneous tissue, muscle and bone
	168	20551	0.6%	Injection(s), single tendon origin/insertion
	169	11040	0.6%	Debridement, skin, partial thickness
	170	64623	0.6%	Destruction by neurolytic agent, paravertebral facet joint nerve, lumbar or sacral, each additional level
	171	64520	0.6%	Injection, anesthetic agent, lumbar or thoracic
	172	12011	0.6%	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes, 2.5 cm or less
	173	20526	0.6%	Injection, therapeutic, carpal tunnel
	174	64622	0.5%	Destruction by neurolytic agent, paravertebral facet joint nerve, lumbar or sacral, 1 level
	175	20670	0.5%	Removal of implant, superficial

[a] Percentage frequency is the frequency of each CPT code within the marketbasket for that service group.

Key: ACL: anterior cruciate ligament; CPT: Current Procedural Terminology; EMG: electromyography; MRI: magnetic resonance imaging; ROM: range of motion; SLAP: superior labral anterior-posterior.

Table TA.2 Description of Marketbasket Contents

Service Group	Number of Codes	% Expenditures Captured by Marketbasket Codes	% Expenditures in Population
Emergency	5	91%	2%
Evaluation and management	13	92%	23%
Major radiology	12	84%	10%
Minor radiology	33	82%	3%
Neurological testing	10	88%	4%
Physical medicine	22	93%	34%
Major surgery	30	65%	18%
Surgical treatment	50	56%	7%
Totals	175	75%	100%

Note: The numbers in this table reflect the 14-state pooled sample from 2005–2006 used to select the marketbasket.

If a state has very different utilization patterns than is seen overall in the 14 states used to create the marketbasket, the results for that state could be biased. If, for example, a state uses significantly more of certain types of physical medicine services and significantly less surgery, the marketbasket weights might overweight surgery and underweight physical medicine as applicable for that state. The sensitivity test shown in Table TA.3 illustrates that the procedures in the marketbasket do represent the majority of the total expenditures for most states.[16] For emergency procedures, the marketbasket captures 79 percent or more of total expenditures in nearly all states. For evaluation and management procedures, the marketbasket captures 88 percent or more of total expenditures. For physical medicine and neurological testing services, the marketbasket captures 75 percent or more of total expenditures in almost all states.[17] The procedures in the marketbasket represent more than 70 percent of total expenditures in major radiology services across all states (except Vermont where 59 percent of total expenditures are captured), and 55 to nearly 80 percent of minor radiology services in most states.[18] For major surgery and surgical treatment, the procedures in the marketbasket represent 50 to 65 percent of total expenditures in most of the states.

[16] For some state/service group cells the notation ‡ is shown. In these cells the underlying claim counts from the DBE were less than 200 and therefore highly unlikely to be representative of the state experience. In these instances a percent of expenditures is not shown.

[17] For physical medicine services, the marketbasket captures 51 percent of total expenditures in Louisiana and 64 percent in Texas. For neurological testing services, the marketbasket captures 65 percent of total expenditures in Louisiana and 63 percent in Oklahoma.

[18] The only exceptions are Florida and Vermont where the marketbasket captures 52 percent and 50 percent of the total expenditures in minor radiology services respectively.

Table TA.3 Percentage of Expenditures Represented by the Marketbasket by State and Service Group

State	Overall	ER Services	E&M	Major Radiology	Minor Radiology	Neuro. Testing	Physical Medicine	Major Surgery	Surgical Treatment
Alabama	78%	95%	92%	83%	76%	89%	90%	65%	55%
Alaska	78%	96%	88%	83%	59%	85%	94%	56%	60%
Arizona	83%	94%	94%	73%	77%	86%	96%	55%	56%
Arkansas	79%	94%	94%	83%	74%	91%	94%	58%	58%
California	76%	96%	88%	87%	63%	87%	79%	58%	50%
Colorado	81%	93%	96%	75%	63%	75%	91%	62%	64%
Connecticut	80%	89%	97%	83%	73%	87%	96%	61%	57%
Delaware	79%	97%	96%	82%	57%	89%	86%	59%	69%
Florida	76%	96%	92%	82%	52%	88%	87%	61%	62%
Georgia	78%	93%	94%	82%	65%	84%	93%	55%	58%
Hawaii	91%	97%	97%	87%	81%	98%	92%	74%	66%
Idaho	75%	82%	93%	81%	74%	91%	91%	60%	56%
Illinois	76%	94%	92%	82%	65%	87%	85%	62%	56%
Kansas	76%	93%	93%	83%	68%	93%	89%	57%	62%
Kentucky	80%	97%	95%	80%	66%	91%	90%	58%	62%
Louisiana	66%	94%	90%	83%	56%	65%	51%	53%	64%
Maine	89%	‡	98%	90%	63%	96%	94%	62%	65%
Maryland	78%	93%	95%	84%	59%	85%	83%	54%	63%
Massachusetts	78%	97%	95%	85%	58%	83%	94%	61%	55%
Michigan	83%	97%	96%	79%	73%	94%	92%	55%	59%
Minnesota	80%	93%	94%	82%	62%	95%	86%	61%	65%
Mississippi	79%	94%	92%	84%	58%	93%	94%	61%	66%
Montana	78%	88%	93%	81%	68%	91%	97%	65%	58%
Nebraska	77%	90%	90%	85%	71%	94%	93%	63%	59%
Nevada	78%	96%	92%	80%	72%	79%	93%	63%	53%
New Mexico	84%	96%	96%	88%	65%	91%	95%	63%	64%
New York	83%	95%	89%	88%	61%	86%	96%	62%	60%
North Carolina	75%	91%	92%	81%	67%	87%	78%	60%	59%
North Dakota	‡	‡	‡	‡	‡	‡	‡	‡	‡
Ohio[a]	83%	n/c	96%	87%	70%	94%	96%	62%	56%
Oklahoma	79%	93%	95%	86%	72%	63%	95%	62%	57%
Oregon	83%	95%	95%	83%	69%	96%	94%	60%	62%
Pennsylvania	78%	95%	94%	80%	59%	85%	83%	55%	62%
Rhode Island[b]	80%	79%	98%	85%	72%	‡	n/c	66%	65%
South Carolina	79%	89%	93%	83%	55%	89%	93%	60%	61%
South Dakota	77%	91%	89%	82%	75%	‡	90%	62%	51%
Tennessee	80%	100%	95%	83%	72%	93%	91%	65%	60%
Texas	71%	96%	95%	80%	65%	84%	64%	53%	59%
Utah	81%	88%	96%	82%	74%	94%	97%	57%	57%
Vermont	80%	79%	96%	59%	50%	‡	89%	64%	63%
Washington	83%	88%	92%	81%	66%	97%	90%	67%	68%
West Virginia	86%	‡	97%	‡	‡	‡	‡	‡	‡
Wyoming	‡	‡	‡	‡	‡	‡	‡	‡	‡

‡ In these cells the underlying claim counts from the Detailed Benchmark/Evaluation (DBE) database were less than 200 and therefore highly unlikely to be representative of state experience. In these instances a percent of expenditures is not shown.

[a] Ohio does not establish rates for the emergency services included in the marketbasket.

[b] Rhode Island has different billing codes for physical medicine and does not establish rates for the majority of the codes.

Key: E&M: evaluation and management; ER: emergency; n/c: not comparable; Neuro.: neurological.

COMPUTING AGGREGATE RATES

To compute the aggregate rates for workers' compensation and Medicare two sets of weights were created. To aggregate from the CPT/procedure level rates to the service group rates, procedure-level frequency weights were utilized. The procedure-level frequency weight for a marketbasket code was calculated as the total number of services with that code divided by the total number of services across all marketbasket procedures within the service group. To aggregate from the service group level to the state level, service group frequency weights were employed. The frequency weight for a service group is the total number of services associated with a service group divided by the total number of all nonhospital services.

The procedure-level frequency weight can be expressed as the following:

$$v_{ij} = \frac{NS_{ij}}{\sum_{j=1}^{M_i} NS_{ij}}$$

where, v_{ij} is the procedure-level frequency weight for procedure code j in service group i,
NS_{ij} is the number of services for procedure code j in service group i,
$j = 1 \ldots M_i$ and M_i is the total number of procedure codes in service group i.

The frequency weight for a service group can be expressed as the following:

$$w_i = \frac{\sum_{j=1}^{M_i} NS_{ij}}{\sum_{i=1}^{N} \sum_{j=1}^{M_i} NS_{ij}}$$

where, w_i is the frequency weight for service group i,
NS_{ij} is the number of services for procedure code j in service group i,
$j = 1 \ldots M_i$ and M_i is the total number of procedure codes in service group i,
$i = 1 \ldots N$ and N is the total number of service groups.

Based on the established marketbasket, aggregate workers' compensation and Medicare rates were calculated using the following steps:

1. Aggregate rates across the marketbasket codes to the service group level using the procedure-level frequency weights in each state.
2. Aggregate rates across the service groups to the state level using the service group frequency weights in each state.
3. For interstate comparison, index the workers' compensation aggregate rates to the aggregate Medicare rates. That is, calculate the percentage above or below the aggregate Medicare rate the aggregate workers' compensation rates are at both the service group level and the state level for each state.

Step 1 can be expressed as the following:

$$P_i = \sum_{j=1}^{M_i} v_{ij} * P_{ij}$$

where, P_i is the aggregate rate for service group i,
P_{ij} is the rate for procedure code j in service group i,
v_{ij} is the procedure-level frequency weight for code j in service group i,
$j = 1 \ldots M_i$ and M_i is the total number of procedure codes in service group i.

Step 2 can be expressed as the following:

$$P_0 = \sum_{i=1}^{N} w_i * P_i$$

where, P_0 is the aggregate rate for overall nonhospital services (state level),
P_i is the aggregate rate for service group i,
w_i is the frequency weight for service group i,
$i = 1 \ldots N$ and N is the total number of service groups.

And step 3 can be expressed as the following:

$$I = \left(\frac{P^s}{P^{Med}} - 1 \right) * 100$$

where, I represents the workers' compensation rate indexed to the Medicare rate.
That is, the percent above or below Medicare the workers' compensation rates are for a state,
P^s is the workers' compensation rate (either for a service group or overall) in a state,
P^{Med} is the Medicare rate (either for a service group or for overall) in a state.

STATE-SPECIFIC RATE COMPUTATIONS

Two points are worth noting regarding the procedure codes: (1) CPT code conversion and crosswalking of the state-specific codes and (2) replacement of obsolete CPT codes by new codes over the period of analysis. First, some states (such as California, Louisiana, Massachusetts, North Carolina, and Texas) have their own state-specific codes for some services. For those states, the state-specific codes were crosswalked to the common definitions wherever possible; when this was not possible, the services were excluded from the analysis. For example, in Louisiana, where physical medicine services by physical therapists are billed using "PT/OT" codes, Louisiana code PT010/OT010 for hot or cold packs was mapped to CPT code 97010. The Louisiana PT/OT codes for therapeutic exercises or activities could not be mapped and thus were not included in the analysis. Because of this, the codes in the marketbasket for physical medicine services in Louisiana represent 51 percent of the total expenditures, rather than the more typical 80 to 97 percent (See

Table TA.3). Second, to maintain the continuity of the same services identified by the CPT codes, in some instances, certain CPT codes were combined to reflect changes in the coding system. For example, in California the codes 62275 and 62298 were combined using frequency weights from the DBE to establish the rate for marketbasket code 62310.

In two other states rates were not established for all the codes included in the marketbasket for a service group. In Ohio there were no rates established for the emergency services codes. In this instance the service group frequency weights (discussed earlier) were adjusted to account for the missing service group. Emergency services, as seen in Table TA.2, is by far the smallest service group, thus reweighting does not introduce significant bias in the state level results.[19] In Rhode Island most physical medicine services are not regulated under the fee schedule. Physical medicine, as seen in Table TA.2, is the largest service group. Reweighting the other service groups to account for physical medicine introduces a large bias in the state level results. Thus Rhode Island is not included in the state level comparisons but only in the service group level comparisons.

In three states, Louisiana, Minnesota, and Vermont, 26 percent to 28 percent of the codes for surgical treatment procedures did not have established rates under the workers' compensation fee schedule. These procedures represented 27 percent of the expenditures in the service group. For these three states the procedure-level frequency weights (discussed earlier) were adjusted to account for the missing rates at the service group level. Treating these service groups as missing, as done with Ohio above, produced results at the state level that were not significantly different from those calculated by reweighting the CPT codes.

In three states there was a seemingly large portion (14 percent to 23 percent) of CPT codes in a service group that did not have rates established. (In California this occurred for physical medicine and surgical treatment, and in Tennessee and Washington it happened for physical medicine.) These procedures represented from less than 1 percent to 3 percent of the service group expenditures in each state, thus no adjustment was made to either the procedure-level or service group weights in these cases. To the extent that the weights differ in these instances, the results may be under or over estimated.

Finally, Texas sets one conversion factor for surgery in a facility setting and another conversion factor for all the other medical services including surgery in an office setting. Surgeries in a facility setting are likely to be a more invasive procedures similar to those in the major surgery service group, thus the unique "surgery in a facility setting" conversion factor was applied to the major surgery service group. The "surgery in an office setting" conversion factor was applied to the surgical treatment service group.

INTERPRETING THE BENCHMARK INDICES

The benchmark, *I*, defined previously in step 3, compares the workers' compensation fee schedule in a given state to the Medicare fee schedule in the same state expressed as the percentage difference from Medicare (most often the premium over Medicare). Because both the aggregate workers' compensation rates and the aggregate Medicare rates use the same set of services, they are fully comparable.

Note that the aggregate workers' compensation fee schedule rate is designed to measure only fee schedule

[19] A sensitivity test was performed by removing emergency services from the marketbasket for all states and comparing the state level workers' compensation rates, state level Medicare rates, and interstate rankings with and without emergency services. The percentage difference between the state rates for both workers' compensation and Medicare were less than 1.3 percent in all states. The interstate ranking was only changed for two states, one moved up a single slot and the other moved down a single slot.

rates. It is not a measure of medical costs or actual medical prices paid, which may differ from the fee schedule.

MEDICARE AS A BENCHMARK FOR WORKERS' COMPENSATION FEE SCHEDULES

Policymakers have shown increasing interest in Medicare as a benchmark to measure workers' compensation fee schedule rates. The Medicare Resource-Based Relative Value Scale (RBRVS) can provide a useful guide to help design workers' compensation fee schedules. It is recognized that there are many concerns surrounding the Medicare system particularly in regard to the final fee schedule rates that are established. These rates are often criticized as being low. In this study it is acknowledged that the optimal level of fee schedule rates is likely not the same as Medicare.

This study utilizes the relative differences in provider expenses across geographic areas established by Medicare through the design of the RBRVS. There are three aspects of Medicare that are important to discuss when using Medicare as a benchmark: the conversion factor (i.e., level), the relative values of services, and the geographic variation in rates. The Medicare rates are established by multiplying geographically adjusted service specific relative value units (RVUs) by a federally established conversion factor that is constant across all services. Each of the three aspects is discussed in turn below.

The Medicare conversion factor is established annually and is the same for all states (or parts of states) and services. For individual procedure codes, the Medicare rates resulting from the chosen conversion factor are not recognized as optimal levels of workers' compensation fee schedule rates in this study. The conversion factor is determined each year partially dependent on the federal budget, therefore introducing a bias that is not related to provider expenses of delivering care.

The Medicare RBRVS ranks services according to the relative costs required to produce them. These costs are defined in terms of units with more complex, time-consuming services, say a shoulder arthroscopy, having higher unit values than less complex, less time-consuming services, perhaps an office visit. The components of the RBRVS reflect several aspects of provider expenses for delivering care, such as the cost of the physician's time and skill (physician work or work value), rent, office staff, supplies, and equipment (physician expense or PE value), as well as malpractice insurance. The Medicare RBRVS, (not the rates themselves but the relative values), provides a good benchmark for evaluating the relationship between fee schedule rates and the provider expenses of delivering care among different services.

The third aspect of Medicare is geographic variation in rates. Each of the components above, work value, PE value, and malpractice insurance, are adjusted before determining the Medicare payment value in a state (or part of state). This adjustment occurs as costs vary according to geographic area. The Centers for Medicare & Medicaid Services (CMS) establishes geographic practice cost indices (GPCIs) for each of the three components in each state (several states have more than one GPCI in the state). Use of the GPCIs explicitly measures area differences in provider expenses of delivering care from state to state.

Because of the RBRVS methodology, the Medicare fee schedule neutralizes the incentives for providers to practice medicine in an unnecessarily costly and invasive manner. This is done by setting relative fee schedule rates according to the costs incurred by health care providers in delivering medical services. The RBRVS takes into account the required provider time, expertise, office practice expenses, malpractice insurance costs, etc. and reflects how these differ for different types of services in different geographic locations. The RBRVS design is based on a general population, not specific to a Medicare population or to an injured worker population. Thus, the Medicare RBRVS fee schedule seeks to equalize the economic returns across all services,

thereby eliminating incentives to overuse certain types of services because they produce a higher economic return.

The relative differences in the Medicare RBRVS across different services and regions are used in this study as an indicator of the relative market prices (that is, the differences in fees across service types and regions). It can therefore provide a good measure of the relative rates at which profitability can be equalized across different services and regions. The Medicare fee schedule rates themselves are not used to determine optimal fee schedule rates.

STATES WITH MULTIPLE REGIONAL WORKERS' COMPENSATION AND MEDICARE FEE SCHEDULES

Most states have one workers' compensation fee schedule for the entire state. However, different workers' compensation fee schedules are published by geographic region for six states. There are 3 geographic regions in Florida, 29 geographic regions in Illinois, 4 geographic regions in New York and Pennsylvania, 8 geographic regions in Texas, and 2 geographic regions in Delaware. To make these six states comparable to other states with a single fee schedule, composite fee schedule rates were created at both the service group and state level using employment population data from the latest U.S. Census and the Bureau of Labor Statistics as weights.

Composite fee schedule rates were created as follows: Pennsylvania's workers' compensation fee schedule defines fee schedule rates for four regions—Philadelphia; Suburbs of Philadelphia and Pittsburgh; Harrisburg and Vicinity; and rest of state—based on zip codes of localities. Using this information each zip code was mapped into a county and the counties into the four areas for which fee schedule rates were available. Next employment population data was pulled from the 2008 Bureau of Labor Statistics by county and employment weights were created and applied to the fee schedule rates by region. The same methodology was followed for Delaware, Florida, New York, and Texas. In Florida, physician fee schedule rates are published for the following regions: Dade and Monroe counties; Broward, Collier, Indian River, Lee, Martin, Palm Beach, and St. Lucie counties; and rest of state. In Delaware, physician fee schedule rates are published for two geozips 197 (three-digit zip codes 197 and 198) and 199, which generally correspond to Kent county combined with Sussex County and New Castle County respectively. In New York, physician fee schedule rates are published for four regions based on zip code. Texas publishes rates for 8 regions by county: Brazoria, Dallas, Galveston, Houston, Beaumont, Ft. Worth, Austin, and rest of state. The Illinois workers' compensation fee schedule defines fees for 29 three-digit zip code regions. For Illinois, employment population data from the 2000 U.S. Census by three-digit zip code region was used.

Similar to the workers' compensation fee schedules that publish separate rates for distinct geographic regions, the Centers for Medicare & Medicaid Services publishes Medicare fee schedule rates for multiple geographic areas in 14 of the 43 states including Florida, Illinois, New York, Pennsylvania, and Texas. The Centers for Medicare & Medicaid Services publishes different Medicare rates in three regions in Florida, in four regions in Illinois, in five regions in New York, in two regions in Pennsylvania, and in eight regions in Texas. Using zip code and county information, a single statewide fee schedule rate was created using employment population weights for the regions as defined in the states' Medicare fee schedules.

The premiums over Medicare by region are presented in Tables TA.4a–f. The two Delaware regions are compared to the single statewide Medicare rate in Table TA.4a. Rates are presented in Table TA.4b for each of the three Florida workers' compensation regions as they correspond directly to the Medicare regions. For Pennsylvania, Table TA.4e, zip code and county data were used to determine that the unique workers'

compensation regions 1 and 2 were most comparable to the Medicare metropolitan Philadelphia region and the unique workers' compensation regions 3 and 4 were most comparable to the combined Medicare regions Harrisburg and vicinity and rest of state. In New York, combined regions 3 and 4, were found to be most comparable to the combined Medicare regions Manhattan, Queens, and New York City suburbs and Long Island. New York workers' compensation combined regions 1 and 2 were found to be comparable to Poughkeepsie and Suburbs and rest of state as shown in Table TA.4d. Premiums over Medicare are presented in Table TA.4f for four fee schedule areas in Texas. In Texas the workers' compensation regions correspond directly to the Medicare regions. For Illinois, premiums over Medicare are presented in Table TA.4c for the highest, lowest, and median of the different fee schedule areas in the state as well as for Chicago. Zip code and county data were used to determine the corresponding workers' compensation geozips and Medicare regions in Illinois.[20]

COMPARABILITY WITH THE 2006 STUDY

The methodology used in this study is similar to that in the 2006 study. However, the numbers in the studies are not directly comparable due to several major differences. The marketbasket used in this study is smaller than that used in 2006. This study has eight service groups compared to five in the 2006 study. This is consistent with the MPI-WC and CompScope™ Medical studies. This study uses frequency weights at the state level rather than expenditure weights as used in the 2006 study. One state has joined the ranks of fee schedule states since the earlier WCRI study. Delaware published a medical fee schedule on May 23, 2008 and implementation of the fee schedule by system participants occurred over time. Rhode Island is no longer compared at the state level but is compared at the service group level.

The two studies may be compared at the state level with caution. The new marketbasket in conjunction with the new weighting scheme is likely to have affected the results in some fashion. The reader should be aware that small intertemporal changes may be due to the differences in the methodology between the studies rather than real changes in a state. Large intertemporal differences, however, are more likely to be real within state changes. The addition of Delaware and deletion of Rhode Island at the state level should not greatly affect interstate comparisons between the 2006 and 2009 studies as Rhode Island was the third highest state in 2006 and Delaware is the third highest state in 2009.

At the service group level intertemporal comparisons are difficult if possible to make. This is due primarily to the different definitions of service groups in the two studies. The reader may be inclined to mutually compare the 2006 group evaluation and management to the 2009 groups emergency services and evaluation and management or the 2006 radiology service group to the 2009 groups major radiology and minor radiology or the 2006 group surgery to the 2009 groups surgical treatment and major surgery. The reader should exhibit caution in making such comparisons as states may have changed rates within different service groups at different rates over time which may not be made obvious with such comparisons. Further, the reader should keep in mind that the underlying marketbasket codes for the service groups vary from 2006 to 2009. The procedure level rates presented in Table 2 of this study and Table 1 of the 2006 study are completely comparable for CPT codes 97110 and 99213.

[20] Geozips 600–605, 607, and 608 were found to correspond to Medicare region suburban Chicago. Geozip 606 was found to correspond to Medicare region Chicago. Geozips 620 and 622 were found to correspond to Medicare region East St. Louis. Geozips 609 to 619 and 623 to 629 were found to correspond to Medicare region rest of state. Another WCRI study details the comparisons for each of the 29 regions in Illinois (Eccleston, 2006).

Table TA.4a Delaware Workers' Compensation Fee Schedule Premium Over Medicare Fee Schedule by Service Group, December 2009

Service Group	Percentage Greater Than or Less Than Medicare			
	New Castle County; Geozip 197	Kent and Sussex County; Geozip 199	Delaware Composite of All Areas	Spread between the Highest and Lowest Percentage Difference
Emergency services	167	170	168	3
Evaluation & management	44	35	41	9
Major radiology	168	137	156	30
Minor radiology	269	209	246	60
Neurological testing	147	108	132	39
Physical medicine	101	86	95	15
Major surgery	375	339	362	36
Surgical treatment	192	149	176	43
Overall	139	118	131	21

Table TA.4b Florida Workers' Compensation Fee Schedule Premium Over Medicare Fee Schedule by Service Group, December 2009

Service Group	Percentage Greater Than or Less Than Medicare				
	Dade and Monroe Counties	Broward, Collier, Indian River, Lee, Martin, Palm Beach, and St. Lucie Counties	Rest of State	Florida Composite of All Areas	Spread between the Highest and Lowest Percentage Difference
Emergency services	4	4	4	4	0.7
Evaluation & management	6	7	6	6	0.3
Major radiology	-15	-15	-14	-14	1.2
Minor radiology	9	10	10	10	1.3
Neurological testing	14	14	14	14	0.7
Physical medicine	2	2	1	1	1.0
Major surgery	37	36	37	37	1.2
Surgical treatment	48	48	49	49	0.9
Overall	9	9	9	9	0.1

Table TA.4c Illinois Workers' Compensation Fee Schedule Premium Over Medicare Fee Schedule by Service Group, December 2009

Service Group	Percentage Greater Than or Less Than Medicare					
	Region with the Lowest Premium Over Medicare; Geozip 622	Region with the Median Premium Over Medicare; Geozip 610	Region with the Highest Premium Over Medicare; Geozip 618	Chicago; Geozip 606	Illinois Composite of All Areas	Spread between the Highest and Lowest Percentage Difference
Emergency services	170	156	244	192	219	87
Evaluation & management	30	49	81	66	54	50
Major radiology	150	232	357	187	214	208
Minor radiology	251	331	416	282	280	165
Neurological testing	142	355	456	277	259	315
Physical medicine	106	103	148	142	125	45
Major surgery	331	468	587	519	504	256
Surgical treatment	153	262	257	230	213	108
Overall	129	174	234	190	180	106

Table TA.4d New York Workers' Compensation Fee Schedule Premium Over Medicare Fee Schedule by Service Group, December 2009

Service Group	Percentage Greater Than or Less Than Medicare			
	WC Sub-State Regions 3&4 Compared to Medicare Regions Manhattan, Queens, and NYC/Long Island	WC Sub-State Regions 1&2 Compared to Medicare Regions Poughkeepsie & North NYC Suburbs and Rest of State	New York Composite of All Areas	Spread between the Highest and Lowest Percentage Difference
Emergency services	51	34	46	16
Evaluation & management	-26	-31	-27	4
Major radiology	33	41	36	8
Minor radiology	101	108	104	7
Neurological testing	93	93	94	1
Physical medicine	3	-3	1	7
Major surgery	170	164	169	7
Surgical treatment	-6	-6	-5	1
Overall	25	21	24	4

Key: NYC: New York City; WC: workers' compensation.

Table TA.4e Pennsylvania Workers' Compensation Fee Schedule Premium Over Medicare Fee Schedule by Service Group, December 2009

Service Group	Percentage Greater Than or Less Than Medicare					
	WC Sub-State Region 1 Compared to Medicare Region Metropolitan Philadelphia	WC Sub-State Region 2 Compared to Medicare Region Metropolitan Philadelphia	WC Sub-State Region 3 Compared to Medicare Region Harrisburg and Vicinity and Rest of State	WC Sub-State Region 4 Compared to Medicare Region Harrisburg and Vicinity and Rest of State	Pennsylvania Composite of All Areas	Spread between the Highest and Lowest Percentage Difference
Emergency services	26	22	21	23	24	5
Evaluation & management	7	4	6	4	8	3
Major radiology	57	56	72	69	69	16
Minor radiology	62	60	76	71	72	16
Neurological testing	32	34	43	42	42	11
Physical medicine	36	31	40	38	38	9
Major surgery	122	117	131	126	129	14
Surgical treatment	34	25	37	37	35	12
Overall	42	38	46	44	45	8

Key: WC: workers' compensation.

Table TA.4f Texas Workers' Compensation Fee Schedule Premium Over Medicare Fee Schedule by Service Group, December 2009

Service Group	Percentage Greater Than or Less Than Medicare					
	Austin	Dallas	Houston	Rest of State	Texas Composite of All Areas	Spread between the Highest and Lowest Percentage Difference
Emergency services	49	49	49	49	49	0
Evaluation & management	49	49	49	49	49	0
Major radiology	49	49	49	49	49	0
Minor radiology	49	49	49	49	49	0
Neurological testing	49	49	49	49	49	0
Physical medicine	49	49	49	49	49	0
Major surgery	86	86	86	86	86	0
Surgical treatment	49	49	49	49	49	0
Overall	53	54	54	54	54	0

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Nicole M. Coomer
Te-Chun Liu
Cambridge, MA
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APPENDIX D

Medicare Claims Processing Manual

Chapter 12 - Physicians/Nonphysician Practitioners

Section 40 – Surgeons and Global Surgery

Effective October 25, 2005, G0372 will be used to recognize additional physician services and resources required to establish and document the need for the PMD and will be added to the Medicare physician fee schedule.

30.6.16 - Case Management Services (Codes 99362 and 99371 - 99373)

(Rev. 1, 10-01-03)
B3-15512

A. Team Conferences

Team conferences (codes 99361-99362) may not be paid separately. Payment for these services is included in the payment for the services to which they relate.

B. Telephone Calls

Telephone calls (codes 99371-99373) may not be paid separately. Payment for telephone calls is included in payment for billable services (e.g., visit, surgery, diagnostic procedure results).

40 - Surgeons and Global Surgery

(Rev. 1, 10-01-03)

B3-4820

A national definition of a global surgical package has been established to ensure that payment is made consistently for the same services across all carrier jurisdictions, thus preventing Medicare payments for services that are more or less comprehensive than intended. The national global surgery policy became effective for surgeries performed on and after January 1, 1992.

The instructions that follow describe the components of a global surgical package and payment rules for minor surgeries, endoscopies and global surgical packages that are split between two or more physicians. In addition, billing, mandatory edits, claims review, adjudication, and postpayment instructions are included.

In addition to the global policy, uniform payment policies and claims processing requirements have been established for other surgical issues, including bilateral and multiple surgeries, co-surgeons, and team surgeries.

40.1 - Definition of a Global Surgical Package

(Rev. 1, 10-01-03)

B3-4821, B3-15900.2

Field 16 of the Medicare Fee Schedule Data Base (MFSDB) provides the postoperative periods that apply to each surgical procedure. The payment rules for surgical procedures apply to codes with entries of 000, 010, 090, and, sometimes, YYY.

Codes with "090" in Field 16 are major surgeries. Codes with "000" or "010" are either minor surgical procedures or endoscopies.

Codes with "YYY" are carrier-priced codes, for which carriers determine the global period (the global period for these codes will be 0, 10, or 90 days). Note that not all carrier-priced codes have a "YYY" global surgical indicator; sometimes the global period is specified.

While codes with "ZZZ" are surgical codes, they are add-on codes that are always billed with another service. There is no postoperative work included in the fee schedule payment for the "ZZZ" codes. Payment is made for both the primary and the add-on codes, and the global period assigned is applied to the primary code.

A. Components of a Global Surgical Package

(Rev. 1, 10-01-03)

B3-15011, B3-4820-4831

Carriers apply the national definition of a global surgical package to all procedures with the appropriate entry in Field 16 of the MFSDB.

The Medicare approved amount for these procedures includes payment for the following services related to the surgery when furnished by the physician who performs the surgery. The services included in the global surgical package may be furnished in any setting, e.g., in hospitals, ASCs, physicians' offices. Visits to a patient in an intensive care or critical care unit are also included if made by the surgeon. However, critical care services (99291 and 99292) are payable separately in some situations.

- Preoperative Visits - Preoperative visits after the decision is made to operate beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures;

- Intra-operative Services - Intra-operative services that are normally a usual and necessary part of a surgical procedure;

- Complications Following Surgery - All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room;

- Postoperative Visits - Follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery;

- Postsurgical Pain Management - By the surgeon;

- Supplies - Except for those identified as exclusions; and

- Miscellaneous Services - Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

B. Services Not Included in the Global Surgical Package

Carriers do not include the services listed below in the payment amount for a procedure with the appropriate indicator in Field 16 of the MFSDB. These services may be paid for separately.

- The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery. Please note that this policy only applies to major surgical procedures. The initial evaluation is always included in the allowance for a minor surgical procedure;

- Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care. This agreement may be in the form of a letter or an annotation in the discharge summary, hospital record, or ASC record;

- Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery;

- Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery;

- Diagnostic tests and procedures, including diagnostic radiological procedures;

- Clearly distinct surgical procedures during the postoperative period which are not re-operations or treatment for complications. (A new postoperative period begins with the subsequent procedure.) This includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Examples of this are procedures to diagnose and treat epilepsy (codes 61533, 61534-61536, 61539, 61541, and 61543) which may be performed in succession within 90 days of each other;

- Treatment for postoperative complications which requires a return trip to the operating room (OR). An OR for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR);

- If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately;

- For certain services performed in a physician's office, separate payment can no longer be made for a surgical tray (code A4550). This code is now a Status B and is no longer a separately payable service on or after January 1, 2002. However, splints and casting supplies are payable separately under the reasonable charge payment methodology;

- Immunosuppressive therapy for organ transplants; and

- Critical care services (codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.

C. Minor Surgeries and Endoscopies

Visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed. For example, a visit on the same day could be properly billed in addition to suturing a scalp wound if a full neurological examination is made for a patient with head trauma. Billing for a visit would not be appropriate if the physician only identified the need for sutures and confirmed allergy and immunization status.

A postoperative period of 10 days applies to some minor surgeries. The postoperative period for these procedures is indicated in Field 16 of the MFSDB. If the Field 16 entry is 010, carriers do not allow separate payment for postoperative visits or services within 10 days of the surgery that are related to recovery from the procedure. If a diagnostic biopsy with a 10-day global period precedes a major surgery on the same day or in the 10-day period, the major surgery is payable separately. Services by other physicians are not included in the global fee for a minor procedures except as otherwise excluded. If the Field 16 entry is 000, postoperative visits beyond the day of the procedure are not included in the payment amount for the surgery. Separate payment is made in this instance.

D. Physicians Furnishing Less Than the Full Global Package

B3-4820-4831

There are occasions when more than one physician provides services included in the global surgical package. It may be the case that the physician who performs the surgical procedure does not furnish the follow-up care. Payment for the postoperative, post-discharge care is split between two or more physicians where the physicians agree on the transfer of care.

When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single physician provides all services (except where stated policies,

e.g., the surgeon performs only the surgery and a physician other than the surgeon provides preoperative and postoperative inpatient care, result in payment that is higher than the global allowed amount).

Where a transfer of care does not occur, the services of another physician may either be paid separately or denied for medical necessity reasons, depending on the circumstances of the case.

E. Determining the Duration of a Global Period

To determine the global period for major surgeries, carriers count 1 day immediately before the day of surgery, the day of surgery, and the 90 days immediately following the day of surgery.

EXAMPLE:

Date of surgery - January 5

Preoperative period - January 4

Last day of postoperative period - April 5

To determine the global period for minor procedures, carriers count the day of surgery and the appropriate number of days immediately following the date of surgery.

EXAMPLE:

Procedure with 10 follow-up days:

Date of surgery - January 5

Last day of postoperative period - January 15

40.2 - Billing Requirements for Global Surgeries

(Rev. 1, 10-01-03)

B3-4822

To ensure the proper identification of services that are, or are not, included in the global package, the following procedures apply.

A. Procedure Codes and Modifiers

Use of the modifiers in this section apply to both major procedures with a 90-day postoperative period and minor procedures with a 10-day postoperative period (and/or a zero day postoperative period in the case of modifiers "-22" and "-25").

1. Physicians Who Furnish the Entire Global Surgical Package

Physicians who perform the surgery and furnish all of the usual pre-and postoperative work bill for the global package by entering the appropriate CPT code for the surgical procedure only. Billing is not allowed for visits or other services that are included in the global package.

2. Physicians in Group Practice

When different physicians in a group practice participate in the care of the patient, the group bills for the entire global package if the physicians reassign benefits to the group. The physician who performs the surgery is shown as the performing physician. (For dates of service prior to January 1, 1994, however, where a new physician furnishes the entire postoperative care, the group billed for the surgical care and the postoperative care as separate line items with the appropriate modifiers.)

3. Physicians Who Furnish Part of a Global Surgical Package

Where physicians agree on the transfer of care during the global period, the following modifiers are used:

- "-54" for surgical care only; or
- "-55" for postoperative management only.

Both the bill for the surgical care only and the bill for the postoperative care only, will contain the same date of service and the same surgical procedure code, with the services distinguished by the use of the appropriate modifier.

Providers need not specify on the claim that care has been transferred. However, the date on which care was relinquished or assumed, as applicable, must be shown on the claim. This should be indicated in the remarks field/free text segment on the claim form/format. Both the surgeon and the physician providing the postoperative care must keep a copy of the written transfer agreement in the beneficiary's medical record.

Where a transfer of postoperative care occurs, the receiving physician cannot bill for any part of the global services until he/she has provided at least one service. Once the physician has seen the patient, that physician may bill for the period beginning with the date on which he/she assumes care of the patient.

EXCEPTIONS:

- Where a transfer of care does not occur, occasional post-discharge services of a physician other than the surgeon are reported by the appropriate evaluation and management code. No modifiers are necessary on the claim.
- If the transfer of care occurs immediately after surgery, the physician other than the surgeon who provides the in-hospital postoperative care bills using subsequent hospital care codes for the inpatient hospital care and the surgical code with the "-

55" modifier for the post-discharge care. The surgeon bills the surgery code with the "-54" modifier.

- Physicians who provide follow-up services for minor procedures performed in emergency departments bill the appropriate level of office visit code. The physician who performs the emergency room service bills for the surgical procedure without a modifier.

- If the services of a physician other than the surgeon are required during a postoperative period for an underlying condition or medical complication, the other physician reports the appropriate evaluation and management code. No modifiers are necessary on the claim. An example is a cardiologist who manages underlying cardiovascular conditions of a patient.

4. Evaluation and Management Service Resulting in the Initial Decision to Perform Surgery

Evaluation and management services on the day before major surgery or on the day of major surgery that result in the initial decision to perform the surgery are not included in the global surgery payment for the major surgery and, therefore, may be billed and paid separately.

In addition to the CPT evaluation and management code, modifier "-57" (decision for surgery) is used to identify a visit which results in the initial decision to perform surgery. (Modifier "-QI" was used for dates of service prior to January 1, 1994.)

If evaluation and management services occur on the day of surgery, the physician bills using modifier "-57," not "-25." The "-57" modifier is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. Moreover, where the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine preoperative service and a visit or consultation is not billed in addition to the procedure.

5. Return Trips to the Operating Room During the Postoperative Period

When treatment for complications requires a return trip to the operating room, physicians must bill the CPT code that describes the procedure(s) performed during the return trip. If no such code exists, use the unspecified procedure code in the correct series, i.e., 47999 or 64999. The procedure code for the original surgery is not used except when the **identical** procedure is repeated.

In addition to the CPT code, physicians use CPT modifier "-78" for these return trips (return to the operating room for a related procedure during a postoperative period.)

The physician may also need to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first procedure and requires the use of the operating room,

this circumstance may be reported by adding the modifier "-78" to the related procedure.

NOTE: The CPT definition for this modifier does not limit its use to treatment for complications.

6. Staged or Related Procedures

Modifier "-58" was established to facilitate billing of staged or related surgical procedures done during the postoperative period of the first procedure. This modifier is not used to report the treatment of a problem that requires a return to the operating room.

The physician may need to indicate that the performance of a procedure or service during the postoperative period was:

a. Planned prospectively or at the time of the original procedure;

b. More extensive than the original procedure; or

c. For therapy following a diagnostic surgical procedure.

These circumstances may be reported by adding modifier "-58" to the staged procedure. A new postoperative period begins when the next procedure in the series is billed.

7. Unrelated Procedures or Visits During the Postoperative Period

Two CPT modifiers were established to simplify billing for visits and other procedures which are furnished during the postoperative period of a surgical procedure, but which are not included in the payment for the surgical procedure.

Modifier "-79": Reports an unrelated procedure by the same physician during a postoperative period. The physician may need to indicate that the performance of a procedure or service during a postoperative period was unrelated to the original procedure.

A new postoperative period begins when the unrelated procedure is billed.

Modifier "-24": Reports an unrelated evaluation and management service by same physician during a postoperative period. The physician may need to indicate that an evaluation and management service was performed during the postoperative period of an unrelated procedure. This circumstance is reported by adding the modifier "-24" to the appropriate level of evaluation and management service.

Services submitted with the "-24" modifier must be sufficiently documented to establish that the visit was unrelated to the surgery. An ICD-9-CM code that clearly

indicates that the reason for the encounter was unrelated to the surgery is acceptable documentation.

A physician who is responsible for postoperative care and has reported and been paid using modifier "-55" also uses modifier "-24" to report any unrelated visits.

8. Significant Evaluation and Management on the Day of a Procedure

Modifier "-25" is used to facilitate billing of evaluation and management services on the day of a procedure for which separate payment may be made.

It is used to report a significant, separately identifiable evaluation and management service by same physician on the day of a procedure. The physician may need to indicate that on the day a procedure or service that is identified with a CPT code was performed, the patient's condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure or service that was performed. This circumstance may be reported by adding the modifier "-25" to the appropriate level of evaluation and management service.

Claims containing evaluation and management codes with modifier "-25" are not subject to prepayment review except in the following situations:

- Effective January 1, 1995, all evaluation and management services provided on the same day as inpatient dialysis are denied without review with the exception of CPT Codes 99221-9223, 99251-99255, and 99238. These codes may be billed with modifier "-25" and reviewed for possible allowance if the evaluation and management service is unrelated to the treatment of ESRD and was not, and could not, have been provided during the dialysis treatment;

- When preoperative critical care codes are being billed for within a global surgical period; and

- When carriers have conducted a specific medical review process and determined, after reviewing the data, that an individual or group have high statistics in terms of the use of modifier "-25," have done a case-by-case review of the records to verify that the use of modifier "-25" was inappropriate, and have educated the individual or group as to the proper use of this modifier.

9. Critical Care

Critical care services provided during a global surgical period for a seriously injured or burned patient are not considered related to a surgical procedure and may be paid separately under the following circumstances.

Preoperative and postoperative critical care may be paid in addition to a global fee if:

- The patient is critically ill and requires the constant attendance of the physician; and

- The critical care is above and beyond, and, in most instances, unrelated to the specific anatomic injury or general surgical procedure performed.

Such patients are potentially unstable or have conditions that could pose a significant threat to life or risk of prolonged impairment.

In order for these services to be paid, two reporting requirements must be met:

- Codes 99291/99292 and modifier "-25" (for preoperative care) or "-24" (for postoperative care) must be used; and

- Documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. An ICD-9-CM code in the range 800.0 through 959.9 (except 930-939), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

10. Unusual Circumstances

Surgeries for which services performed are significantly greater than usually required may be billed with the "-22" modifier added to the CPT code for the procedure. Surgeries for which services performed are significantly less than usually required may be billed with the "-52" modifier. The biller must provide:

- A concise statement about how the service differs from the usual; and

- An operative report with the claim.

Modifier "-22" should only be reported with procedure codes that have a global period of 0, 10, or 90 days. There is no such restriction on the use of modifier "-52."

B. Date(s) of Service

Physicians, who bill for the entire global surgical package or for only a portion of the care, must enter the date on which the surgical procedure was performed in the "From/To" date of service field. This will enable carriers to relate all appropriate billings to the correct surgery. Physicians who share postoperative management with another physician must submit additional information showing when they assumed and relinquished responsibility for the postoperative care. If the physician who performed the surgery relinquishes care at the time of discharge, he or she need only show the date of surgery when billing with modifier "-54."

However, if the surgeon also cares for the patient for some period following discharge, the surgeon must show the date of surgery and the date on which postoperative care was relinquished to another physician. The physician providing the remaining postoperative care must show the date care was assumed. This information should be shown in Item 19

on the paper Form CMS-1500, in the narrative portion of the HA0 record on the National Standard Format, and in the NTE segment for ANSI X12N electronic claims.

C. Care Provided in Different Payment Localities

If portions of the global period are provided in different payment localities, the services should be billed to the carriers servicing each applicable payment locality. For example, if the surgery is performed in one state and the postoperative care is provided in another state, the surgery is billed with modifier "-54" to the carrier servicing the payment locality where the surgery was performed and the postoperative care is billed with modifier "-55" to the carrier servicing the payment locality where the postoperative care was performed. This is true whether the services were performed by the same physician/group or different physicians/groups.

D. Health Professional Shortage Area (HPSA) Payments for Services Which are Subject to the Global Surgery Rules

HPSA bonus payments may be made for global surgeries when the services are provided in HPSAs. The following are guidelines for the appropriate billing procedures:

- If the entire global package is provided in a HPSA, physicians should bill for the appropriate global surgical code with the applicable HPSA modifier.

- If only a portion of the global package is provided in a HPSA, the physician should bill using a HPSA modifier for the portion which is provided in the HPSA.

EXAMPLE

The surgical portion of the global service is provided in a non-HPSA and the postoperative portion is provided in a HPSA. The surgical portion should be billed with the "-54" modifier and no HPSA modifier. The postoperative portion should be billed with the "-55" modifier and the appropriate HPSA modifier. The 10 percent bonus will be paid on the appropriate postoperative portion only. If a claim is submitted with a global surgical code and a HPSA modifier, the carrier assumes that the entire global service was provided in a HPSA in the absence of evidence otherwise.

NOTE: The sum of the payments made for the surgical and postoperative services provided in different localities will not equal the global amount in either of the localities because of geographic adjustments made through the Geographic Practice Cost Indices.

40.3 - Claims Review for Global Surgeries

(Rev. 1, 10-01-03)

B3-4823

A. Relationship to Correct Coding Initiative (CCI)

The CCI policy and computer edits allow carriers to detect instances of fragmented billing for certain intra-operative services and other services furnished on the same day as the surgery that are considered to be components of the surgical procedure and, therefore, included in the global surgical fee. When both correct coding and global surgery edits apply to the same claim, carriers first apply the correct coding edits, then, apply the global surgery edits to the correctly coded services.

B. Prepayment Edits to Detect Separate Billing of Services Included in the Global Package

In addition to the correct coding edits, carriers must be capable of detecting certain other services included in the payment for a major or minor surgery or for an endoscopy. On a prepayment basis, carriers identify the services that meet the following conditions:

- Preoperative services that are submitted on the same claim or on a subsequent claim as a surgical procedure; or
- Same day or postoperative services that are submitted on the same claim or on a subsequent claim as a surgical procedure or endoscopy;
- and -
- Services that were furnished within the prescribed global period of the surgical procedure;
- Services that are billed without modifier "-78," "-79," "-24," "25," or "-57" or are billed with modifier "-24" but without the required documentation; and
- Services that are billed with the same provider or group number as the surgical procedure or endoscopy. Also, edit for any visits billed separately during the postoperative period without modifier "-24" by a physician who billed for the postoperative care only with modifier "-55."

Carriers use the following evaluation and management codes in establishing edits for visits included in the global package. CPT codes 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 99271, 99272, 99273, 99274, and 99275 have been transferred from the excluded category and are now included in the global surgery edits.

Evaluation and Management Codes for Carrier Edits

92012	92014	99211	99212	99213	99214
99215	99217	99218	99219	99220	99221
99222	99223	99231	99232	99233	99234

99235	99236	99238	99239	99241	99242
99243	99244	99245	99251	99252	99253
99254	99255	99261	99262	99263	99271
99272	99273	99274	99275	99291	99292
99301	99302	99303	99311	99312	99313
99315	99316	99331	99332	99333	99347
99348	99349	99350			
99374	99375	99377	99378		

NOTE: In order for codes 99291 or 99292 to be paid for services furnished during the preoperative or postoperative period, modifier "-25" or "-24," respectively, must be used and documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. An ICD-9-CM code in the range 800.0 through 959.9 (except 930-939), which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

If a surgeon is admitting a patient to a nursing facility for a condition not related to the global surgical procedure, the physician should bill for the nursing facility admission and care with a "-24" modifier and appropriate documentation. If a surgeon is admitting a patient to a nursing facility and the patient's admission to that facility relates to the global surgical procedure, the nursing facility admission and any services related to the global surgical procedure are included in the global surgery fee.

C. Exclusions from Prepayment Edits

Carriers exclude the following services from the prepayment audit process and allow separate payment if all usual requirements are met:

Services listed in §40.1.B; and

Services billed with the modifier "-25," "-57," "-58," "-78," or "-79."

Exceptions

See §§40.2.A.8, 40.2.A.9, and 40.4.A for instances where prepayment review is required for modifier "-25." In addition, prepayment review is necessary for CPT codes 90935, 90937, 90945, and 90947 when a visit and modifier "-25" are billed with these services.

Exclude the following codes from the prepayment edits required in §40.3.B.

92002	92004	99201	99202	99203	99204
99205	99281	99282	99283	99284	99285
99321	99322	99323	99341	99342	99343
99344	99345				

40.4 - Adjudication of Claims for Global Surgeries

(Rev. 1, 10-01-03)

B3-4824, B3-4825, B3-7100-7120.7

A. Fragmented Billing of Services Included in the Global Package

Since the Medicare fee schedule amount for surgical procedures includes all services that are part of the global surgery package, carriers do not pay more than that amount when a bill is fragmented. When total charges for fragmented services exceed the global fee, process the claim as a fee schedule reduction (except where stated policies, e.g., the surgeon performs only the surgery and a physician other than the surgeon provides preoperative and postoperative inpatient care, result in payment that is higher than the global surgery allowed amount). Carriers do not attribute such reductions to medical review savings except where the usual medical review process results in recoding of a service, and the recoded service is included in the global surgery package.

The maximum a nonparticipating physician may bill a beneficiary on an unassigned claim for services included in the global surgery package is the limiting charge for the surgical procedure.

In addition, the limitation of liability provision (§1879 of the Act) does not apply to these determinations since they are fee schedule reductions, not denials based upon medical necessity or custodial care.

Claims for surgeries billed with a "-22" or "-52" modifier, are priced by individual consideration if the statement and documentation required by §40.2.A.10 are included. If the statement and documentation are not submitted with the claim, pricing for "-22" is it the fee schedule rate for the same surgery submitted without the "-22" modifier. Pricing for "-52" is not done without the required documentation.

Separate payment is allowed for visits and procedures billed with modifier "-78," "-79," "-24," "-25," "-57," or "-58." Modifier "-24" must be accompanied by sufficient documentation that the visit is unrelated to the surgery. Also, when used with the critical care codes, modifiers "-24" and "-25" must be accompanied by documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed. An ICD-9-CM code in the range 800.0 through 959.9 (except 930-939),

which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

Carriers do not allow separate payment for evaluation and management services furnished on the same day or during the postoperative period of a surgery if the services are billed without modifier "-24," "-25," or "-57." These services should be denied. Carriers do not allow separate payment for visits during the postoperative period that are billed with the modifier "-24" but without sufficient documentation. These services should also be denied. Modifier "-24" is intended for use with services that are absolutely unrelated to the surgery. It is not to be used for the medical management of a patient by the surgeon following surgery. Recognize modifier "-24" only for care following discharge unless:

- The care is for immunotherapy management furnished by the transplant surgeon;
- The care is for critical care for a burn or trauma patient; or
- The documentation demonstrates that the visit occurred during a subsequent hospitalization and the diagnosis supports the fact that it is unrelated to the original surgery.

Carriers do not allow separate payment for an additional procedure(s) with a global surgery fee period if furnished during the postoperative period of a prior procedure and if billed without modifier "-58," "-78," or "-79." These services should be denied. Codes with the global surgery indicator of "XXX" in the MFSDB can be paid separately without a modifier.

B. Claims From Physicians Who Furnish Less Than the Global Package (Split Global Care)

For surgeries performed January 1, 1992, and later, that are billed with either modifier "-54" or "-55," carriers pay the appropriate percentage of the fee schedule payment. Fields 17-19 of the MFSDB list the appropriate percentages for pre-, intra-, and postoperative care of the total RVUs for major surgical procedures and for minor surgeries with a postoperative period of 10 days. The intra-operative percentage includes postoperative hospital visits.

Procedures with a "000" entry in Field 16 have an entry of "0.0000" in Fields 17-19. Split global care does not apply to these procedures.

Carriers multiply the fee schedule amount (Field 34 or Field 35 of the MFSDB) by this percentage and round to the nearest cent. Assume that a physician who bills with a "-54" modifier has provided both preoperative, intra-operative and postoperative **hospital** services. Pay this physician the combined preoperative and intra-operative portions of the fee schedule payment amount.

Where more than one physician bills for the postoperative care, carriers apportion the postoperative percentage according to the number of days each physician was responsible

for the patient's care by dividing the postoperative allowed amount by the number of post-op days and that amount is multiplied by the number of days each physician saw the patient.

EXAMPLE

Dr. Jones bills for procedure "42145-54" performed on March 1 and states that he cared for the patient through April 29. Dr. Smith bills for procedure "42145-55" and states that she assumed care of the patient on April 30. The percentage of the total fee amount for the postoperative care for this procedure is determined to be 17 percent and the length of the global period is 90 days. Since Dr. Jones provided postoperative care for the first 60 days, he will receive 66 2/3 percent of the total fee of 17 percent since 60/90 = .6666. Dr. Smith's 30 days of service entitle her to 30/90 or .3333 of the fee.

6666 x .17 = .11333 or 11.3%; and

3338 x .17 = .057 or 5.7%.

Thus, Dr. Jones will be paid at a rate of 11.3 percent (66.7 percent of 17 percent). Dr. Smith will be paid at a rate of 5.7 percent (33.3 percent of 17 percent).

C. Payment for Return Trips to the Operating Room for Treatment of Complications

When a CPT code billed with modifier "-78" describes the services involving a return trip to the operating room to deal with complications, carriers pay the value of the intra-operative services of the code that describes the treatment of the complications. Refer to Field 18 of the MFSDB to determine the percentage of the global package for the intra-operative services. The fee schedule amount (Field 34 or 35 of the MFSDB) is multiplied by this percentage and rounded to the nearest cent.

When a procedure with a "000" global period is billed with a modifier "-78," representing a return trip to the operating room to deal with complications, carriers pay the full value for the procedure, since these codes have no pre-, post-, or intra-operative values.

When an unlisted procedure is billed because no code exists to describe the treatment for complications, carriers base payment on a maximum of 50 percent of the value of the intra-operative services originally performed. If multiple surgeries were originally performed, carriers base payment on no more than 50 percent of the value of the intra-operative services of the surgery for which the complications occurred. They multiply the fee schedule amount for the original surgery (Field 34 or 35) by the intra-operative percentage for the procedure (Field 18), and then multiply that figure by 50 percent to obtain the maximum payment amount.

[.50 X (fee schedule amount x intra-operative percentage)]. Round to the nearest cent.

If additional procedures are performed during the same operative session as the original surgery to treat complications which occurred during the original surgery, carriers pay the additional procedures as multiple surgeries. Only surgeries that require a return to the operating room are paid under the complications rules.

If the patient is returned to the operating room after the initial operative session, but on the same day as the original surgery for one or more additional procedures as a result of complications from the original surgery, the complications rules apply to each procedure required to treat the complications from the original surgery. The multiple surgery rules would not also apply.

If the patient is returned to the operating room during the postoperative period of the original surgery, not on the same day of the original surgery, for multiple procedures that are required as a result of complications from the original surgery, the complications rules would apply. The multiple surgery rules would also not apply.

If the patient is returned to the operating room during the postoperative period of the original surgery, not on the same day of the original surgery, for bilateral procedures that are required as a result of complications from the original surgery, the complication rules would apply. The bilateral rules would not apply.

D. MSN and Remittance Messages

When carriers deny separate payment for a visit because it is included in the global package, include one of the following statements on the MSN to the beneficiary and the remittance notice sent to the physician. Remittance messages and codes in detail can be found at: http://www.cms.hhs.gov.medlearn/appmsn.pdf.

1. Messages for Fragmented Billing by a Single Physician

When a single physician bills separately for services included in the global surgical package, carriers include one of the following statements on the MSN and remittance advice.

MSN:

> 23.1 - "The cost of care before and after the surgery or procedure is included in the approved amount for that service. You should not be billed for this item or service. You do not have to pay this amount." (add on message 16.34)

Remittance Record

> "Claim/service denied/reduced because this procedure/service is not paid separately." (Reason Code B15. Group code CO 97)

2. Messages for Global Packages Split Between Two or More Physicians

When a physician furnishes only the pre- and intra-operative services, but bills for the entire package, the following statements on the MSN and remittance advice.

> 23.5 - "Payment has been reduced because a different doctor took care of you before and/or after the surgery. You should not be billed for this item or service. You do not have to pay this amount." (add on message 16.34)

Remittance Record

> "Charges denied/reduced because procedure/service was partially or fully furnished by another physician." (Reason Code B20, Group Code CO B20)

3. Message for Procedure Codes With "ZZZ" Global Period Billed as Stand-Alone Procedures

When a physician bills for a surgery with a "ZZZ" global period without billing for another service, include one of the following statements on the MSN and remittance notice.

Carriers include the following message on the MSN for claims:

> 9.2 - "This item or service was denied because information required to make payment was missing." (CO 16)
>
> 9.3 - "Please ask your provider to submit a new, complete claim to us."
>
> (**NOTE:** Add on to other messages as appropriate).
>
> 16. When using 16, carriers should also use a claim remark code such as a return/reject code (MA 29MA 43, etc.) to show why claim rejected as incomplete.

4. Message for Payment Amount When Modifier "-22" Is Submitted Without Documentation

When a physician submits a claim with modifier "-22" but does not provide additional documentation, use the following or a similar remittance advice message:

> 9.7 - "We have asked your provider to resubmit the claim with the missing or correct information." (**NOTE:** Add on to other messages as appropriate.) MA 130

40.5 - Postpayment Issues

(Rev. 1, 10-01-03)

It may not always be possible to identify instances where more than one physician furnishes postoperative care before the carrier has paid at least one of the physicians. In addition, situations where a physician renders less than the full global package but does not add the applicable modifier to the procedure code are not detectable until another physician submits a claim.

Several other categories of fragmented bills cannot be or are difficult to detect on a prepayment basis. When a new claim reveals fragmented billing by a single provider after payment for some services was already made to that physician, carriers must adjust the amount due on the new claim by the amount previously paid.

When a new claim indicates that an incorrect payment may have been made to another physician who submitted a previous bill, carriers must determine which bill is correct. (Review the claims and any submitted records to be sure that the providers correctly used modifiers and are billing for services that are included in the global fee. If necessary, a carrier representative must contact one or both physicians to determine which claim is correct.) If the carrier determines that the first claim is incorrect, they follow the overpayment procedures in the Medicare Financial Management Manual, Chapter 3, for recovery of the incorrect payment from the first physician. They pay the second physician according to the services performed. If the carrier determines that the second claim is incorrect, they deny payment and include the following message on the MSN:

> **English:** "This service/item is a duplicate of a previously processed service. No appeal rights are attached to the denial of this service except for the issue as to whether the service is a duplicate. Disregard the appeals information on this notice unless you are appealing whether the service is a duplicate." (MSN message 7.3)
>
> **Spanish:** "Este servicio/articulo es un duplicado de otro servicio procesado previamente. No tiene derechos de apelación por la denegación de este servicio, excepto si cuestiona que este servicio es un duplicado. Haga caso omiso a la información sobre apelaciones en esta notificatión, en relación a sus derechos de apelación, a menos que esté apelando si el servicio fue duplicado."

Carriers must include the following message on the remittance advice:

> "Charges denied/reduced because procedure/service was partially/fully furnished by another provider." (Reason Code B20.)

Carriers must include the appropriate language regarding beneficiary liability according to §40.4.D, above.

Nonparticipating physicians who furnish less than the full global package, but who bill for the entire global surgery, may be guilty of violating their charge limits. In addition, physicians who engage in such practices may be guilty of fraud. See the Medicare Financial Management Manual, Chapter 3, and the Medicare Program Integrity Manual,

Chapter 3, for further information on recovery of overpayments, charge limit monitoring, and fraud.

40.6 - Claims for Multiple Surgeries

(Rev. 1, 10-01-03)

B3-4826, B3-15038, B3-15056

A. General

Multiple surgeries are separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same patient on the same day.

Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. These intra-operative services, incidental surgeries, or components of more major surgeries are not separately billable. See Chapter 23 for a description of mandatory edits to prevent separate payment for those procedures. Major surgical procedures are determined based on the MFSDB approved amount and not on the submitted amount from the providers. The major surgery, as based on the MFSDB, may or may not be the one with the larger submitted amount.

Also, see subsection D below for a description of the standard payment policy on multiple surgeries. However, these standard payment rules are not appropriate for certain procedures. Field 21 of the MFSDB indicates whether the standard payment policy rules apply to a multiple surgery, or whether special payment rules apply. Site of service payment adjustments (codes with an indicator of "1" in Field 27 of the MFSDB) should be applied before multiple surgery payment adjustments.

B. Billing Instructions

The following procedures apply when billing for multiple surgeries by the same physician on the same day.

- Report the more major surgical procedure without the multiple procedures modifier "-51."

- Report additional surgical procedures performed by the surgeon on the same day with modifier "-51."

There may be instances in which two or more physicians each perform distinctly different, unrelated surgeries on the same patient on the same day (e.g., in some multiple trauma cases). When this occurs, the payment adjustment rules for multiple surgeries

may not be appropriate. In such cases, the physician does not use modifier "-51" unless one of the surgeons individually performs multiple surgeries.

C. Carrier Claims Processing System Requirements

Carriers must be able to:

1. Identify multiple surgeries by both of the following methods:

    - The presence on the claim form or electronic submission of the "-51" modifier; and

    - The billing of more than one separately payable surgical procedure by the same physician performed on the same patient on the same day, whether on different lines or with a number greater than 1 in the units column on the claim form or inappropriately billed with modifier "-78" (i.e., after the global period has expired);

2. Access Field 34 of the MFSDB to determine the Medicare fee schedule payment amount for each surgery;

3. Access Field 21 for each procedure of the MFSDB to determine if the payment rules for multiple surgeries apply to any of the multiple surgeries billed on the same day;

4. If Field 21 for any of the multiple procedures contains an indicator of "0," the multiple surgery rules do not apply to that procedure. Base payment on the lower of the billed amount or the fee schedule amount (Field 34 or 35) for each code unless other payment adjustment rules apply;

5. For dates of service prior to January 1, 1995, if Field 21 contains an indicator of "1," the standard rules for pricing multiple surgeries apply (see items 6-8 below);

6. Rank the surgeries subject to the standard multiple surgery rules (indicator "1") in descending order by the Medicare fee schedule amount;

7. Base payment for each ranked procedure on the lower of the billed amount, or:

    - 100 percent of the fee schedule amount (Field 34 or 35) for the highest valued procedure;

    - 50 percent of the fee schedule amount for the second highest valued procedure; and

    - 25 percent of the fee schedule amount for the third through the fifth highest valued procedures;

8. If more than five procedures are billed, pay for the first five according to the rules listed in 5, 6, and 7 above and suspend the sixth and subsequent procedures for manual review and payment, if appropriate, "by report." Payment determined on a "by report" basis for these codes should never be lower than 25 percent of the full payment amount;

9. For dates of service on or after January 1, 1995, new standard rules for pricing multiple surgeries apply. If Field 21 contains an indicator of "2," these new standard rules apply (see items 10-12 below);

10. Rank the surgeries subject to the multiple surgery rules (indicator "2") in descending order by the Medicare fee schedule amount;

11. Base payment for each ranked procedure (indicator "2") on the lower of the billed amount:

    - 100 percent of the fee schedule amount (Field 34 or 35) for the highest valued procedure; and

    - 50 percent of the fee schedule amount for the second through the fifth highest valued procedures; or

12. If more than five procedures with an indicator of "2" are billed, pay for the first five according to the rules listed in 9, 10, and 11 above and suspend the sixth and subsequent procedures for manual review and payment, if appropriate, "by report." Payment determined on a "by report" basis for these codes should never be lower than 50 percent of the full payment amount. Pay by the unit for services that are already reduced (e.g., 17003). Pay for 17340 only once per session, regardless of how many lesions were destroyed;

    NOTE: For dates of service prior to January 1, 1995, the multiple surgery indicator of "2" indicated that special dermatology rules applied. The payment rules for these codes have not changed. The rules were expanded, however, to all codes that previously had a multiple surgery indicator of "1." For dates of service prior to January 1, 1995, if a dermatological procedure with an indicator of "2" was billed with the "-51" modifier with other procedures that are **not** dermatological procedures (procedures with an indicator of "1" in Field 21), the standard multiple surgery rules applied. Pay no less than 50 percent for the dermatological procedures with an indicator of "2." See §§40.6.C.6-8 for required actions.

13. If Field 21 contains an indicator of "3," and multiple endoscopies are billed, the special rules for multiple endoscopic procedures apply. Pay the full value of the highest valued endoscopy, plus the difference between the next highest and the base endoscopy. Access Field 31A of the MFSDB to determine the base endoscopy.

EXAMPLE

In the course of performing a fiber optic colonoscopy (CPT code 45378), a physician performs a biopsy on a lesion (code 45380) and removes a polyp (code 45385) from a different part of the colon. The physician bills for codes 45380 and 45385. The value of codes 45380 and 45385 have the value of the diagnostic colonoscopy (45378) built in. Rather than paying 100 percent for the highest valued procedure (45385) and 50 percent for the next (45380), pay the full value of the higher valued endoscopy (45385), plus the difference between the next highest endoscopy (45380) and the base endoscopy (45378).

Carriers assume the following fee schedule amounts for these codes:

45378 - $255.40

45380 - $285.98

45385 - $374.56

Pay the full value of 45385 ($374.56), plus the difference between 45380 and 45378 ($30.58), for a total of $405.14.

NOTE: If an endoscopic procedure with an indicator of "3" is billed with the "-51" modifier with other procedures that are **not** endoscopies (procedures with an indicator of "1" in Field 21), the standard multiple surgery rules apply. See §§40.6.C.6-8 for required actions.

14. Apply the following rules where endoscopies are performed on the same day as unrelated endoscopies or other surgical procedures:

    - Two unrelated endoscopies (e.g., 46606 and 43217): Apply the usual multiple surgery rules;

    - Two sets of unrelated endoscopies (e.g., 43202 and 43217; 46606 and 46608): Apply the special endoscopy rules to each series and then apply the multiple surgery rules. Consider the total payment for each set of endoscopies as one service;

    - Two related endoscopies and a third, unrelated procedure: Apply the special endoscopic rules to the related endoscopies, and, then apply the multiple surgery rules. Consider the total payment for the related endoscopies as one service and the unrelated endoscopy as another service.

15. If two or more multiple surgeries are of equal value, rank them in descending dollar order billed and base payment on the percentages listed above (i.e., 100 percent for the first billed procedure, 50 percent for the second, etc.);

16. If any of the multiple surgeries are bilateral surgeries, consider the bilateral procedure at 150 percent as one payment amount, rank this with the remaining

procedures, and apply the appropriate multiple surgery reductions. See §40.7 for bilateral surgery payment instructions.);

17. Round all adjusted payment amounts to the nearest cent;

18. If some of the surgeries are subject to special rules while others are subject to the standard rules, automate pricing to the extent possible. If necessary, price manually;

19. In cases of multiple interventional radiological procedures, both the radiology code and the primary surgical code are paid at 100 percent of the fee schedule amount. The subsequent surgical procedures are paid at the standard multiple surgical percentages (50 percent, 50 percent, 50 percent and 50 percent);

20. Apply the requirements in §§40 on global surgeries to multiple surgeries;

21. Retain the "-51" modifier in history for any multiple surgeries paid at less than the full global amount; and

22. Follow the instructions on adjudicating surgery claims submitted with the "-22" modifier. Review documentation to determine if full payment should be made for those distinctly different, unrelated surgeries performed by different physicians on the same day.

D. Ranking of Same Day Multiple Surgeries When One Surgery Has a "-22" Modifier and Additional Payment is Allowed

(Rev. 1, 10-01-03)

B3-4826

If the patient returns to the operating room after the initial operative session on the same day as a result of complications from the original surgery, the complications rules apply to each procedure required to treat the complications from the original surgery. The multiple surgery rules would not apply.

However, if the patient is returned to the operating room during the postoperative period of the original surgery, not on the same day of the original surgery, for multiple procedures that are required as a result of complications from the original surgery, the complications rules would apply. The multiple surgery rules would also not apply.

Multiple surgeries are defined as separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same patient on the same day.

Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. These intra-operative services, incidental surgeries, or components of more major surgeries are not separately billable. See Chapter 23 for a description of mandatory edits to prevent separate payment for those procedures.

40.7 - Claims for Bilateral Surgeries

(Rev. 1, 10-01-03)

B3-4827, B3-15040

A. General

Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day.

The terminology for some procedure codes includes the terms "bilateral" (e.g., code 27395; Lengthening of the hamstring tendon; multiple, bilateral.) or "unilateral or bilateral" (e.g., code 52290; cystourethroscopy; with ureteral meatotomy, unilateral or bilateral). The payment adjustment rules for bilateral surgeries do not apply to procedures identified by CPT as "bilateral" or "unilateral or bilateral" since the fee schedule reflects any additional work required for bilateral surgeries.

Field 22 of the MFSDB indicates whether the payment adjustment rules apply to a surgical procedure.

B. Billing Instructions for Bilateral Surgeries

If a procedure is not identified by its terminology as a bilateral procedure (or unilateral or bilateral), physicians must report the procedure with modifier "-50." They report such procedures as a single line item. (**NOTE**: This differs from the CPT coding guidelines which indicate that bilateral procedures should be billed as two line items.)

If a procedure is identified by the terminology as bilateral (or unilateral or bilateral), as in codes 27395 and 52290, physicians do not report the procedure with modifier "-50."

C. Claims Processing System Requirements

Carriers must be able to:

1. Identify bilateral surgeries by the presence on the claim form or electronic submission of the "-50" modifier **or** of the same code on separate lines reported once with modifier "-LT" and once with modifier "-RT";

2. Access Field 34 or 35 of the MFSDB to determine the Medicare payment amount;

3. Access Field 22 of the MFSDB:

- If Field 22 contains an indicator of "0," "2," or "3," the payment adjustment rules for bilateral surgeries do not apply. Base payment on the lower of the billed amount or 100 percent of the fee schedule amount (Field 34 or 35) unless other payment adjustment rules apply.

  NOTE: Some codes which have a bilateral indicator of "0" in the MFSDB may be performed more than once on a given day. These are services that would never be considered bilateral and thus should not be billed with modifier "-50." Where such a code is billed on multiple line items or with more than 1 in the units field and carriers have determined that the code may be reported more than once, bypass the "0" bilateral indicator and refer to the multiple surgery field for pricing;

- If Field 22 contains an indicator of "1," the standard adjustment rules apply. Base payment on the lower of the billed amount or 150 percent of the fee schedule amount (Field 34 or 35). (Multiply the payment amount in Field 34 or 35 for the surgery by 150 percent and round to the nearest cent.)

4. Apply the requirements §§40 - 40.4 on global surgeries to bilateral surgeries; and

5. Retain the "-50" modifier in history for any bilateral surgeries paid at the adjusted amount.

   (**NOTE:** The "-50" modifier is not retained for surgeries which are bilateral by definition such as code 27395.)

40.8. Claims for Co-Surgeons and Team Surgeons

(Rev. 1, 10-01-03)

B3-4828, B3-15046

A. General

Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure(s) and/or the patient's condition. In these cases, the additional physicians are not acting as assistants-at-surgery.

B. Billing Instructions

The following billing procedures apply when billing for a surgical procedure or procedures that required the use of two surgeons or a team of surgeons:

- If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier "-62." Co-surgery also refers to surgical procedures involving two surgeons performing the parts of

the procedure simultaneously, i.e., heart transplant or bilateral knee replacements. Documentation of the medical necessity for two surgeons is required for certain services identified in the MFSDB. (See §40.8.C.5.);

- If a team of surgeons (more than 2 surgeons of different specialties) is required to perform a specific procedure, each surgeon bills for the procedure with a modifier "-66." Field 25 of the MFSDB identifies certain services submitted with a "-66" modifier which must be sufficiently documented to establish that a team was medically necessary. All claims for team surgeons must contain sufficient information to allow pricing "by report."

- If surgeons of different specialties are each performing a different procedure (with specific CPT codes), neither co-surgery nor multiple surgery rules apply (even if the procedures are performed through the same incision). If one of the surgeons performs multiple procedures, the multiple procedure rules apply to that surgeon's services. (See §40.6 for multiple surgery payment rules.)

For co-surgeons (modifier 62), the fee schedule amount applicable to the payment for **each** co-surgeon is 62.5 percent of the global surgery fee schedule amount. Team surgery (modifier 66) is paid for on a "By Report" basis.

C. Claims Processing System Requirements

Carriers must be able to:

1. Identify a surgical procedure performed by two surgeons or a team of surgeons by the presence on the claim form or electronic submission of the "-62" or "-66" modifier;

2. Access Field 34 or 35 of the MFSDB to determine the fee schedule payment amount for the surgery;

3. Access Field 24 or 25, as appropriate, of the MFSDB. These fields provide guidance on whether two or team surgeons are generally required for the surgical procedure;

4. If the surgery is billed with a "-62" or "-66" modifier and Field 24 or 25 contains an indicator of "0," payment adjustment rules for two or team surgeons do not apply:

    - Carriers pay the first bill submitted, and base payment on the lower of the billed amount or 100 percent of the fee schedule amount (Field 34 or 35) unless other payment adjustment rules apply;

    - Carriers deny bills received subsequently from other physicians and use the appropriate MSN message in §§40.8.D. As these are medical necessity denials, the instructions in the Program Integrity Manual regarding denial of unassigned claims for medical necessity are applied;

5. If the surgery is billed with a "-62" modifier and Field 24 contains an indicator of "1," suspend the claim for manual review of any documentation submitted with the claim. If the documentation supports the need for co-surgeons, base payment for each physician on the lower of the billed amount or 62.5 percent of the fee schedule amount (Field 34 or 35);

6. If the surgery is billed with a "-62" modifier and Field 24 contains an indicator of "2," payment rules for two surgeons apply. Carriers base payment for each physician on the lower of the billed amount or 62.5 percent of the fee schedule amount (Field 34 or 35);

7. If the surgery is billed with a "-66" modifier and Field 25 contains an indicator of "1," carriers suspend the claim for manual review. If carriers determine that team surgeons were medically necessary, each physician is paid on a "by report" basis;

8. If the surgery is billed with a "-66" modifier and Field 25 contains an indicator of "2," carriers pay "by report";

   NOTE: A Medicare fee may have been established for some surgical procedures that are billed with the "-66" modifier. In these cases, all physicians on the team must agree on the percentage of the Medicare payment amount each is to receive. If carriers receive a bill with a "-66" modifier after carriers have paid one surgeon the full Medicare payment amount (on a bill **without** the modifier), deny the subsequent claim.

9. Apply the rules global surgical packages to each of the physicians participating in a co- or team surgery; and

10. Retain the "-62" and "-66" modifiers in history for any co- or team surgeries.

D. Beneficiary Liability on Denied Claims for Assistant, Co- surgeon and Team Surgeons

MSN message 23.10 which states "Medicare does not pay for a surgical assistant for this kind of surgery," was established for denial of claims for assistant surgeons. Where such payment is denied because the procedure is subject to the statutory restriction against payment for assistants-at-surgery. Carriers include the following statement in the MSN:

"You cannot be charged for this service." (Unnumbered add-on message.)

Carriers use Group Code CO on the remittance advice to the physician to signify that the beneficiary may not be billed for the denied service and that the physician could be subject to penalties if a bill is issued to the beneficiary.

If Field 23 of the MFSDB contains an indicator of "0" or "1" (assistant-at-surgery may not be paid) for procedures CMS has determined that an assistant surgeon is not generally medically necessary.

For those procedures with an indicator of "0," the limitation on liability provisions described in Chapter 30 apply to assigned claims. Therefore, carriers include the appropriate limitation of liability language from Chapter 21. For unassigned claims, apply the rules in the Program Integrity Manual concerning denial for medical necessity.

Where payment may not be made for a co- or team surgeon, use the following MSN message (MSN message number 15.13):

Medicare does not pay for team surgeons for this procedure.

Where payment may not be made for a two surgeons, use the following MSN message (MSN message number 15.12):

Medicare does not pay for two surgeons for this procedure.

Also see limitation of liability remittance notice REF remark codes M25, M26, and M27.

Use the following message on the remittance notice:

Multiple physicians/assistants are not covered in this case. (Reason code 54.)

40.9 - Procedures Billed With Two or More Surgical Modifiers

(Rev. 1, 10-01-03)

B3-4829

Carriers may receive claims for surgical procedures with more than one surgical modifier. For example, since the global fee concept applies to all major surgeries, carriers may receive a claim for surgical care only (modifier "-54") for a bilateral surgery (modifier "-50"). They may also receive a claim for multiple surgeries requiring the use of an assistant surgeon.

Following is a list of possible combinations of surgical modifiers.

(**NOTE:** Carriers must price all claims for surgical teams "by report.")

- Bilateral surgery ("-50") and multiple surgery ("-51").
- Bilateral surgery ("-50") and surgical care only ("-54").
- Bilateral surgery ("-50") and postoperative care only ("55").
- Bilateral surgery ("-50") and two surgeons ("-62").
- Bilateral surgery ("-50") and surgical team ("-66").
- Bilateral surgery ("-50") and assistant surgeon ("-80").

- Bilateral surgery ("-50"), two surgeons ("-62"), and surgical care only ("-54").
- Bilateral surgery ("-50"), team surgery ("-66"), and surgical care only ("-54").
- Multiple surgery ("-51") and surgical care only ("-54").
- Multiple surgery ("-51") and postoperative care only ("55").
- Multiple surgery ("-51") and two surgeons ("-62").
- Multiple surgery ("-51") and surgical team ("-66").
- Multiple surgery ("-51") and assistant surgeon ("-80").
- Multiple surgery ("-51"), two surgeons ("-62"), and surgical care only ("-54").
- Multiple surgery ("-51"), team surgery ("-66"), and surgical care only ("-54").
- Two surgeons ("-62") and surgical care only ("-54").
- Two surgeons ("-62") and postoperative care only ("55").
- Surgical team ("-66") and surgical care only ("-54").
- Surgical team ("-66") and postoperative care only ("55").

Payment is not generally allowed for an assistant surgeon when payment for either two surgeons (modifier "-62") or team surgeons (modifier "-66") is appropriate. If carriers receive a bill for an assistant surgeon following payment for co-surgeons or team surgeons, they pay for the assistant only if a review of the claim verifies medical necessity.

50 - Payment for Anesthesiology Services

(Rev. 1859; Issued: 11-20-09; Effective Date: For services furnished on or after 01-01-10; Implementation Date: 01-04-10)

A. General Payment Rule

The fee schedule amount for physician anesthesia services furnished on or after January 1, 1992 is, with the exceptions noted, based on allowable base and time units multiplied by an anesthesia conversion factor specific to that locality. The base unit for each anesthesia procedure is communicated to the Part B Contractors by means of the HCPCS file released annually. The public can access the base units on the CMS homepage through the anesthesiologist's center. The way in which time units are calculated is described in §50.G. CMS releases the conversion factor annually.

B. Payment at Personally Performed Rate