EK HEALTH
Transforming Managed Care

Compliance and Regulations Newsletter

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CALIFORNIA

DWC Issues Second 30-Day Comment Period for Proposed Hospital Outpatient Department and Ambulatory Surgical Centers Fee Schedule

In a June 6th Newsline, DWC issued a second 30-day comment period for modification of hospital outpatient department and ambulatory surgical centers fee schedule rules proposed in 2015.

Proposed modifications include:

- Clarification that for services rendered on or after September 1, 2014, but before the effective date of the amended rules, "other services" means Hospital Outpatient Department Services payable under the Medicare Hospital Outpatient Prospective Payment System (HOPPS) that are not surgical, emergency department visits, facility only services, or services that are an integral part thereof. Services rendered after the effective date of the amended rules, "other services" will not include facility only services.
- Discontinuation of the current payment model which determines maximum allowance for "other services" based on the Resource-Based Relative Value Scale (RBRVS) physician fee schedule relative values.
- Implementation of a payment policy allowances for all hospital outpatient department services that are payable under the Medicare HOPPS including "other services," shall be determined based on the Medicare HOPPS. Payment of services based on the Medicare HOPPS would reduce payment complications, but would increase maximum allowable fees for hospital outpatient services unless the 120% multiplier for surgery services and emergency department visits is adjusted so there would be no change in the estimated aggregate allowance. Based on a RAND impact analysis, if "other services" are paid at 100% of Medicare HOPPS, a budget neutral adjustment would be required for surgery services and emergency department visits reducing the multiplier from 120% to 117.8% of HOPPS.
- Expansion of the definition of surgical procedure HCPCS codes to conform to Medicare's HOPPS definition of surgical procedures for services rendered on or after the effective date of this amendment.

Written comments will be accepted through July 6th.

Potential Impact
This proposed rulemaking is needed to make the payment method for "other services" more specific. Medicare occasionally changes its coding practices making it necessary to provide direction on the proper HCPCS code to use for calculating "other services" maximum payment amounts when a different HCPCS code is used to describe comparable "other services" under CMS' Hospital Outpatient Departments Prospective Payment System (CMS HOPPS) and the OMFS RBRVS. Without improving the payment methodology to include direction on which HCPCS code to use may result in denial of outpatient services.

Source 1
Source 2

DWC to Accept Public Comments on Proposed Home Health Care Fee Schedule

The DWC is accepting comments on the proposed modifications to the home health care fee schedule regulation which aim to provide more organization and clarity.

Proposed changes include rate increases from 4-5%, addition of six codes, and deletion of three codes compared to regulations proposed in October 2015.

The amended proposed rates derived from the federal Office of Workers' Compensation Programs (OWCP) fee schedule for home health care services. OWCP rates are higher than those in the previous draft which were based on federal Medicare and state In-home Supportive Services programs.

Potential Impact
"The proposed regulations set forth a payment methodology and fees for skilled care by licensed medical professionals and unskilled personal and chore services for injured workers in the home setting that will provide incentives for an adequate number of potential care providers to participate in home health care for injured workers while containing costs to the overall workers' compensation system," said DWC in the May 24th Newsline No. 2016-55.

Source 1
Source 2

Bill Would Permit DWC to Suspend Doctors Following Fraud Convictions

Under current law, the Director of Health Care Services is authorized to suspend providers from participating in the Medi-Cal program (California's Medicaid system) if they are convicted of fraud. Assemblyman Adam Gray (D), amended language in AB 1244 to require DWC to suspend providers from participating in the workers' compensation program in any capacity if suspended by the Department of Health Care Services (DHCS).

This bill would require DHCS to notify the Administrative Director (AD) of DWC when a provider is suspended from participating in the Medi-Cal program. Upon notification, the DWC AD would promptly suspend the provider from participating in the workers' compensation system, including, but not limited to participation as a qualified medical examiner, a provider in the medical provider network, or an independent medical reviewer.

The bill would require the administrative director to adopt regulations for revocation of a suspended provider's participation in the workers' compensation system, subject to specified notice and hearing requirements. Providers whose participation in the workers' compensation system have been suspended or revoked would not be allowed to submit claims for payment. However; providers would be allowed to bill for services provided prior to the date of suspension or revocation.

Potential Impact
Providers convicted of fraud should not benefit financially from treating workers' compensation patients. Suspending them from the workers' compensation system does not afford providers an opportunity to continue fraudulent practices.

Source

FLORIDA

Rule Workshop Held for Dispute Resolution Process

The Florida Division of Workers' Compensation held a workshop on June 10th to discuss proposed changes that would decrease its involvement in disputes between workers' compensation carriers and health care providers.

Among the proposed changes is a rule that would address the Division's role for disputes involving a contract, rate agreement, or managed care arrangement. The Department's determination will only be based on the fee schedule, practice parameters, and protocols of treatment. The carrier and health care provider must apply the contract, rate agreement, or resolve the dispute utilizing the workers' compensation managed care arrangement grievance process.

Other proposed changes include revised forms which require greater detail for information to be included in a petition for dispute resolution, extension of the time permitted for submission of a petition for dispute resolutions from 30 days to 45 days, and carrier response time is extended from 10 days to 30 days. Another rule specifies consequences, including fines and penalties for failure to comply with Department Determinations.

One key proposed change is to Rule 69L-31.005 which states which party may have the advantage in the dispute. The rule states "If the carrier has authorized the health care provider to provide treatment and care to the injured worker without limitation as to the type of treatment and care that may be provided, and then denies, disallows or adjusts reimbursement on the basis that the specific treatment or care provided is not medically necessary or compensable, the determination will be presumptively in favor of the health care provider. If the carrier, in its authorization, has specifically limited the type of treatment and care that may be provided, and the health care provider provides treatment and care inconsistent with the carrier's limitation, the determination will be presumptively in favor of the carrier."

Potential Impact
Removing disputes involving contracts, rate agreement, or managed care arrangements from the Division is a good idea as the Division is not a party to these agreements. The state should be able to focus on the accurate application of the fee schedule and treatment protocols. Extending the carrier response time from 10 days to 30 days gives the carrier/payer a more adequate amount of time to thoroughly review the provider's request to ensure it is handled appropriately.

Source

RHODE ISLAND

Rhode Island DWC Published Hospital Rates

The Rhode Island Division of Workers' Compensation published hospital rates for inpatient, ambulatory surgery, and emergency room services performed on or after July 1, 2016. Reimbursement is determined by multiplying billed charges by the appropriate percentage below.

Hospital	Inpatient	Ambulatory Surgery	Emergency Room
Butler Hospital	53.30 %	N/A	N/A
Kent Hospital	39.53 %	37.28 %	23.90 %
Landmark Medical Center	27.73 %	25.85 %	19.59 %
Memorial Hospital	70.10 %	59.80 %	58.67 %
Miriam Hospital	34.73 %	25.98 %	20.33 %
Newport Hospital	59.46 %	49.38 %	21.50 %
Rhode Island Hospital	41.15 %	35.63%	31.05 %
Rehabilitation Hospital of RI	34.66 %	N/A	N/A
Roger Williams Hospital	44.91 %	31.99 %	16.11 %
St. Joseph Hospital	42.10%	48.19 %	16.69 %
South County Hospital	55.08 %	25.08 %	20.12 %
Westerly Hospital	44.59 %	25.70 %	32.54 %
Women & Infants Hospital	47.67 %	41.33 %	58.73 %

Potential Impact

Rates for inpatient and ambulatory services increased an average of 3.19% and 1.06% of billed charges respectively. Emergency room rates decreased an average of 9.41% with two facilities showing a decrease of more than 30% each (Memorial Hospital & Newport Hospital).

Source

TENNESSE

Proposed Case Management Rules to Go Before Committee

Tennessee's Bureau of Workers' Compensation will present proposed case management rules to the state's Joint Government Operations Committee.

Proposed rules will require case managers and case manager assistants to be registered with the Bureau by completing the registration and paying the appropriate fee of $100.00. Case Managers and case manager assistants currently registered will be required to pay a renewal fee of $50.00 every two years when the regular renewal date occurs.

Case managers must have at least four hours of continuing education each year that is specific to the treatment of injured workers.

Registered Case Manager Assistants must obtain certification as a Case Manager within 24 months of the effective date of this rule or the Bureau will terminate their registration. Assistants will still be allowed to provide services during this 24-month period.

Any case managers committing violations such as, but not limited to, prepare the panel of physicians or influencing the employee's choice of physician, determining if the case is work-related, questioning the physician or employee regarding compensability, or accepting compensation as the result of a settlement, may be assessed a civil penalty of $500 for each action. If more than three violations have been assessed in a two year period, the Administrator has the discretion to suspend the registration of any case manager for up to one year.

If the Joint Government Operations Committee approves the rules, they will become effective August 29, 2016.

Potential Impact
Penalties that would be assessed if the rules are violated should be a deterrent for case managers. The continuing education requirement ensures case managers are exposed to material specifically impacting injured workers. This may arm case managers with more tools to perform their tasks more effectively and efficiently.

Source

VIRGINIA

Virginia WCC Seeks Firm to Develop Fee Schedule for Medical Services

The Virginia Workers' Compensation Commission has submitted a request for proposal from actuarial firms to develop the medical fee schedule mandated under Senate Bill 631.

SB 631 which would establish a workers' compensation fee schedule effective January 1, 2018. The initial fee schedule will be based on reimbursement which is the average of all amounts paid to providers in the same category of providers for the medical service in the same medical community. There are seven categories in each of six geographic areas which will be determined by zip codes.

The bill requires the Commission to select an actuarial firm with nationwide experience and actuarial expertise to assist in drafting the initial fee schedules. The Commission must also review and revise the fee schedules in the year after they become effective and every two years thereafter.

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

Source 1
Source 2

WASHINGTON

New Medical Fee Schedule Effective July 1, 2016

The Washington State Department of Labor & Industries has adopted a new medical fee schedule effective July 1, 2016. The following changes have been made to the Washington Administrative Code (WAC) and payment changes.

- Fee schedule updates effective July 1, 2016
- Anesthesia rates increased
- Physical therapy daily cap increase from $124.44 to $125.68
- Occupational therapy daily cap increase from $93.33 to $94.26
- Audiology and Hearing Services - codes added
  - 5095V - wax guards $1.25 each up to 150 per year
  - 5094V - replacement tubes/domes $25 per visit
- Impairment Rating section
  - 1190M added for comprehensive hearing loss exam
- Interpretive Services
  - Face-to-face interpretive services must be recorded on updated L&I Interpreting Services Appointment Record (ISAR) 06-2015 form and signed by the interpreter.
  - Mileage will be reimbursed in whole miles.
- Pathology & Laboratory - new codes added; old codes deleted
- Facility rates including APR DRG rates have been updated
- Fee schedules, factors, and rates have been updated

Potential Impact

Washington typically updates its fee schedule each year in January and July. No significant changes were made other than those noted above.

Source

NATIONAL

DataPath Launches Medicare Set Aside Payment Solution

On June 15, 2016, DataPath launched RelianceCard, a card-based payment method for Medicare Set Aside (MSA) settlement funds. MSA recipients have access to funds and network discounts while the card helps insurance carriers and pharmacy benefit managers (PBMs) ensure the funds are used for related care. The card is linked to the claimant's MSA account and can be linked to the PBM's pharmacy or ancillary network so discounts can be applied. DataPath's patented technology tracks documents and receipts for detailed recordkeeping and CMS reporting. Cards may be customized offering more flexibility. If a card is lost or stolen, funds are protected against fraud. According to its website, DataPath is an electronic payments processor which links healthcare and workers' compensation payments to their proprietary debit card solutions and offers large-scale provider payment processing for insurance entities.

Potential Impact

The card is convenient for the MSA recipient and provides a tracking mechanism for insurance carriers and PBMs to ensure funds are used for related care. There is also fraud protection in case a card is lost or stolen.

Source