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Workers' Compensation Commission

Memorandum

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From: Gary R. Thibault

Date: September 18, 2009

Subject: ***2010 Medical Services Provider Manual***

The *Medical Services Provider Manual*, developed, approved and published by the Commission, sets the maximum allowable fees physicians and other medical providers may be paid for authorized services provided to a workers' compensation patient. The Commission published the first fee schedule in 1950, the last in 2003. (See Attachment 1: *2003 Medical Services Provider Manual.*) Until 1995, the fee schedule was charge based. That is, prices were based on an informal survey of physicians' charges for various procedures and discounted. Since 1995, prices have been based on the resources necessary to provide the service.

Development of the *2010 Medical Services Provider Manual* included collection and analysis of utilization data for 2008, review of new procedures, review of changes in relative values, and comparison of the *Medical Services Provider Manual* with fee schedules in other states and with Medicare.

Statutory Authority

The Workers' Compensation Commission is the regulatory agency of the State of South Carolina responsible for overseeing and administering the South Carolina Workers' Compensation Act. SC Code Ann. §§ 42-1-10 et seq. (1976). The Commission has the authority to approve or deny medical fees, as well as the statutory and regulatory discretion to set the amount of fees. (§ 42-15-90, R 67-1302)

> **§ 42-15-90. Fees of attorneys and physicians and hospital charges shall be approved by the Commission.**
> Fees for attorneys and physicians and charges of hospitals for services under this title shall be subject to the approval of the Commission.
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> **R 67-1302. Maximum Allowable Payments to Medical Practitioners.**
> A. The Commission shall establish maximum allowable payments for medical services provided by medical practitioners based on a relative value scale and a conversion factor set by the Commission.
> (1) The maximum allowable payments and any policies governing the billing and payment of services provided by medical practitioners shall be published in a medical services provider manual.
> (2) The Commission may review and update the relative values and/or conversion factor as needed.

Background & Development Process

The *2003 Medical Services Provider Manual* went into effect on January 1, 2003 and was based on the Centers for Medicare & Medicaid Services (CMS), Resource Based Relative Value Scale (RBRVS). RBRVS, updated and published annually by CMS, establishes a relative value unit for most medical services. (See Attachment 2 for examples of relative values published in the Federal Register, Volume 73, Number 224, Wednesday, November 19, 2008.). Medical services are identified by current procedural terminology (CPT) codes which describe procedures and services performed by physicians and other health care providers. CPT codes are published and updated annually by the American Medical Association. The relative value for each procedure is multiplied by a conversion factor set by the Commission, currently $52, to arrive at the maximum allowable payment (MAP). MAPs represent the maximum amount that a provider can be paid for rendering services under the Workers' Compensation Act. In instances where the provider's usual charge is lower than the MAP amount, or where the provider has agreed by contract with an employer or insurance carrier to accept discounts resulting in fees lower than the Commission's MAPs, payment is made at the lower amount.

R 67-1302. Maximum Allowable Payments to Medical Practitioners.

C. An employer or insurance carrier may not pay, and a medical practitioner may not accept, more than the maximum allowable payment amounts listed in the provider manual.

RBRVS is a well recognized method for determining price based on the work involved, the expense associated with providing that service, and malpractice insurance costs. RBRVS attempts to ensure that fees are based on the resources used to provide each service. It utilizes one of the most systematic methods for setting price and is a system which has been adopted by commercial insurance carriers and workers' compensation programs in other states. It has broad base support in the business, insurance and medical communities.

In 2003 the Commission approved a 5.0% average increase in prices. Between 1998 and 2002 relative values increased 9.1% and to increase total payments 5% required a decrease in the conversion factor of $2.03, from $54.03 to $52.00. The anesthesia conversion factor was increased to $24.00, proportionally the same as the Medicare conversion factor for anesthesia and the Medicare conversion factor, 46%.

Since the adoption of RBRVS, the Commission has:

- Added a Pharmacy Section
- Added Pathology & Lab
- Added Durable Medical Equipment
- Established site of service payment differential
- Enhanced the narrative to be more user friendly
- Updated CPT codes.

Comments Received

On May 22, 2009, a notice of general public interest was published in the State Register and posted on the Commission's website announcing that the Commission was in the process of reviewing and revising the *Medical Services Provider Manual.* The notice stated that the next edition of the fee schedule would be a complete revision and include updates to payment policies, billing policies, evaluation and management services, anesthesia, surgery, radiology, pathology and lab services, medicine and injections, physical medicine, special reports and services, supplies and durable medical equipment. The notice invited comments and recommendations. The public hearing was held Friday, June 19, 2009, at the offices of the Commission. It is important to note that a public hearing was not required and was held to provide an additional avenue for comments on the fee schedule. While the Commission's regulations provide the method of determining

prices, new or revised fee schedules are established by a vote of the Full Commission at a monthly business meeting. In addition to Commissioners and staff, nine people attended. Written comments were requested by June 30, 2009, and accepted through August 25, 2009. All comments received, as well as a summary of those comments, and the transcript of the hearing, can be found in Attachment 3.

The Commission has long recognized that it must balance the interests of the employee, business, insurance and medical communities to make sure that workers' compensation patients have access to quality health care services at a reasonable price. In order to maintain this important balance, the Commission assured the medical, business and insurance communities that it was committed to monitoring the financial impact of the schedule and making changes when necessary. While historically the Commission has not committed to a course of action which automatically would recognize annual fee adjustments based on one of the inflation indices, it has committed to an ongoing review of all fee schedules.

Analysis

The Commission established a data set representing over 381,000 procedures representing $34.2 million in costs performed for workers' compensation patients in South Carolina during 2008. The data set was provided by two large insurance carriers and one self-insured fund. The data set is considered sufficiently large to be representative of workers' compensation cases in this state. Those companies represent approximately 14% of the South Carolina workers' compensation market. (See Attachment 4, "Effect of Adopting 2009 Relative Values.") Based on this data set, the entire market for all procedures covered under the *Medical Services Provider Manual* is estimated at $244.3 million for 2008.

While the American Medical Association publishes codes for over 7,000 separate procedures, approximately 1,200 are used in workers' compensation. Of the 1,200, the top 200 procedures represent 80.5% of total expenditures in workers' compensation in our state. While the initial analysis was based on all procedures in the data set, the Commission's final analysis was based on the top 200 codes, which represented, in this data set, approximately $27.5 million in payments to providers.

How South Carolina Compares to Other States

Since 1993, the Workers' Compensation Research Institute (WCRI), Cambridge, Massachusetts, has published the most comprehensive studies on workers' compensation

fee schedules. It will soon publish its 2009 report in a series titled "Benchmarks for Designing Workers Compensation Fee Schedules". Those reports, published in 1993, 1994, 1996, and 2002 contain similar findings as found in the most recent 2006 study:

- There are substantial differences in fee schedule rates from state to state. The highest state's fee schedule rates are on average 3.5 times higher than the lowest states fee schedule rates.

- Alaska and Illinois have the highest average fee schedules, while Massachusetts has the lowest average fee schedule.

- The interstate variation is not rationally related to the interstate variation in the expenses that medical providers incur in producing the services.

- Most state fee schedules create financial incentives to underuse primary care and overuse invasive and specialty care. A few states avoid this by following a reasonably fully transitioned RBRVS and setting similar conversion factor across the different services groups within their state. (Hawaii, Texas, Washington, Michigan, West Virginia, South Carolina, Maine Florida, Massachusetts and Maryland)

- Several states have fee schedules that may be higher than necessary. The most likely candidates are state fee schedules that are double or more the state's Medicare rates.

- A few states may have fee schedules that are so low as to raise concerns about access to quality care.

- Currently more than half of the 42 states base their workers' compensation fee schedule on the RBRVS system, at least in part.

- Absent information concerning the efficacy of care, and absent information regarding access to care, it is difficult to determine the optimal fee schedule price.

(*Benchmarks for Designing Workers' Compensation Medical Fee Schedules: 2006*, Workers Compensation Research Institute, Cambridge, Massachusetts, November 2006)

Establishing rates involves a delicate balance. If fee schedules set prices too high, savings will be negligible and the goal of medical cost containment will not be met. If fees are set too low, fewer providers will elect to treat workers' compensation patients and

access to quality care may be affected. It has been the public policy of most states, including South Carolina, since workers' compensation insurance is required of most employers, with the cost ultimately paid by all citizens of the state as part of the price of goods and services they purchase, that medical costs be contained as are other costs in workers' compensation, including disability and wage loss. Forty-three jurisdictions have implemented workers' compensation medical fee schedules, the tool most often used to contain medical costs.

WCRI Medical Price Index, MPI-WC

WCRI has developed a medical price index for a market basket of non-hospital, non-facility procedures common in workers' compensation. This market basket is comprised of office visits, consultations, surgery, radiology and physical medicine and includes approximately 80% to 90% of all non-hospital expenditures. The report quantifies the relative prices paid for workers' compensation medical care in 25 states as well as the trend in prices paid in those states. The study, published in June 2008, tracks price changes from 2001 to 2006 and includes South Carolina, North Carolina and Georgia among the states studied. It also tracks changes in prices paid within those states and allows for interstate comparisons.

Based on WCRI's analysis, in 2006 South Carolina had a price index of 90, that is, the prices paid in South Carolina were 10% lower than the prices paid in the median state. North Carolina also had a fee index of 90 and Georgia had a price index of 100. The three lowest states were Maryland, Texas and New York with indices of 76, 82 and 86 respectively. The highest were Wisconsin, Illinois and New Jersey with indices of 195, 161 and 144. (See Attachment 5, *Medical Price Index for Workers' Compensation: The MPI-WC, Second Edition, June 2008*, Workers Compensation Research Institute, Cambridge, Massachusetts.)

WCRI also measured the difference between prices set in each state for workers' compensation purposes and those set for Medicare. Medicare, which is a major payer of medical services in all states, adjusts prices in each state according to the differences in the cost of providing medical treatment. It is one of the few national payers what has designed a system that adjusts prices based on a geographical practice cost index. (See Attachment 6, 2009 Geographic Adjustment Factors; and 2009 Geographic Practice Cost Indices by State and Medicare Locality.) Thus the prices Medicare sets and pays for services provided in Alabama, for example, differ than the prices set for Alaska. This allows comparison between states, not only of Medicare prices but the comparison of the prices set by other payers as well. For example, by using Medicare as the baseline, the percentage difference in what each state pays in relation to Medicare provides another benchmark to compare workers' compensation fees. According to WCRI, South Carolina's *Medical Services*

Provider Manual, on average sets, as of July 2006, prices 47% higher than Medicare. North Carolina sets fees 39% higher than Medicare and Georgia 58% higher.

The three lowest states were Massachusetts, Hawaii and West Virginia. Massachusetts fees, on average, were 13% below Medicare prices and Hawaii's workers' compensation fee schedule was 10% above Medicare. West Virginia was 13% higher than Medicare's. The three highest states, Alaska, Illinois, and Rhode Island set fees 236%, 163% and 116% higher than Medicare. (See Attachment 7: "Workers' Compensation Fee Schedule Premium Over Medicare Fee Schedule, by Service Group, July 2006".)

Inflation

Since January 2003, the date of the last overall increase in medical fees, the Consumer Price Index for Medical Care, in cities with populations between 50,000 and 1,500,000 in the South, increased 26.8% (January 2003 through July 2009). Over this same period of time the price for medical care services increased 28.9% for urban areas in the South. The Consumer Price Index for all items increased 17.6% during this period. (See Attachment 8, Bureau of Labor Statistics, Consumer Price Index.)

Another measure of change in the cost of physician services is the Medicare Economic Index (MEI). The MEI measures the average annual price change for various inputs need to produce physician services. It is comprised of two categories: the physician's own time, to include wages, salaries and fringe benefits, and the physicians practice expense. The physicians practice expense includes nonphysician employee compensation, office expense, drugs and medical supplies, liability insurance costs, medical equipment and other expenses. The MEI is adjusted to reflect productivity growth.

The MEI is projected to increase 1.6% in 2009 after having increased 15.7% from 2003 to 2008 for a total increase of 17.3% during this period. (See Attachment 9, "Increase in the Medicare Economic Index Update for CY 2009", Attachment 10, "Medicare Economic Index, 2003 – 2009" and Attachment 11, "Medicare Economic Index & CPI, 2003 – 2009.")

Pharmacy

In 2003, based on recommendations from its Pharmacy Advisory Committee, the Commission included a pharmacy section as part of the fee schedule. Payment for prescription drugs, both brand name and generic, is limited to the average wholesale price plus a $5.00 dispensing fee or the pharmacist's or health care provider's usual and

customary charge, whichever is less. The *Red Book*, published by Thomson Reuters, and the *Blue Book*, published by First Databank, are the sources of average wholesale prices. All prescriptions must be filled using generic drugs, if available, unless the treating physician directs otherwise.

It is important to note that average wholesale price is not equivalent to acquisition cost. It is a price determined by manufacturers. Pharmacies receive substantial discounts and rebates to average wholesale price and there is considerable variation in the discounts and rebates received.

While the payments under this formula are higher than some health insurance plans, our payment system is not as fluid, with a substantially higher number of payers involved and slightly higher transaction costs. The fee schedule amount is the maximum allowable payment a provider can be paid under the Workers' Compensation Act. In instances where the pharmacy's charge is lower than the maximum allowable payment, or where the pharmacy has agreed by contract with an employer or insurance carrier to accept discounts or lower fees, payment is to be made at the lower amount.

While no change is being recommended in the prescription pricing formula, it is an issue that will need further consideration as a result of ongoing national litigation over the method for calculating average wholesale prices. (For example, see New England Carpenters Health Benefits Fund et. al. v. First Data Bank, Inc., and McKesson Corporation. As a result of $350 million settlement in this class action lawsuit, in two years First Databank will no longer publish the *Blue Book*. See Attachment 12, "Settlement to Reduce Brand-Name Drug Prices in Many States", Workcompcentral, September 9, 2009.) In addition, there are changes underway in Medicare's pricing of drugs, specifically, changes in how prescription drugs will be priced for inclusion in set-aside agreements.

Recommendations for 2010

Based on this analysis, the following is recommended: a 3.1% average increase in prices for 2010, adoption of CMS's 2009 relative values, to include facility and non-facility relative values where applicable, and inclusion of the most recent current procedural codes published by the American Medical Association. Between 2003 and 2009 relative values increased 3.1% (See Attachment 4, Effect of Adopting 2009 Relative Values). To increase total payments 3.1%, the conversion factor would remain $52.00. The anesthesia conversion factor would be $30.00, proportionally the same as the Medicare conversion factor for anesthesia and the Medicare conversion factor, 58%. The current anesthesia

conversion factor is $24.00. The 26% increase in the anesthesia conversion factor is a result of changes implemented by Medicare since 2002.

Independent Medical Examinations

It is recommended that the fee for an independent medical examination be increased from $600 to $750. The American Medical Association defines an independent medical examination, CPT Code 99456, as a work related or medical disability examination by other than the treating physician that includes: completion of a medical history commensurate with the patient's condition, performance of an examination commensurate with the patient's condition; formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; development of future medical treatment plan; and completion of necessary documentation/certificates and report. It is also recommended that CPT Code 99455, impairment rating by the treating physician, be increased from $97 to $150. With this change, it is recommended that in extenuating or complex circumstances, an IME fee greater than the maximum allowable payment may be approved, either by a commissioner or through administrative review by the Commission's Medical Services Division. Appropriate supporting documentation must be submitted with the request.

The following changes in fees are also recommended:

- CPT Code 99075, Medical testimony, physician, first hour from $536 to $600;
- CPT Code 99076, Medical testimony, physician, each additional quarter hour from $134 to $150;
- CPT Code 99145, Testimony by deposition, physician first hour from $320 to $400; and
- CPT Code 99146, Testimony by deposition, physician, each additional quarter hour, from $80 to $100.

For all other fees where a relative value is not available, the price will be calculated in the same manner as the 2003 schedule or the increase will be same as the overall increase approved.

National Correct Coding Initiative

It is also recommended that the National Correct Coding Initiative be cited and used to guide the billing and payment of procedures. This coding initiative was developed by the Centers for Medicare and Medicaid Services to promote correct coding of health services and prevent payment for improperly coded services. It consists of edits to evaluate claims when a provider bills more than one service for the same patient for the same date of service. It is based on coding conventions in the American Medical Associations

Current Procedural Terminology manual, coding guidelines from national societies and analysis of Medicare medical and surgical practices. Its purpose is to ensure that the most comprehensive group of codes are billed rather than the component parts and to edit two codes that cannot reasonably be performed together based on either the definition or anatomical considerations. It is a national recognized system used by Medicare since 1996, many state Medicaid programs and many health insurance carriers. The Commission for many years has used the correct coding edits as a basis for resolving bill disputes. It provides a system to determine which procedures are part of, and thus included in the payment of, the same service. The recommendation is to include a statement in the fee schedule citing its use thus providing greater clarification and guidance for proper billing and payment. If any disputes arise concerning proper coding, the dispute can be handled in the same manner as provided by R67-1305, Medical Bill Review.

The effective date of the new schedule would be January 1, 2010, or as soon thereafter as possible.

Impact on Total Payments & Premium

The National Council on Compensation Insurance (NCCI) estimates that the adoption of Medicare's 2009 relative values and the change in the anesthesia conversion factor would result in a 3.8% increase in physician costs. The dollar impact on overall workers' compensation system costs would be $7.6 million. (See Attachment 13, "Analysis of Changes to the South Carolina Physician Fee Schedule Proposed to be Effective January 1, 2010", National Council on Compensation Insurance, September 17, 2009.)

GRT:t

Attachments

1. *2003 Medical Services Provider Manual*
2. Federal Register, Vol. 73, No 224, Wednesday, November 19, 2008
3. Summary of Comments Received, Comments Received and Public Hearing Transcript
4. Effect of Adopting 2009 Relative Values
5. *WCRI Medical Price Index For Workers' Compensation: The MPI-WC, Second Edition*
6. 2009 Geographic Adjustment Factors; 2009 Geographic Practice Cost Indices by State and Medicare Locality
7. "Workers' Compensation Premium Over Medicare by Service Group, July 2006"

8. Bureau of Labor Statistics, Consumer Price Index
9. "Increase in the Medicare Economic Index Update for CY 2009"
10. "Medicare Economic Index, 2003 – 2009"
11. "Medicare Economic Index and CPI, 2003 – 2009"
12. "Settlement to Reduce Brand-Name Drug Prices in Many States", Workcompcentral, September 1, 2009.
13. "Analysis of Changes to the South Carolina Physician Fee Schedule Proposed to be Effective January 1, 2010", National Council on Compensation Insurance, Inc., September 17, 2009.