State of Oklahoma Workers' Compensation Commission
Schedule of Medical and Hospital Fees

Report: Summary of Proposed Changes

December 20, 2019

Updated January 23, 2020

Proprietary and Confidential

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Schedule of Medical and Hospital Fees

Summary of Proposed Changes

FAIR Health has been meeting with the Workers' Compensation Commission regularly since September 2019. Pursuant to their instructions, we have researched provisions of the fee schedule and the rate tables included in the fee schedule. We have reviewed the Oklahoma fees in comparison to other states and private insurance claims as reflected through FAIR Health data collected from health plans and third-party administrators for services provided in Oklahoma. In addition, we have reviewed the data provided by the National Council on Compensation Insurance (NCCI) for paid bills in 2017 and 2018 to evaluate and project the impact of changes on paid amounts for 2020.

The following is a summary of potential changes to the fee schedule for 2020. FAIR Health is providing information to support decision making by the Workers' Compensation Commission (Commission). All decisions are the responsibility of the Commission. FAIR Health provides research and support but does not determine which, if any, of the potential changes will be adopted by the Commission.

This report, dated January 23, 2020, is an update of a report published December 20, 2019, which includes decisions made by the Commission and that are reflected in the draft fee schedule that will be posted for stakeholder comment.

For ease of use, the format of this document follows that of the fee schedule.

General Information

The following suggested updates, if approved, would be made to the fee schedule.

- Update references to the Workers' Compensation Court to the Workers' Compensation Commission.
- Remove provisions relating to the Court of Existing Claims and the Workers' Compensation Court.
- Update all copyright dates.
- Include copyright information for the American Dental Association.
- Update rate tables:
    - Remove obsolete codes.
    - Add new codes established since 2011.
    - Include CPT, HCPCS and CDT code descriptions.
    - Update maximum allowable reimbursement (MAR) rates reflecting updated Oklahoma conversion factors applied to Centers for Medicare and Medicaid Services (CMS) RVUs.
    - When permitted by statute, cap increases/decreases to plus or minus 10% when compared to the 2012 fee schedule. (See the Surgery section for exceptions for surgical codes.)
    - Identify codes for possible exceptions to the calculation formula.
    - Include American Medical Association (AMA) icons to identify add-on codes that must be used in conjunction with another code and codes that are exempt from the Modifier 51 separate procedure rule.

Rate Tables and Conversion Factors – Professional Fees

- Proposed conversion factors
    - Conversion factors are applied to Medicare non-facility rates

Service Area	Oklahoma – Existing		Oklahoma – Codes Added 2012		Proposed CF	2020 CMS CF	OK as a % of CMS
	Avg.	Median	Avg.	Median			
E/M	47.04	47.91			54.13**	36.0896	150%
Anesthesia	46.48*		46.48*		48.50	22.2016	218%
Surgery	53.32	52.84	57.98	59.45	59.45	36.0896	165%
Radiology	55.07	50	57.98	61.99	NA***	36.0896	NA
Path/Lab	52.36	48.72	51.66	51.47	52.35	36.0896	145%
General Medicine	61	44.12	46.3	45.61	47.27	36.0896	131%
Physical Medicine	40.72	36.44			40.72	36.0896	113%

* Oklahoma currently pays for Anesthesia services based on 15 minute time units for the first 2 hours and 10 minute time units after 2 hours; the equivalent dollar value for 15 minutes after 2 hours is $69.87.
** The original conversion factor considered for evaluation and management services was 47.91, however by statute, E/M services must be reimbursed an amount equal to 150% of Medicare or more, so the conversion factor was increased to 54.13.
*** The calculated conversion factor of 65.42 is not relevant for the Radiology section as rates are defined in the statute as the lesser of the 2010 Oklahoma fee schedule MAR or 207% of the Medicare rate.

- Proposed methodology for calculating MAR values:
    - Generally the MAR for professional fees is equal to the CMS RVU x the Oklahoma conversion factor.
    - Control costs to the system by preventing any rate from increasing by more than 10% over the previous (2012) fee schedule rate.
    - If a rate decreases by more than 10% from the prior fee schedule, use the rate from the previous (2012) fee schedule.
    - Surgery codes may not be lower than the value from the 2012 fee schedule.
    - Consider making exceptions for selected codes based on customized rates from prior fee schedules, rates established in the ground rules or the statute, stakeholder feedback and common workers' compensation practices. (E.g., many states do not separately pay for hot/cold packs; they are included in the billing for the physical therapy code.)
    - An Excel spreadsheet is provided to facilitate decision making based on the procedures and services that are most highly utilized (or represent the highest expense) in the Oklahoma Workers' Compensation program.

Projecting Payment Amounts for the 2020 Fee Schedule

FAIR Health received data from NCCI for professional services that included paid amounts for 2017 and 2018 aggregated at the procedure code/modifier level. The NCCI data also included the number of times that each procedure was performed. These data enabled FAIR Health to compare actual paid amounts to projected paid amounts based on the fee schedule MAR for each code. The fee schedule projections illustrate the maximum payments and do not recognize a number of factors reflected in the actual paid amounts, including:

- Provider contracted payments that are less than the fee schedule MAR amounts.
- Services that when performed in a facility are billed at less than the non-facility (e.g., office) rates that are the basis for the fee schedule.
- Codes for services that were reported as "By Report" and reimbursed based on usual and customary rates. Approximately 19% of the codes included in the 2020 fee schedule will be new. Many of the services that were formerly billed as By Report can be reported with these newly included CPT and HCPCS codes and will reimbursed based on the fee schedule MAR.

When the Commission has reviewed and evaluated this report and provided direction about the changes they wish to include for the 2020 fee schedule, FAIR Health will run a final analysis of the 2020 projected payments in comparison to fee schedule amounts. This information can be used to adjust conversion factors if needed to balance changes to the fee schedule with the projected payments under the program.

General Ground Rules

- To avoid repeating the same language in multiple sections of the fee schedule, the following paragraphs can be moved to the General Ground Rules section:
    - Definition of "By Report".
    - Durable medical equipment and supplies provided by the physician.
    - Unlisted services or procedures.
    - Payment disputes.
- Update language so that reimbursement will be based on the lesser of the provider's usual and customary charge or the fee schedule MAR for each covered service on the claim.
    - This replaces the current rule which allows reimbursement based on the total aggregate charges for all services on the claim. See example below:

CPT Code	Provider Charges	Fee Schedule MAR	Current Max	Proposed Max
99203	$75.00	$146.61	$75.00	$75.00
95860-26	$100.00	$87.42	$100.00	$87.42
	$175.00	$234.03	$175.00	$162.42

- Remove the cap from the multiple procedure rule
    - Under the current fee schedule, the primary procedure is paid at 100% of the MAR and other procedures are paid at 50% of the fee schedule MAR up to a maximum payment for the additional procedures of 100% of the MAR for the primary procedure.

- To align with standard practice, this limit can be eliminated in the 2020 fee schedule. Multiple procedures can be paid at 50% with no cap, subject to National Correct Coding Initiative code edits (described below).

- Adopt the National Correct Coding Initiative code editing system. Implemented by CMS, this coding system promotes correct coding methodologies and identifies services that should not be reported together or are a component of another service.

Modifiers and Payment Guidelines

- Include a separate section for Modifiers after the General Ground Rules section.
- Consolidate the listing of modifiers in this section and when appropriate, include Oklahoma payment guidelines to determine how the fee schedule MAR is impacted when certain modifiers are used.

Evaluation and Management (E/M)

- To align with Centers for Medicare & Medicaid Services (CMS) practices, CPT 99241-99245 should not be used for consultations.
    - Consultation services may be billed using CPT 99201-99205 for office-based consultations and 99221-99223 for inpatient consultations.
- To comply with the statue that requires the MAR for E/M codes to be at least 150% of the Medicare rate, update the conversion factor for E/M codes to 150% of CMS or 54.13.

    (CMS CF 36.0896 *150% = 54.13)

- Address issues with timing of updates to the CMS and Oklahoma fee schedules to ensure compliance with the statute. Options include:
    - CMS updates the fee schedule every year effective January 1 and the Oklahoma fee schedule is evaluated every two years and has an effective date of July 1.
        - The Oklahoma fee schedule will be in effect July 1, 2020 – June 30, 2022, during which time CMS will update their fee schedules three times, with effective dates of January 1 2020, 2021 and 2022.
    - Post interim year rates on the Commission's website for E/M (and Radiology, which has a similar restriction based on Medicare updates).
        - Administrators, plans and providers can download the updated rates and implement the revised rates in their systems.
    - Incorporate CMS changes by reference: reference the CMS files and effective dates in the ground rules so administrators, plans and providers can calculate updated rates.
        - This option places a burden on stakeholders to do the work to calculate compliant rates.

Anesthesia

- Update the Anesthesia rate tables to include the CMS base units for each anesthesia service and remove the calculated MAR amount for each code. Example:

CPT Code	Description	Base Unit
00100	ANESTHESIA SALIVARY GLANDS WITH BIOPSY	5
00102	ANESTHESIA CLEFT LIP INVOLVING PLASTIC REPAIR	6
00103	ANESTHESIA EYELID RECONSTRUCTIVE PROCEDURE	5
00104	ANESTHESIA ELECTROCONVULSIVE THERAPY	4
00120	ANESTHESIA EXTERNAL MIDDLE & INNER EAR W/BX NOS	5
00124	ANES EXTERNAL MIDDLE & INNER EAR W/BX OTOSCOPY	4
00126	ANES XTRNL MID & INNER EAR W/BX TYMPANOTOMY	4
00140	ANESTHESIA EYE NOT OTHERWISE SPECIFIED	5
00142	ANESTHESIA EYE LENS SURGERY	4

- Update the ground rules to provide the formula for anesthesia reimbursement, based on applying the conversion factor to the total number of units included on the claim.
    - Base units – based on the complexity of the service; CMS is the source for the base units.
    - Time units – one unit is assigned for every 15 minute time period; time of 8 minutes or more will roll up to one time unit.
    - Physical status modifiers – additional units may be added based on the patient's health status at the time of surgery.
    - Qualifying circumstances – additional units may be added when anesthesia services are provided under unusual risk factors or due to the patient's extraordinary condition.
- Eliminate the use of 10 minute time units after two hours of anesthesia time.
    - Based on the Oklahoma data for anesthesia in the FAIR Health database, less than 20% of anesthesia bills are for surgeries in excess of two hours
- Consider increasing the Anesthesia conversion factor. 48.50 aligns with the FAIR Health median allowed conversion factor.
    - FAIR Health develops conversion factor benchmarks for anesthesia administered in Oklahoma for the full, non-discounted amounts charged by providers and the imputed in-network allowed amounts accepted by providers who participate in a plan's network.

		Percentiles						
	Mean	25th	45th	50th	55th	60th	70th	75th
Allowed Anesthesia*	52.04	38.845	46.431	48.512	50.448	53.777	62.167	64.7
Billed Anesthesia**	113.89	79.569	95.925	100.247	105.518	117.244	129.422	134.674
*August 2019 release								
** May 2019 release								

- Delete the provision related to monitoring equipment. This equipment is typically provided by the facility.

Surgery

- Remove the anesthesia base rate units from the surgical rate tables. Anesthesia services may be billed based on the service provided. The America Society of Anesthesiologists (ASA) provides a crosswalk of anesthesia codes to surgery codes, however it is not a one-to-one relationship. In some cases, there is more than one anesthesia code that may be used for a certain type of surgery.

  Example:

CPT Code	MOD	DESCRIPTION	MAR	FUD	ASST
10060		INCISION & DRAINAGE ABSCESS SIMPLE/SINGLE	204.51	010	1
10061		INCISION & DRAINAGE ABSCESS COMPLICATED/MULTIPLE	354.92	010	1
10080		INCISION & DRAINAGE PILONIDAL CYST SIMPLE	356.11	010	1
10081		INCISION & DRAINAGE PILONIDAL CYST COMPLICATED	515.43	010	1
10120		INCISION & REMOVAL FOREIGN BODY SUBQ TISS SIMPLE	256.23	010	1
10121		INCISION & REMOVAL FOREIGN BODY SUBQ TISS COMPL	461.33	010	1
10140		I&D HEMATOMA SEROMA/FLUID COLLECTION	288.33	010	1
10160		PUNCTURE ASPIRATION ABSCESS HEMATOMA BULLA/CYST	220.56	010	1
10180		INCISION & DRAINAGE COMPLEX PO WOUND INFECTION	433.99	010	1
11000		DBRDMT EXTENSV ECZEMA/INFECT SKN UP 10% BDY SURF	95.71	000	1
11001		DBRDMT EXTNSVE ECZEMA/INFECT SKN EA 10% BDY SURF	39.83	ZZZ	1
11004		DBRDMT SKN SUBQ T/M/F NECRO INFCTJ GENT&PR	991.63	000	1
11005		DBRDMT SKN SUBQ T/M/F NECRO INFCTJ ABDL WALL	1350.7	000	0
11006		DBRDMT SKN SUBQ T/M/F NECRO INFCTJ GENT/ABDL	1218.13	000	1
11008		REMOVAL PROSTHETIC MATRL ABDL WALL FOR INFECTION	475.01	ZZZ	0

- Reimburse multiple procedures at 50% of the listed MAR and eliminate the current cap. (See General Ground Rules above for more information.)
- Review rates for most commonly performed orthopedic and neurosurgery codes. In many states, these procedures are a subject of focus and the Commission may want to consider valuing some of these codes as exceptions.

Radiology

- Remove the language for MRI with strength of at least 1.0 Tesla. This is not relevant given current MRI technology.
- Rates in the Radiology section are governed by statute and must be the lesser of the 2010 fee schedule rate or 207% of the current Medicare amount.
    - In the analyses of MAR amounts for the Radiology section, FAIR Health provided a comparison of the 2010 fee schedule rates and 207% of Medicare to the value generated by the formula (OK conversion factor x Medicare RVU). This was provided for comparative purposes as the values must be aligned with the statute.
    - Similar to Evaluation and Management codes discussed above, Radiology rates should align to CMS changes which become effective each January. This can be accomplished in two ways:

- Post updated Radiology rates to the Commission's website for the interim years (e.g. rates effective on January 1 of 2021 and 2022).
    - Administrators, plans and providers can download the updated rates and implement in their systems.
- Incorporate CMS changes by reference: reference the CMS files and effective dates in the ground rules so administrators, plans and providers can calculate updated rates.
    - This option places a burden on stakeholder to do the work to calculate compliant rates.

Pathology

- Include language for presumptive and definitive urine drug testing.
    - Presumptive urine drug testing is reported using CPT 80305-80307 and definitive testing is reported with HCPCS codes G0480-G0483 (based on the number of drug classes tested) or G0659 that distinguishes between structural isomers.
    - Do not establish fees for CPT codes 80320-80377 which are used for definitive drug testing and billed based on the specific drug being tested. Billing based on the specific drug tested leaves more room for potential over-billing for drug testing services.
    - This proposed method for reimbursing for urine drug testing has been adopted by multiple state workers' compensation fee schedules as well as by many private health insurance carriers.

Dental

- List CDT codes and descriptions used for dental billing and include a specific maximum allowable reimbursement (MAR) in the fee schedule.
    - The formula remains the same – 70% of usual and customary charges, however, the Commission may select a FAIR Health percentile to define as the usual and customary rate.
    - The draft fee schedule provides dental MAR values based on the FAIR Health 95th percentile of charges. This percentile was chosen as 70% of these values generally aligns the values in the NCCI data for amounts paid for dental services

Durable Medical Equipment, Supplies, Orthotics and Prostheses

- Continue reimbursing MAR at 90% of the Oklahoma fee from the CMS DMEPOS fee schedule.
- Rate tables for DMEPOS have been included in the draft fee schedule, listing the HCPCS codes, descriptions and MAR values based on 90% of Medicare. Alternatives include:
    - Remove the reference to the CMS fee schedule as they have been in the draft fee schedule. Values are pegged to the CMS fee schedule in effect when the rate tables are updated. These rates would remain in effect until the next update of the Oklahoma fee schedule. This assumes the fee schedule would be updated every two years when evaluated by the Commission.

- Similar to Evaluation and Management and Radiology codes which are governed by the statute (DMEPOS codes are not), the DMEPOS rate tables could be updated and posted to the Commission's website in interim years.
- Continue to reference the DMEPOS fee schedule in the ground rules and enable the rates to float as the DMEPOS fee schedule is updated by CMS. If the fee schedule will not be updated regularly, this may be the most efficient option to maintain currency of the rates.

Ambulance Services

- Maintain reimbursement for ambulance services based on the current methodology:
  - Emergency transport – 150% of Medicare fees.
  - Non-emergency transport – 125% of the Medicare fee schedule.
  - Air ambulance – 100% of Medicare fees.

Pharmaceutical Services

- Maintain the current reimbursement of 90% of the average wholesale price of a prescription plus a $5 dispensing fee as provided in the statue.

Facility Reimbursement

FAIR Health requested and received data from NCCI for facility payments. The data are aggregated separately for facility services provided in an Ambulatory Surgery Center (ASC) and in a hospital outpatient department for the following categories: non-surgery, surgery, DRG, hospital revenue codes and other. FAIR Health did not receive payment data for inpatient facility services.

When evaluating potential changes to the fee schedule, FAIR Health typically reviews payment data for services that have the highest impact to the program – generally highly utilized codes and high cost services. We review the paid amounts and frequencies and use this information with the proposed fee schedule MAR amounts to project future paid amounts.

The lack of data at the procedure code level makes it impossible to project the impact of fee schedule changes on workers' compensation payments to facilities.

FAIR Health received from NCCI amounts paid to facilities for a small number (approximately 25) procedure codes. However, an analysis of these data in comparison to Medicare rates show that some of the Oklahoma paid amounts were extremely low (in some cases 35% - 40% of Medicare fee schedule values), while others were significantly higher than Medicare (between 150% – 200% of Medicare values). Given the variation within this limited set of data, FAIR Health is unable to make cost projections for facility services performed in an outpatient hospital or ASC setting.

Additionally, we did not receive any payment data for inpatient facilities. Thus we are unable to make any determinations as to the impact on costs of any proposed changes to the Inpatient or Inpatient Rehabilitation sections of the fee schedule.

After multiple discussions on this topic, the Commission requested that FAIR Health include outpatient rates applicable to services performed in hospital outpatient and ASC settings in the draft fee schedule for comment by stakeholders.

Ambulatory Surgical Center (and Hospital Outpatient)

- Update language in this section to clarify that rules apply to both hospital outpatient and ASC facility settings. Include and update definitions of a hospital outpatient facility and an ASC.
- Clarify language relating to implantables to better define which implantable materials are eligible for reimbursement.
- Clarify that facility costs should be billed using the UB-04 form.
- Outpatient MAR values in the draft fee schedule have been provided based on the following methodology:
    - The outpatient maximum allowable reimbursement (MAR) is based on the Medicare Outpatient Prospective Payment System (OPPS). The OPPS assigns procedure codes to ambulatory payment classification (APC) groups.
    - Reimbursement for the APC group includes all costs related to the primary procedure, including related procedures, supplies, materials and implants.
    - The outpatient MAR in the draft fee schedule has been set to 175% of the OPPS fee schedule.
    - Because Oklahoma reimburses for the cost of implants separately based on the device cost, FAIR Health proposes to subtract the cost of the device from the Medicare OPPS payment rate before applying the Oklahoma multiplier.
        - This practice prevents the multiplier from being applied to the cost of the device and thus overpaying for the implant.
        - The result is that the Oklahoma multiplier is applied to the reimbursement amount for facility services and the device would be paid based on the invoice price as under the current fee schedule rules.

      The outpatient MAR would apply to services performed in a hospital outpatient setting as well as in an ASC.
    - Several states use this OPPS-based methodology for outpatient facility reimbursement.
    - As noted above, we are not able to assess the impact on projected payments by changing to this methodology since we have a very limited view into the codes or utilization of services that have been used to bill for facility services in the past. The Commission provided information that NCCI has determined that Oklahoma is paying approximately 165% of Medicare rates for outpatient facility services. Paid data are always lower than values projected based on fee schedule amounts because the fee schedule includes the *maximum* allowable reimbursement amount. Paid data reflect network discounts and provider usual and customary charges that are lower than the fee schedule amounts.

      Based on that information, FAIR Health included in the draft fee schedule, a methodology for outpatient hospital and ASC reimbursement based on 175% of the 2020 CMS Outpatient Prospective Payment System (OPPS), to be presented for stakeholder feedback.

      Several states that FAIR Health works with use a similar methodology to reimburse hospital outpatient and ASC facility services; it is working well for them.
    - While there may be a number of reasons that we did not receive significant stakeholder feedback related to outpatient reimbursement, one such reason could be that facilities are satisfied with the current level of reimbursement. This may imply that the current reimbursement methodology is generous to facilities.

Inpatient Hospital

- Current inpatient hospital reimbursement is calculated by multiplying the Medicare MS-DRG relative weight, which is updated annually by CMS, by the Oklahoma base rate, which is currently $4,016.58.
- The Oklahoma base rate is low in comparison to other states and we have received stakeholder feedback that also identifies the low base rate.
    - Medicare uses a hospital-specific base rate for inpatient facility reimbursement. The range of base rates for Oklahoma hospitals is:
        - Minimum - $5,264.05
        - Median - $5.740.14
        - Average - $5,935.69
        - Maximum - $8,173.27
- The Commission could consider increasing the current base rate, which would apply to all facilities or adopting a hospital-specific base rate. Both of these methodologies are employed in other states' fee schedules.
- As noted above, FAIR Health is not able to analyze the increase in payments that may be associated with updates to the base rate used to calculate inpatient facility reimbursement.
- While FAIR Health does not have access to DRG-level paid data to do an analysis, because the base rate is multiplied by the DRG relative weight, it can be estimated that a 10% increase to the base rate would produce an approximate 10% increase in the projected payment amounts in the future. This does not take into account the fluctuation of the Medicare MS-DRG relative weights, but can provide some directional information to inform a decision to update the base rate. If the workers' compensation program is willing/able to absorb increased payment amounts for 2020 and beyond, the Commission could consider increasing the base rate by a corresponding percentage.
    - At the direction of the Commission, FAIR Health applied a 15% increase to the inpatient base rate in the draft fee schedule to bring it to $4,619.07.
- An updated table containing the 2020 MS-DRG relative weights has been included in the draft fee schedule. Similar to the options for Evaluation and Management, Radiology, and DMEPOS, there are several alternatives to consider to ensure the currency of the fee schedule:
    - Include the MS-DRG table in the fee schedule. Instead of listing the relative weights, FAIR Health can use the relative weights to calculate the inpatient MAR, making it easy for stakeholders to find the rates and load the information into their systems. If the fee schedule is updated on a two year schedule, reimbursement for inpatient facility services would lag for a time, but would never be more than two years old.
    - If a two year time lag is a concern, the Commission could opt to recalculate the rates and post them to the Commission's website on an annual basis. Language to this effect would be included in the ground rules.
    - Remove the MS-DRG Relative Weights table from the ground rule, but adopt it by reference. This will enable the rates to be adjusted as CMS updates the DRGs each year. If the fee schedule will not be updated regularly, this may be the most efficient option to maintain the fee schedule.

Inpatient Rehabilitation

- Update the Case Mix Group table to the 2020 version, providing the most recent average length of stay values.
- Similar to the discussion of Inpatient Facility reimbursement above, FAIR Health does not have access to data to analyze the impact of a change to the Inpatient Rehabilitation Facility base rate.
- No changes have been made to the formula for calculating inpatient rehabilitation rates, however as noted above the Case Mix Group table has been brought current to 2020.

Contact Information

FAIR Health appreciates working with the Oklahoma Workers' Compensation Commission and assisting with the updates to the Schedule of Medical and Hospital Fees. We look forward to continuing to meet on a regular basis and updating the fee schedule ground rules and rate tables in accordance with the Commission's decisions.

We will schedule a meeting in early January 2020 to discuss the contents of this report and plan for the next phases of the fee schedule project. In the interim, please contact us if you have any questions.

Donna Smith
Executive Director of Business Development
dsmith@fairhealth.org
281-513-0904

Chris O'Donnell
Executive Director of Customer Experience
codonnell@fairhealth.org
212-257-2367

Appendix – Stakeholder Feedbacl

OKLAHOMA SPINE & BRAIN INSTITUTE

6802 South Olympia Ave, Suite 300, Tulsa, OK 74132 • Office: (918) 749-0762 • Fax: (918) 744-4246

November 01, 2019

To: OKfeedback@fairhealth.org

RE: Review of OK fee schedule

To Whom It May Concern:

Thank you for your time and attention in review of our Oklahoma fee schedule. I wanted to touch on some replacement codes that pertain to our practice. Posterior Lumbar Interbody Fusion codes 22612 and 22630 have been replaced with 22633 and 22630. Please keep in mind that while these are replacement codes have come into play it is the same work product as the 2012 codes and our fee schedule should reflect that. 22851 has been replaced with 22853. 38220 is now 20939 and 22520, 22521, 22522 have been replaced with 22513, 22514 and 22515.

During the presentation at our conference it was mentioned that there was not a plan to look at the rules at this time, only the fee schedule. It is my belief that these two go hand in hand. One example is the multiple bilateral procedure rule for surgery. If you give me dollar for dollar per code that you do in Arkansas I will be paid less in Oklahoma because of the multiple bilateral procedure rule cap.

I know that this is a very complex process and we certainly appreciate your time and expertise in assisting Oklahoma with this review. If I can be a resource at any time please do not hesitate to contact me.

Sincerely,

Sheila Harless

Director of Workers' Compensation

Oklahoma Workers' Compensation Commission

Fair Health

Comments Regarding Oklahoma Workers' Compensation Fee Schedule

October 29, 2019

I appreciate the opportunity to comment on the Oklahoma Workers' Compensation Fee Schedule. I have been involved both in using the Fee Schedule to review Workers' Compensation Claims as well as providing input for changes to the Fee Schedule for almost 30 years.

Healthcare costs continue to rise, and this is one of the most dynamic topics facing Oklahoma Workers' Compensation today. The last fee schedule change occurred in 2012. Medicine has continued to evolve so there are many new procedures and codes that are currently not part of the 2012 schedule. By the time a new fee schedule is developed it will have been 8 plus years of changes in medicine that should be addressed.

In 2016 I was part of a group that studied the Fee Schedule and made recommendations to the Commission. The study group reviewed data and at that time determined to leave the Fee Schedule as it was. This was partially because of how the Fee Schedule had been put together in the past. There has never been a formula for a Provider Section such as Surgery. Certain surgery codes were increased while other codes were decreased. It was obvious then and still is now, that it will be very difficult to make changes to the Fee Schedule by using a mathematical formula that is tied to Medicare or another Index. Some providers will be hurt, and others would applaud the change. It seems the only fair way is to look at individual specialties and make changes within that specialty group.

The issue also exists that three sections of the Fee Schedule have been mandated by the Legislature. Currently under Title 85A, and House Bill 2367, Radiology, Evaluation and Management and Pharmacy have formulas for Maximum Allowable Reimbursement. I believe any new fee schedule developed by the Commission should include a better explanation of the fee for Radiology. The law is confusing since it specifically states, "the reimbursement rate shall be the lesser of the reimbursement rate allowed by the 2010 Oklahoma Fee Schedule and two hundred seven percent (207%) of the Medicare Fee Schedule." Is the Medicare Fee Schedule the 2010 Medicare Fee Schedule or the current year Medicare Fee Schedule? The

same question exists for the Evaluation and Management section. House Bill 2367 simply says "reimbursement rate shall not be less than 150% of the Medicare Fee Schedule." Is this the current Medicare Fee Schedule? Since all three sections contain formulas on how to calculate MAR, are these changed yearly, or do they follow the requirements of every two years?

The most important part of all Fee Schedules is the Ground Rules. My company reviews medical bills in 20 states and the states with well written ground rules and simple formulas seem to have fewer issues between the Insurance Carrier / TPA, Providers and Claimants. Not everyone likes what they say, but if they are well written there is very little problem with interpretation. When we first started in Oklahoma there were very few Ground Rules. The Ground Rules were developed both to clarify how a charge was to be reviewed but also to help stop over-aggressive billing. Some Providers were charging excessive amounts for equipment, supplies and services simply because there was nothing in writing preventing them from doing so.

I would encourage the Commission to make sure all Ground Rules are kept in place. Some may need to be changed, but I think for the most part the current Ground Rules are a good indicator and roadmap for the Providers, Insurance Carriers, Third Party Administrators, and Claimants. Without the Ground Rules, provider bills become items of conflict, which then causes additional time and money for hearings to resolve the conflicts that should never have occurred in the first place.

Finally, in several states where companies have been hired to help with development of a new Fee Schedule, the company hired gets to sell the new Fee Schedule and in some cases the cost has become outrageous to Providers, Insurance Companies and Third-Party Administrators. I have always appreciated the fact that the Oklahoma Workers' Compensation Court, and not the Oklahoma Workers' Compensation Commission has made the Fee Schedule available at minimum or no charge and that has always been available online. I would encourage the Commission to continue that practice.

Respectfully Submitted

Bob Altmiller

Medical Claims Review Services, Inc.

November 6, 2019

Fair Health Oklahoma Fee Schedule Consulting Team
Via Email to OKFeedback@FairHealth.org

Re: Medical Fee Schedule Review

Dear Consulting Team:

The American Property Casualty Insurance Association (APCIA)[1] appreciates the opportunity to comment on the review of the Oklahoma workers' compensation medical fee schedule.

APCIA believes the current medical fee schedule should remain in effect, without revision. The current fee reimbursement rates are fair and more than adequate. A recent study by the Workers Compensation Research Institute ("WCRI") shows Oklahoma's fee schedule provides a 41% premium to medical providers over Medicare's reimbursement rates. Olesya Formenko and Te-Chun Liu, *Designing Workers' Compensation Medical Fee Schedules 2019*, p. 30. WCRI, May 2019. https://www.wcrinet.org/reports/designing-workers-compensation-medical-fee-schedules-2019. This 41% premium rate is certainly fair and is more generous than states such as Massachusetts, New York, Florida, California, Hawaii, Maryland, Michigan, West Virginia, South Carolina, and the District of Columbia.

Significantly, there is no access problem in Oklahoma's workers' compensation system. There are no reports of injured workers being unable to find a treating provider for a workplace injury. As the current rates are adequate, comparable to reimbursement rates in other state workers' compensation system, and there are no medical provider access problems for injured workers, no compelling reason justifies modifying Oklahoma's current medical fee schedule. Raising reimbursement rates would only unnecessarily increase medical costs for Oklahoma employers.

If ultimately a decision is made to revise the medical fee schedule and increase reimbursement rates, APCIA recommends that the current medical fee guidelines be made mandatory rather than be merely a "standard of reference" for medical providers. Requiring medical treatment according to evidence-based nationally recognized medical treatment guidelines will ensure that the injured worker receives the most effective medical care for his injury to ensure prompt recovery to health and appropriate return to work. Adherence to objective, evidence-based treatment guidelines will protect workers from ineffective and

[1] APCIA represents nearly 60 percent of the U.S. property casualty insurance market and the broadest cross-section of home, auto, and business insurers of any national trade association. APCIA members represent all sizes, structures, and regions, protecting families, communities, and businesses in the U.S. and across the globe.

unnecessary medical treatment. Medical providers should be required to treat according to such evidence-based guidelines unless the Oklahoma Workers' Compensation Commission makes a specific finding that deviation from the guidelines is necessary under the circumstances to avoid an unreasonable risk to the health or life of the employee.

APCIA thanks you for your consideration of these issues.

Sincerely,

Steven A. Bennett
Assistant Vice President, Workers Compensation Programs & Counsel
American Property Casualty Insurance Association

From:	Pam Dunlap
To:	OKFeedback
Cc:	Major Cunnigham; "Jay Cunningham"; Jeremy Haney
Subject:	Oklahoma Society of Anesthesiologists Feedback
Date:	Friday, November 15, 2019 9:03:30 AM

Oppose Work Comp link to Medicare rates for anesthesiologists.
Support reforms that address anesthesia payment disparity.

To Whom it May Concern:

Medicare payments for the services of physician anesthesiologists have long been marked by inequality and instability. For physician anesthesiologists providing anesthesia services, the Medicare "33% problem" has been a persistent challenge. If reimbursements for anesthesia services are tied to Medicare rates, then anesthesia payment rates will be *reduced by more than 50 percent*. This rate will put work comp a few dollars above Medicare and far below other government payers.

In 2011, the most recent, significant amendment to the WC fee schedule, anesthesiologists were "held harmless" from being tied to Medicare rates for reimbursement. We support continuing the current fee schedule that separates anesthesia services from Medicare.

Medicare pays for anesthesia services at only 33% of commercial pay rates. In contrast, MedPAC reports that the average Medicare payments for other physician services are 80% of commercial pay rates. The Centers for Medicare and Medicaid Services' (CMS) recent release of Medicare billing data found that physician anesthesiologists are one of the lowest paid medical specialties when ranked by Medicare allowed payment amounts per individual physician. The billing data indicates that when ranked by Medicare payment allowed amounts per individual physician, anesthesiology is among the lowest (48^{th} out of 50) of physician specialties.

In Oklahoma, anesthesiologists are reimbursed $20.27 per unit by Medicare while private plan rates pay an average rate of $65 unit. Anesthesiologists are currently reimbursed $46.58 for work comp cases which is 72% of average private plan rates and below other physician service reimbursement rates. An 8% increase in the current fee schedule would bring anesthesiologists to $50.30 per unit and near 78% of commercial rates which is right in line with other physician reimbursement rates.

Anesthesiologists provide care for patients as they present at the hospital or surgery center. They are not the primary physician for work comp patients and do not receive, diagnose or order procedures for the patients.

To maintain beneficiary access to anesthesiology services, OSA favors a fee schedule for anesthesiology services that is not tied to Medicare rates and respectfully requests consideration of an 8% increase in the fee schedule to bring anesthesiologist rates in line with other physicians.

Sincerely,

Major Cunningham, MD

President
Oklahoma Society of Anesthesiologists

Pam Dunlap, CAE
Executive Director
Oklahoma Society of Anesthesiologists
PO Box 4087
Edmond, OK 73083
405-412-4137
www.osahq.org

From: Pam Dunlap
To: Christine O"Donnell
Subject: RE: Additional Anesthesia Feedback
Date: Tuesday, December 10, 2019 9:32:54 AM

Chris

I met with commission staff last week just to discuss anesthesia billing in Oklahoma. As you know, anesthesiologists bill differently than other specialties (base plus time system). With all of the commissioners and staff being relatively new, I thought it was wise to just discuss anesthesia reimbursement.

During that meeting an issue came up about the "bump" in anesthesia reimbursement after 2 hours. I did some additional research after that meeting. The majority of commercially insured cases in Oklahoma use the 4-4-6 model. Our initial submission of comments were based on the assumption that the 4-4-6 model would be maintained. If there is any change to that model, we would respectfully request to reevaluate our initial compensation proposal.

If I need to resubmit this communication as a comment to the feedback email account, please let me know and I will happily comply.

Thank you so much for your time and attention to this matter.

Sincerely,
Pam

Pam Dunlap, CAE
Executive Director
Oklahoma Society of Anesthesiologists
PO Box 4087
Edmond, OK 73083
405-412-4137
www.osahq.org

From: Christine O'Donnell <codonnell@fairhealth.org>
Sent: Monday, December 09, 2019 2:18 PM
To: Pam Dunlap <pdunlap@osahq.org>
Subject: RE: Additional Anesthesia Feedback

Thanks Pam, I appreciate the additional feedback. I will share your comments with the Commission as we move ahead on the fee schedule project.

Best regards,

Chris

From: Pam Dunlap <pdunlap@osahq.org>
Sent: Monday, December 9, 2019 11:31 AM
To: OKFeedback <okfeedback@fairhealth.org>
Subject: Additional Anesthesia Feedback

The Oklahoma Society of Anesthesiologists made previous comments regarding the update of the WC fee schedule in Oklahoma. In an effort to provide additional background information, we submit the attached explanation and history of the Medicare disparity of payment for anesthesiologists.

If you have any questions, please don't hesitate to contact me.

Sincerely,

Pam Dunlap

Pam Dunlap, CAE
Executive Director
Oklahoma Society of Anesthesiologists
PO Box 4087
Edmond, OK 73083
405-412-4137
www.osahq.org

Medicare Payment for Anesthesiology

Medicare payment for anesthesiology is about 33% of commercial payer rates. In most other specialties, it hovers around 80% of commercial fee schedules. Considering the fact that Medicare has not increased for anyone at the same rate as commercial programs, that number is likely lower today.

- Why is this?
    - In 1992, Medicare changed its payment rate from “usual, customary and reasonable” (UCR) to a system known to this day as RBRVS (Resource-Based Relative Value Scale).
    - RBRVS was created by William C. Hsiao, Ph.D., who was contracted by Medicare to develop a new system.
    - Originally, there was some consideration to move anesthesiology to a procedure-based system, but instead a decision was made to stay with the “base units plus time” system that we know today.
    - When the conversion away from UCR to RBRVS was implemented, it was accompanied by a 29% reduction in the Medicare conversion factor.
    - This drastic reduction is believed to have happened because of a severe calculating error comparing anesthesia work values to other physician specialties.
    - Medicare used a limited and inaccurate comparison of anesthesia services to procedures performed by other specialties that resulted in the reduction to the anesthesia conversion factor, which was the start of the severe Medicare undervaluation of anesthesia care we have today.
- Why hasn’t it been fixed?
    - It is a constant on the high-priority “to do” list.
    - Remember, Medicare payment is a zero-sum game because for our rate to be increased, even after showing a problem, it has to come from someone else. No new dollars are added into the system.
    - We have sought correction through the former “Five Year Review” process, which resulted in some improvements.
    - Corrections have occurred over the years. There was a modest correction in 1997, and we won a 23% increase in 2008. But over time, in real

dollars, when there were increases in the conversion factors, because of our inaccurately low rates, these updates in real dollars were very small, and compounding over the years has magnified the problem.

- Addressing the 33% rule is always a primary advocacy focus for us.
    - We are always looking to explore different pathways to make every attempt to fix the issue, and we plan to increase our focus in this area.
    - We have worked aggressively to protect anesthesia payments during the implementation of the new Quality Payment Program (QPP) of the MACRA law.
    - I am organizing a small work group of our best and brightest payment experts to examine options under this new Administration and new HHS and CMS leadership.
    - We have had behind-the-scenes conversations with members of Congress about potential opportunities to fix the “33% problem.”
    - The problem always will lie in the fact that unless extra dollars are put into the system, others at the table will struggle with a fix because it could mean dollars taken from other specialties. Getting extra dollars from Congress for physician payment is extremely challenging.

From: Vera, John B
To: OKFeedback
Subject: Ideas for the Fee Schedule Update in Oklahoma
Date: Monday, December 2, 2019 2:44:45 PM

Good afternoon,

Here are a few suggestions I have about the Fee Schedule:

1. Make it clear that medical care will be coded by the most recent rules (ICD-10 currently). There are instances where current coding is either not covered by a DRG code, or may be in conflict with the DRG description. Example: a posterior/posterolumbar surgery is billed per ICD-10 the same as a posterior/anterior surgery was in 2012. There may also not be a DRG code in the Fee Schedule, though it is the proper code under current rules. Example DRG 520. Make it clear If there is a code that complies with ICD-10 coding rules that is not covered in the Fee Schedule, the principles of the coding rules governs and the closest available code(s) in the Fee Schedule are applied, if that is the desired result.

2. Reimbursements to Ambulatory Surgical Centers should be made only as indicated in that ground rule. It appears to me that the intent is to reimburse the provider by the terms of 4. *Computation of maximum allowable reimbursement* and only that. So, clarity about billing and reimbursement is needed. Make it clear that the billing should be on UB04 form, include the provider's usual and customary charges and the DRG code. The current language under billing, I suspect the part requiring appropriate coding, has led many bill review companies, and even some judges, to believe that the amount a medical provider bills is to be limited to the amount indicated as MAR for the CPT coded procedure, then they apply the lesser of these 3 methods to further reduce the reimbursement to the provider. If intent is to limit reimbursement calculations to the lesser of the three provided formulas (as it seems to clearly say), add language that says that the CPT code reimbursements found in other ground rules do not apply to determining the proper reimbursement under the ASC Ground rules.

3. Implantables – clarify the definition. "implantables" is defined as "services indicated by . . . which involve an item or device intended for permanent placement in the body. 'Implantable items' include rods, pins, scres, plates, . . . " This seems to indicate that there are two different things being defined. The first is "implantables," which defined all the services coded as indicated and involved in placing the "implantable item(s)." "Implantable items," are the actual item intended for permanent placement in the body. There is frequent argument/confusion about a couple things. The first is an implantable item that for some reason is implanted and later explanted during the surgery. Use of the wording, "intended for permanent placement" indicates to me that the intent is to have the implantable item reimbursed with the 5% markup. It shouldn't matter whether the item is removed during the original surgery or removed 1, 3, 6 months or even years later. The same logic applies. The second common dispute arises about "implantables." Does it include items purchased with the implantable items for purposes of placement thereof. Most of these, if not all, are single time use items. When I make the argument that they should be included and reimbursed with the 5% markup, opponents and even judges ask why wouldn't that also include sutures,

scalpels, etc. The answer is that those items aren't billed under the proper revenue codes to fall within the two prong definition: (1) proper revenue code; and (2) involved in placing implantable items in the body. If language is added to make it clear, either way, that would be very helpful.

These are current thoughts and issues I have encountered.

John B. Vera
Legal Counsel
INTEGRIS Health, Inc.
3366 N.W. Expressway, Suite 800
Oklahoma City, Oklahoma 73112
Telephone: (405) 951-4786
Alternate Telephone: (405) 951-2834
Fax: (405) 951-4790

Rick Snyder, FHFMA
Vice President, Finance & Information Services

December 17, 2019

FAIR Health VIA email
530 Fifth Avenue, 18th Floor
New York, New York 10036

RE: Oklahoma Workers' Compensation fee schedule review

Greetings:

On behalf of our more than 110 member hospitals, the Oklahoma Hospital Association would like to offer comments for your consideration in the development of fee schedule recommendations to the Oklahoma Workers' Compensation Commission.

I have three specific recommendations on the inpatient hospital fee schedule, which in summary are:

1. Please increase the base rate for inpatient hospital services significantly. Inpatient payment rates for Oklahoma workers compensation are far below the rates approved in other states.
2. Rather than listing payment weights for all inpatient MS-DRGs, the inpatient hospital ground rule could specify the use of the Medicare inpatient MS-DRG weight in effect for the date of discharge of the workers compensation patient.
3. Consider using true Medicare-based payment amounts, recognizing that the Medicare program now includes quality adjustments as factors in differentiating rates to different hospitals, in addition to local wage rates and other factors.

1. Inadequate Oklahoma payment rates for inpatient hospital services.

Oklahoma hospitals are paid much less than hospitals in other states for taking care of injured workers. The problem has been made worse by the lack of even inflationary updates to the medical fee schedule since the state's transition from the Workers' Compensation Court to the Commission.

NCCI's *Medical Data Report for the state of: Oklahoma* (October, 2018) analyzed inpatient costs from 2016 for Oklahoma compared with the region and the nation. The report included the following comparisons (attached):

Average Inpatient Paid Amount per Stay for Hospital Inpatient Services

Oklahoma	$22,782	
Regional	$29,775	(30.7% more than in Oklahoma)
National	$29,876	(31.1% more than in Oklahoma)

The NCCI report also analyzed hospital inpatient payments as a percentage of Medicare payment rates for the same services. Oklahoma were paid on average 133% of Medicare rates, compared with a regional average of 203% of Medicare, and 191% countrywide.

The same Medical Data Report showed even greater deficiencies for hospital outpatient surgery payments with Oklahoma at 166% of Medicare rates, compared with a regional average of 277%, and 256% countrywide.

The WCRI Hospital Outpatient Payment Index, 8th edition reported that payments for hospital outpatient surgical episodes in Oklahoma were 46% below the 36-state median. (Yang, 2019)

Oklahoma's extremely low inpatient payment rates create a significant disadvantage for Oklahoma hospitals and for the injured workers needing hospital care.

2. Allow inpatient MS-DRG weights to change along with Medicare's weights.

The Centers for Medicare and Medicaid Services (CMS) publishes annual changes to the Medicare Inpatient Prospective Payment System (IPPS) for each federal fiscal year, which begins October 1. Each October 1, CMS puts into effect an updated version of the MS-DRG grouper. The grouper is a software system that assigns a claim to a diagnosis-related group based on the claim's diagnosis and procedure codes and the patient's age, gender, and discharge status. Some years, the MS-DRG grouper changes include new, revised, and deleted MS-DRG codes. CMS recalculates the weight assigned to each MS-DRG annually, based on the current national average costs for each MS-DRG, and does this in a budget-neutral manner so that total spending isn't affected.

Oklahoma's workers compensation medical fee schedule was last updated (for 2012) using the groupings and weights from grouper version 29. On Oct. 1, 2019 CMS implemented MS-DRG grouper version 37.

The commission should establish a ground rule that specifies the use of current Medicare MS-DRG weights, rather than publishing a list of the rates in effect at the time of publication. This would automatically set a maximum allowable amount for any new MS-DRG codes added between medical fee schedule updates. This would also adjust for changes in the relative reimbursement rates automatically and more timely than the waiting for the next medical fee schedule update. The minor annual increases and decreases would reflect national changes in the delivery of hospital care.

Annual grouper updates also include changes in the codes classified as complications, or major complications, and these codes directly affect MS-DRG assignment. The annual grouper changes also are necessary to reflect new and revised diagnosis (ICD-10-CM) codes.

Publication in the medical fee schedule of the current Medicare MS-DRGs and their Medicare weights, as Oklahoma has done since adopting the MS-DRG-based MAR, is appropriate until Medicare makes an annual update. After October 1, the medical fee schedule's MS-DRG weights, and perhaps the MS-DRG listing itself, will be obsolete. Especially if the commission does not anticipate making annual

updates to the medical fee schedule, it would work best for the hospital inpatient maximum allowable reimbursement to be tied to the applicable Medicare MS-DRG weight as of the date of discharge, using the current version of the MS-DRG grouper in effect for that date.

3. Consider using true Medicare-based payment amounts.

Several states that use DRG-based reimbursement amounts base these on the amount Medicare would have paid the specific hospital for the service, rather than the statewide $4,016.58 currently used in Oklahoma. For example, Texas's rate is 143% of the hospital-specific Medicare rate (or Medicare's rate plus 43%). Texas gives hospitals the option to receive separate payment for the cost of implants; in this case, the rate paid is 108% of Medicare's.

Medicare recognizes that labor costs vary between urban and rural parts of the state, and reflects these differences in their hospital payment rates. In recent years, Medicare has incorporated a number of quality adjustments, set annually, in their rates. The adjustments penalize hospitals with excessive readmissions, with higher than normal rates of hospital-acquired complications, and for low overall quality scores. These factors mean that almost every hospital is paid slightly different rates by Medicare for inpatient care.

CMS offers the PC-PRICER, a free software package that allows other payers to determine the Medicare payment rate for a MS-DRG at a specific hospital on a specific date. Many plans use the PC-PRICER to pay contractually set "Medicare plus" rates. This approach could be adopted by the Oklahoma medical fee schedule as a replacement for the $4,016.58 base rate.

In addition to the DRG amount, Medicare pays hospitals certain "pass through" costs, most significantly for bad debt for Medicare deductibles and coinsurance. These pass through costs are not applicable to workers compensation patients. If the Commission adopts an inpatient schedule based on hospital-specific Medicare rates, Medicare's pass through payments should be specifically excluded.

Thank you for considering these ideas for improvement of the inpatient hospital section of the medical fee schedule. I would be glad to provide additional information, answer questions, or do anything else to help inform this process.

Sincerely,

Rick Snyder

Rick Snyder
Vice President, Finance and Information Services

December 20, 2019

Oklahoma Workers' Compensation Commission
1915 N. Stiles Avenue
Oklahoma City, OK 73105

Dear Commissioners:

On behalf of United Physicians, LLC, a group of independent treating physician practices, we would like to thank you for the work you are doing on the Oklahoma Worker's Comp Medical Fee Schedule. We appreciate your willingness to take input from treating healthcare providers and take into consideration our input on workers comp healthcare-related issues. As treating providers for injured workers in our state we want to bring to your attention key provisions in past workers compensation legislation that has impacted the medical community. We offer the following comments for the Commission and Fair Health to consider in the drafting of an updated Medical Fee Schedule.

We have recommendations to the medical fee schedule, which in summary are:

1. Continue to attract Oklahoma's most talented physicians and healthcare providers to treat injured workers in rural and urban Oklahoma by addressing CPT codes.
2. Careful consideration is needed when applying replacement CPT codes.
3. Caution of the negative impact of blind PPO's to treating healthcare providers and hospitals.

1. Addressing CPT Codes

- Historically, the Oklahoma workers compensation system has had some of the state's most talented and quality physicians and healthcare providers treating injured workers in the state. We believe to continue to attract these outstanding health professionals, modernizing and increasing CPT codes is paramount.
- For decades Oklahoma had robust reimbursement rates for medical professionals to treat injured workers and attracted a network of healthcare professionals that made workers comp patients a priority in their respective practices. Even with a stagnate fee schedule that has been reduced and frozen for almost 15 years, these physicians are still offering that same level of exceptional care to their fellow urban and rural Oklahomans today.

Need for Increasing CPT Codes

- Oklahoma physicians are paid less than physicians in other states for taking care of injured workers. The problem has been made worse by the lack of any adjustments, even inflationary updates to the medical fee schedule since 2012.
- As an example, NCCI's *Medical Data Report for the state of Oklahoma* (October 2018) analyzed workers comp medical costs as a comparison of current payment to corresponding Medicare rates from 2016 for Oklahoma compared with the region and the nation. The report included the following comparisons **(Attachment A):**

Physician Payment as a Percent of Medicare

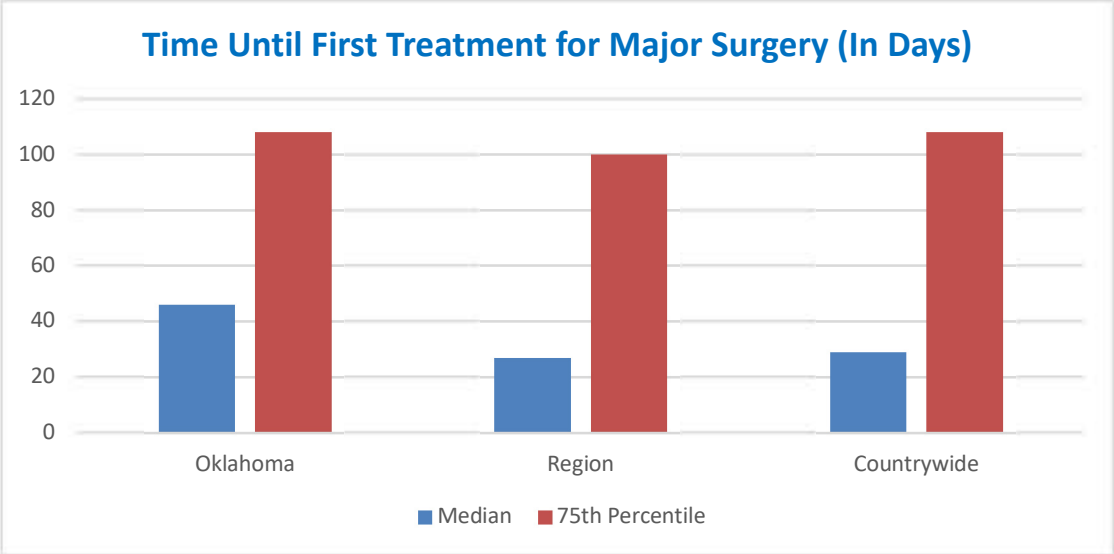
Physician Service Category	Oklahoma	Region	Countrywide
Surgery	142%	345%	275%
Radiology	206%	328%	236%
General and Physical Medicine	99%	152%	131%
Evaluation and Management	124%	166%	141%

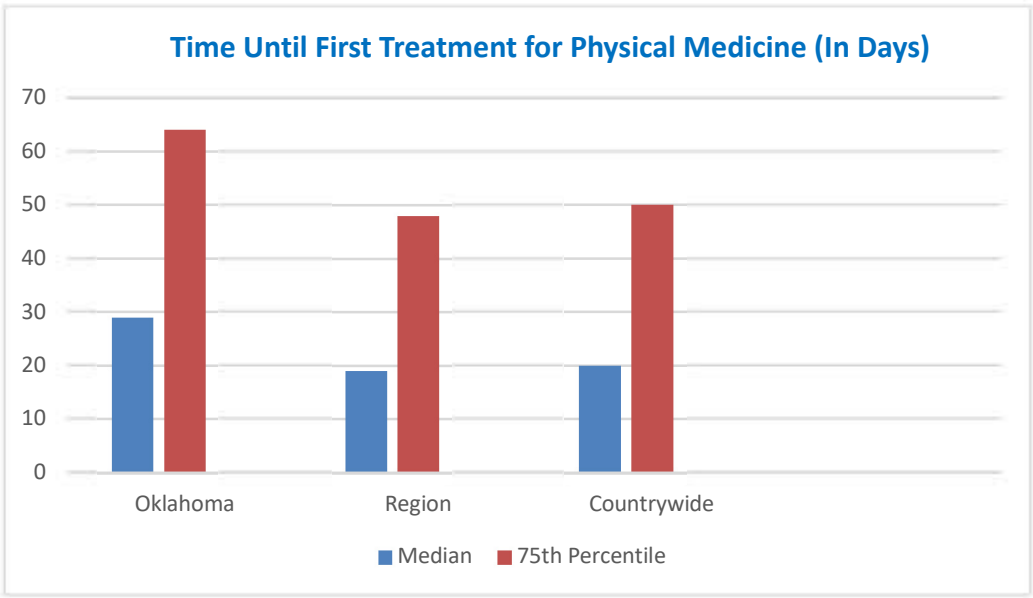
ALL Physician Services	**124%**	**203%**	**167%**

- While the Oklahoma workers comp medical fee, schedule has been virtually untouched since January 2012, the current fee schedule came on the heels of years of reductions to surgical CPT codes, representing an average 13% decrease in surgical CPT codes that directly impacted treating physicians.
- 2004 – 2012 – The 8 years leading up to adoption of the latest medical fee schedule, surgical services had taken a 25% reduction in fees, approximately 10% from the worker's compensation fee schedule, and on average, 15% discounts from Certified Workplace Medical Plans.
- 2012 - The most recent cut was a mandated $40 million reduction in the 2011 workers comp legislation, SB 878 that required a 5% or over a $40 million reduction to all medical providers.
- Over the last decade, surrounding states have been reviewing, updating and increasing their respective state work comp medical fee schedules to recruit and retain quality medical providers to treat injured workers, while keeping up with increasing healthcare costs and inflation as illustrated in the table above.

Access to Treating Physicians for Injured Workers to Expedite Return to Work

- Expediting return to work for injured workers is a top priority for policy makers. Treating medical providers share the same goals and passion and these healthcare providers have made workers comp patients a priority in their respective practices.
- They maintain additional professional staff to help an injured worker through the process of treatment and healing so they can return to work quickly.
- However, NCCI's *Medical Data Report for the state of Oklahoma* (October 2018) analyzed one measure of availability of medical services, Time to Treatment (TTT). This measures the number of days between date of injury and the date on which the worker first received medical services. **(Attachment B):**





Comparison of Treatment and Patient Care for Health Insurance vs. Worker's Compensation

- Due to the nature of the workers injury, there is a uniqueness in treating workers compensation patients versus a patient with health insurance such as private insurance or Medicare (**see Attachment C**), *Comparison of Treatment and Patient Care of Health Insurance vs. Worker's Compensation*.
- The additional administrative and regulatory burdens associated with workers' compensation cases are often too cumbersome for providers to justify a reduced compensation resulting from low medical fee schedules.
- The studies point out that the hourly practice expense for treating physicians who accepted workers' compensation patients was determined to be 2.5 to 3 times the hourly rate for a Medicare practice expense.
- If practice expenses associated with treating workers' compensation patients are reduced, it will impede the state's ability to maintain high quality physician participation levels.
- The objective of the treating physician practice is to provide impeccable quality medical treatment to the injured worker and get them back on the job as soon as possible.
- Oklahoma's present work comp medical fee schedule lags behind surrounding states and states in our region. We are recommending a modernized and robust fee schedule that will result in continuation of valuable services provided to adjustors, case managers and attorneys by physician practices so we can continue to provide a 24-hour turn around on work status forms or other valuable services that moves the workers' compensation claim through the system in a timely fashion.

2. Replacement Surgery CPT Codes

There are some replacement surgical codes that pertain to some physician practices. Posterior Lumbar Interbody Fusion codes 22612 and 22630 have been replaced with 22633 and 22630. We ask that you please keep in mind that while these replacement codes have changed it is the identical work product as the 2012 codes and we ask that the proposed fee schedule reflect that amount.

22851 has been replaced with 22853,
38220 is now 20939,
22520, 22521, 22522 have been replaced with 22513, 22514 and 22515.

During Fair Health's presentation at the OWCC conference it was mentioned that there was not a plan to look at the ground rules at this time, only the fee schedule. However, we believe these two go hand in hand. One example is the multiple bilateral procedure rule for surgery. If you proposed a dollar for dollar reimbursement code that they do in Arkansas, Oklahoma treating providers will be paid less in Oklahoma because of the multiple bilateral procedure rule that is caped

3. Blind Preferred Provider Organization (PPO's)

The blind PPO issue negatively impacts treating physician practices and hospitals. A silent PPO is when a workers' comp insurer or self-insured employer's TPA leases or purchases a PPO discounted fee schedule and applies the reduced PPO reimbursements to bills received from the workers' comp provider. Even though the treating physician practice, nor the hospital signed a contract with the workers' comp insurers and self-insured employers and never agreed to this discounted rate. The treating providers would never accept these discounted rates for workers comp because of the complexity and additional resources required when treating patients in the work comp system.

Thank you for considering these ideas for improvement of the workers comp medical fee schedule. We are glad to provide additional information, answer questions or do anything else to help inform the Commission and Fair Health as the medical fee schedule update is developed.

Sincerely,

Sheila Harless

Sheila Harless
Director of Workers' Compensation
Oklahoma Spine and Brain Institute
(918) 855-0735
sheila@osbi.net

United Physicians, LLC, is a group of independent treating physician practices whose goal is to pursue a positive regulatory environment that ensures the longevity and financial fortitude of physician practices in the State of Oklahoma. United Physicians' issues are related to scope of practice, patient choice of physicians, maintenance of office and surgical fees, lawsuit reform, workers compensation legislation and medical malpractice.

Physicians

Results from NCCI's study, "The Price Impact of Physician Fee Schedules" (April 2014), show that the median workers compensation price for a physician service is always at, or very near, the maximum allowable reimbursement (MAR) amount set by the fee schedule. In the 1970s, fewer than a dozen states had physician fee schedules in place. In the 1990s, several states established such schedules. Today, few states remain without a physician fee schedule. Recent changes in the schedules indicate greater attention to provisions that often seek to balance cost containment with service provider availability.

One measure of workers compensation medical costs is a comparison of current payments to the Medicare rates.

The chart below shows the average percentage of Medicare schedule reimbursement[2] amounts for physician payments by category for Oklahoma, the region, and countrywide. Note that "all physician services" in Chart 5 below refers only to the four categories listed in the chart.

Chart 5

Physician Payments as a Percentage of Medicare

Physician Service Category	Oklahoma	Region	Countrywide
Surgery	142%	345%	275%
Radiology	206%	328%	236%
General and Physical Medicine	99%	152%	131%
Evaluation and Management	124%	166%	141%
All Physician Services	**124%**	**203%**	**167%**

[2] The calculation for Surgery takes into account Medicare's endoscopic procedures reimbursement rules.

Attachment B

One measure of the availability of medical services is time until first treatment. Time to treatment (TTT) is measured by the number of days between date of injury and the date on which the worker first received medical services. Charts 19 through 22 show the median and 75th percentile[3] TTT by physician service category for Oklahoma, the region, and countrywide. No adjustment has been made to account for injuries that may take time to develop, such as an occupational disease, that may extend the time between the date a work-related injury or disease is reported to a workers compensation insurer and the first medical treatment an insurer is responsible for.

Chart 19

Time Until First Treatment for Major Surgery[4] (in Days)

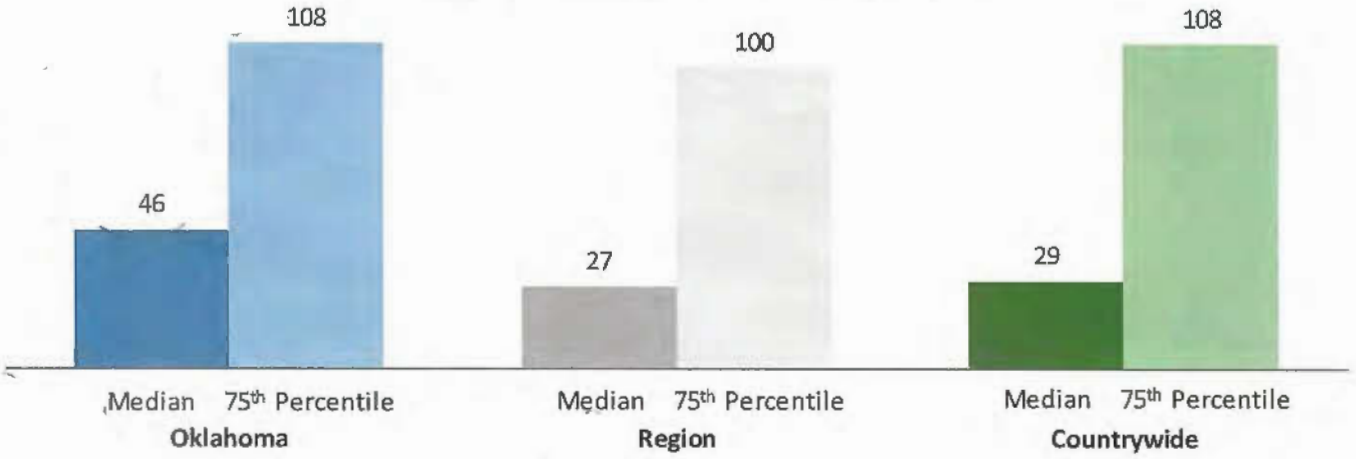
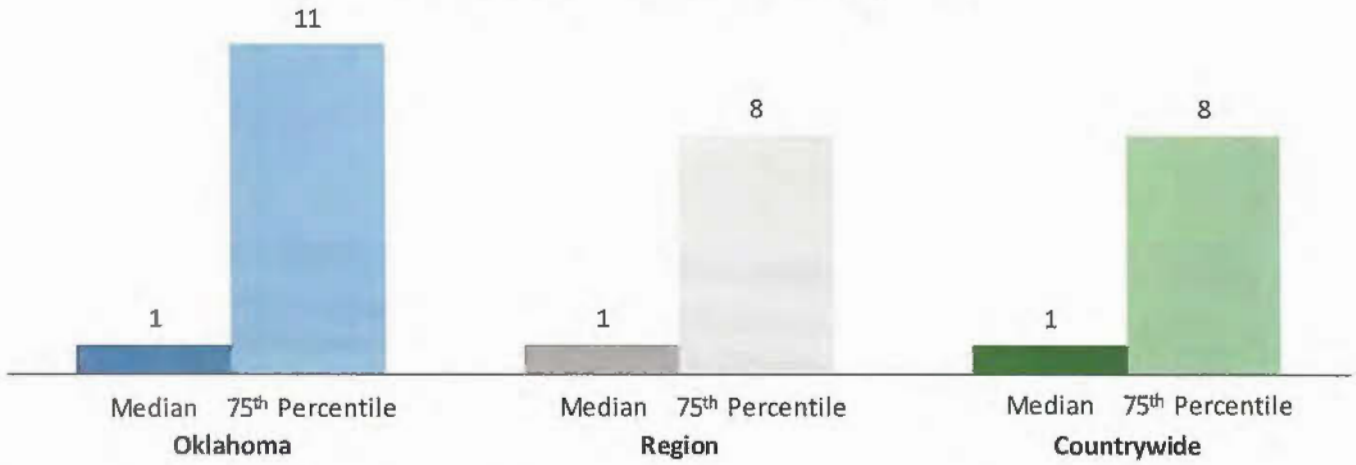


Chart 20

Time Until First Treatment for Radiology (in Days)



Source: NCCI's Medical Data Call for Accident Year 2016 and Service Years 2016 and 2017.

[3] The median is the TTT where one-half of all TTT values are higher and one-half are lower. This statistic is less affected by extremely low or extremely high values. The 75th percentile is the TTT where 75% of all TTT values are lower and 25% are higher. For example, Chart 19 indicates that out of 100 claimants, 75 will receive major surgical treatment within 108 days of their accident date. Comparing the median to the 75th percentile illustrates the variation in TTT between claims.

[4] A surgical service is defined as "major surgery" or "minor surgery" within the surgical category as defined by the AMA.

Chart 21

Time Until First Treatment for Physical and General Medicine (in Days)

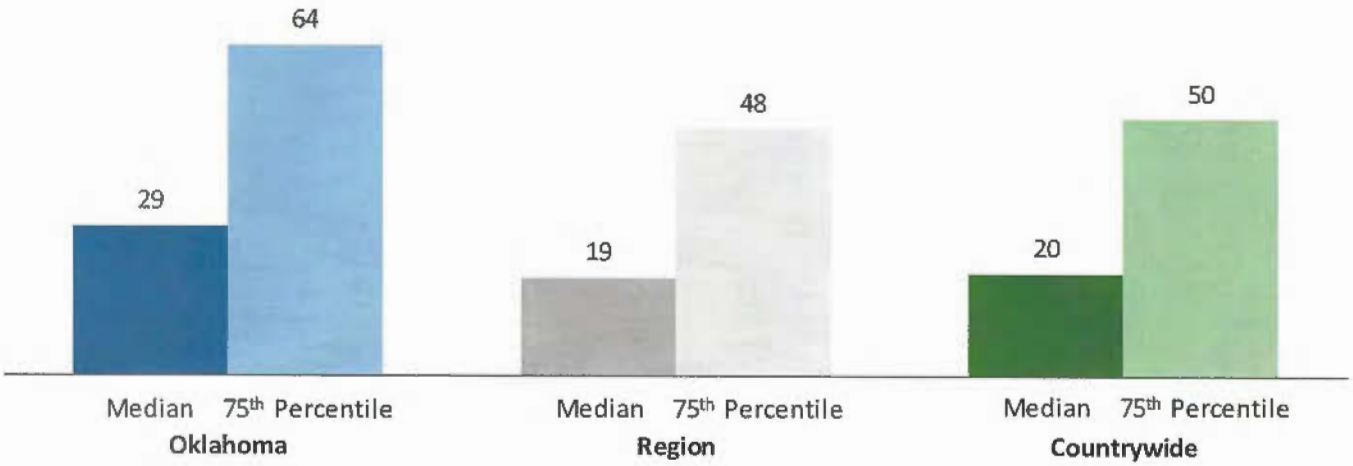
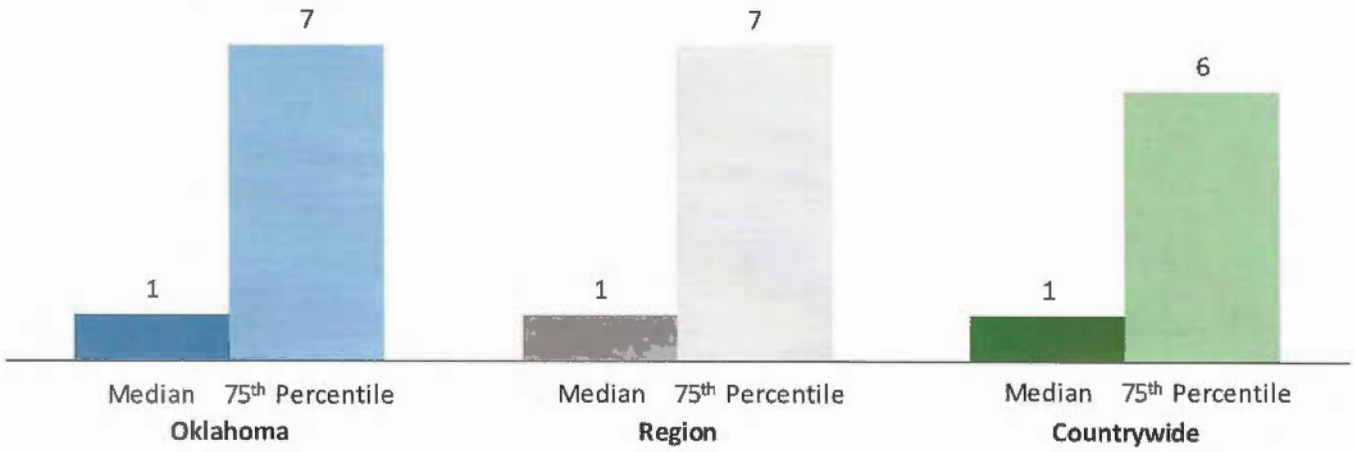


Chart 22

Time Until First Treatment for Evaluation and Management Visit (in Days)



Source: NCCI's Medical Data Call for Accident Year 2016 and Service Years 2016 and 2017.

Attachment C

Comparison of Treatment and Patient Care for Health Insurance vs. Worker's Compensation

Medicare, Health Insurance or Self-Pay Patients	Worker's Compensation Patient
Scheduling Appointment ▪ Auth/referral not required except Indian Health, Medicaid and HMOs. ▪ Patient to bring films to appointment	**Scheduling Appointment** ▪ Authorization always required and always specific. ▪ Completion of WC form detailing all info re: claimant, injury, employer, adjustor, case manager, attorneys and/or judge (if present). ▪ After above is completed/verified, schedule patient. ▪ Coordinate appt time with pt and field CM, if present. ▪ Schedule w/in 72 hours or later if requested. ▪ Patient to bring films to appointment. May require reschedule. Adjustor and case manager are notified and new appt time coordinated. ▪ Patient must be scheduled every 30 days. ▪ Impairment ratings require separate scheduling and details during appointment.
Patient seen for Appointment as Scheduled ▪ Medical records and films reviewed. ▪ No work status form completed	**Patient seen for Appointment as Scheduled** ▪ Patient seen ONLY for what is authorized. ▪ Usually has a larger amt of records/films to review. ▪ Patient may be seen with a case manager or if no contact, case manager may see doctor after appt. ▪ Work status form completed and given to patient and then faxed to adjustor and case manager at the time of each and every appointment. ▪ Impairment ratings require different form of exam with specific legal report generated.
Transcription ▪ Completed and cc to PCP/referral	**Transcription** ▪ Completed but with attention to required format. CC to adjustor, case manager, employer, attorneys & judges (if present). ▪ Faxed/emailed within 72 hours maximum. ▪ Impairment ratings require different format.
Testing, Referrals, Surgery, F/U Visits ▪ Auth or Precert required for IHS and some insurance carriers. ▪ Schedule in network	**Testing, Referrals, Surgery, F/U Visits** ▪ Auth always required and specific to facility. ▪ Authorization for F/U visit always required. ▪ Coordination of F/U visits between patients CM. ▪ Completion of work status form. Faxing to all. ▪ Transcription with copies to all parties as before. ▪ ODG even as a reference and not a mandate has added layers to the auth process as well as peer to peer reviews and delays in treatment.
Field/Telephonic Case Management ▪ Rare	**Field/Telephonic Case Management** ▪ Usual. May have both. ▪ Field CM attends appts or sees Dr. after patient. ▪ ↑ Phone calls and emails ▪ ↑ Transcription and records w/in specific time.
Phone calls and/or additional requests ▪ Infrequent. Maybe 2 out of 10 patients	**Phone calls and/or additional requests** ▪ Frequent. 8 out of 10 patients. ▪ Document all calls. May lead to other additional calls. ▪ ↑Completion of reports, transcription and fax time.
Personnel Requirement ▪ Usual and customary	**Personnel Requirement** ▪ Work Comp Coordinator ▪ ↑ Personnel for ↑ work & time to complete.