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STATE OF OKLAHOMA
WORKERS' COMPENSATION COMMISSION

PUBLIC COMMENTS 2020 PROPOSED MEDICAL FEE SCHEDULE

Public Comment Period:
January 27, 2020 to February 27, 2020

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- Oklahoma Spine and Brain Institute - Sheila Harless
- Oklahoma Surgical Hospital - Madonna Burton
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- Patti Swain, CPC, CPPM
- Spine Surgery, Inc. – Dr. James M. Odor, MD and Valerie S. Lavender-Little
- Robert Remondino, M.D. and Kevin Blaylock, CPA
- Richard Foster, CPO, LP, LO, BSME
- Teresa Johnston
- Terrell R. Phillips D.O.
- Terry Shaw, PhD.
- Tulsa Integrated Pain Services – Yvonne Redington
- United Safety & Claims Inc. – Chali Stevens
- Walmart – Samantha Watkins

Lauren Hammonds Johnson

From: Jeff Fox <jefffoxmd@gmail.com>
Sent: Thursday, February 27, 2020 9:07 AM
To: WCC Fee Schedule Comments
Subject: [External] Comments regarding the Proposed Medical Fee Schedule
Attachments: 20 Feb 24 Comments re Medical fee schedule.pdf

Good morning,

Please find attached my comments regarding the proposed changes to the medical fee schedule.

Thank you,
Jeff Fox, MD
Advanced Orthopedics

February 26, 2020

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

Dear Commissioners:

As a former member of the Physician Advisory Committee (PAC) and on behalf of independent treating physician practices, we would like to thank you for the work you are doing on 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. We offer the following comments in response to the proposed 2020 Medical Fee Schedule.

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.

The FAIR Health report mentions their proposed methodology for calculating MAR and their fourth bullet point of that explanation is a recommendation that you ***"consider making exceptions for selected codes based on customized rates from prior fee schedules …"*** On page six of the FAIR Health report the last bullet point under the Surgery heading suggests that you ***"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."*** In reviewing the FAIR Health report, the value of several surgery codes are flat after a decade of cuts, coupled with a decade of a stagnant fee schedule.

Below are thirteen codes commonly used by surgeons that we believe need to be addressed:

ARTHROSCOPY SHOULDER W/CORACOACRM LIGMNT RELEASE	29826
ARTHROSCOPY SHOULDER ROTATOR CUFF REPAIR	29827
ARTHROSCOPY SHOULDER SURG DEBRIDEMENT EXTENSIVE	29823
ARTHRODESIS POSTERIOR/POSTEROLATERAL LUMBAR	22612
LAM FACETECTOMY & FORAMOTOMY 1 SEGMENT LUMBAR	63047
ARTHRS KNE SURG W/MENISCECTOMY MED/LAT W/SHVG	29881
AUTOGRAFT SPINE SURGERY BICORT/TRICORT SEP INC	20938
ARTHRS KNEE ABRASION ARTHRP/MLT DRLG/MICROFX	29879
LAM FACETECTOMY&FORAMTOMY 1 SGM EA CRV THRC/LMBR	63048
INSJ BIOMCHN DEV INTERVERTEBRAL DSC SPC W/ARTHRD	22851 (22853)
ARTHRODESIS POSTERIOR INTERBODY LUMBAR	22630
POSTERIOR SEGMENTAL INSTRUMENTATION 3-6 VRT SEG	22842
NEUROPLASTY &/TRANSPOS MEDIAN NRV CARPAL TUNNE	64721

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. While the 2020 Proposed Medical Fee Schedule by Fair Health is a step in the right direction, it falls short in addressing critical CPT codes.

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 is further adjusted.

Sincerely,

Jeff Fox, MD
Advanced Orthopedics

February 26, 2020

Chairman Mark Liotta
Commissioner Jordan Russell
Commissioner Megan Tilly
Oklahoma Workers' Compensation Commission
1915 North Stiles Avenue
Oklahoma City, Oklahoma 73105

Via Electronic Mail: feeschedulecomments@wcc.ok.gov

Re: Proposed 2020 Medical Fee Schedule

Dear Commissioners Liotta, Russell and Tilly:

The American Property Casualty Insurance Association (APCIA)[1] appreciates the opportunity to comment on the proposed 2020 fee schedule.

While APCIA appreciates the work the Oklahoma Workers' Compensation Commission and its consultant, Fair Health, performed in designing the proposed fee schedule, we believe the current Oklahoma 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 current 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

[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, including approximately 70% of the workers' compensation market countrywide. APCIA members represent all sizes, structures, and regions, protecting families, communities, and businesses in the U.S. and across the globe.

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 Workers' Compensation Commission propose that the legislature make the current medical fee guidelines 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 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 of the employee.

Thank you for your consideration of these issues.

Sincerely,

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

Lauren Hammonds Johnson

From: Bowen, Ashley B (HSC) <Ashley-Bowen@ouhsc.edu>
Sent: Thursday, January 23, 2020 4:10 PM
To: WCC Fee Schedule Comments
Subject: [External] public comment

To whom it may concern,
If the fee schedule goes down, you will need to find another urologist.
Thanks
Ash Bowen, MD

Lauren Hammonds Johnson

From: Garrett Watts <gwatts@baortho.com>
Sent: Thursday, February 27, 2020 12:15 AM
To: WCC Fee Schedule Comments
Subject: [External] 2020 Fee Schedule

Dear sirs,

I am greatly relieved to see a modest increase in reimbursements according to the proposed 2020 fee schedule.

For those of us who enjoy providing care to injured workers, the time commitments and expenses of providing those services have increased by approximately 50% in the last 15 years. As a result, many providers have had to join ever larger groups or become employed by hospital systems. That results in diminished quality of patient care.

Comp patients are generally more time consuming and difficult than regular private patients; therefore, reimbursement needs to justify the extra commitment.

Cost savings in the comp system are best achieved by utilization review, more timely referrals to specialists and aggressive return to work programs. I suggest that the Commision employ nurse case managers to achieve these goals.

Thank you all for your commitment to providing the best medical care to our injured workers.

Garrett Watts, M.D.
Broken Arrow Orthopedics

Sent from my iPad

CONSOLIDATED
BENEFITS RESOURCES
MEMBER • NATIONAL COUNCIL OF SELF-INSURERS

February 24, 2020

Commissioner Mark Liotta
Commissioner Megan Tilly
Commissioner Jordan Russell
Oklahoma Workers' Compensation Commission
1915 N. Stiles
Oklahoma City, OK 73105

Via: feeschedulecomments@wcc.ok.gov

Dear Commissioners:

Consolidated Benefits Resources (CBR) appreciates the opportunity to review the proposed fee schedule adjustments and to offer public comments. CBR represents over 1,200 Oklahoma employers and we know that rising medical and prescription costs are a national and local concern. We also know the value of having access to qualified occupation physicians and surgeons as well as a fair and equitable fee schedule is vital in the workers' compensation arena.

Attached is a letter with recommendations from Equian and we agree with their recommendations. Equian is a national expert in state's workers' compensation fee schedules and they assist CBR clients in reviewing over 50,000 medical bills that we receive each year.

At this time, we would like to highlight and comment on a few of their recommendations:

- *In-Patient Stop Loss*- we agree with Equian that the $70,000 threshold is too low. This figure was set in 2012 and there is no recommendation for an increase by Fair Health. However, costs of medical services have increased since 2012 and we believe that the threshold figure should be increased to $150,000-$200,000.

- *Physician dispensing of prescription drugs*-the Equian recommendation to allow only a 10-day supply is reasonable and very valuable to the patient. It is also consistent with the new Opioid Law in Oklahoma as it relates to physician dispensing at the initial evaluation. This proposed change is advantageous to the patient because they would have immediate access to the prescribed medicines, but then they could move the long-term dispensing of these drugs to their local pharmacy where their personal pharmacist can review and advise them on any possible drug interactions and/or contradictions that the workers' compensation medicine may have with other prescriptions being taken for underlying health issues. There is also a cost factor to be considered in that the physician dispensed prescriptions we have seen are significantly higher than using a local pharmacy or by mail order.

- *Assistant (Second) Physician at Surgery*- If the assistant surgeon is merely an observer or providing services that an RN or technician can provide, it does not make sense that our clients should pay for the second physician. The medical should provide clear detail of the role and duties performed at surgery by this assistant physician.

- *Time limit to submit medical bills and file for reconsideration*-the current fee schedule dictates that the carrier or self-insured employer pay a bill within 45 days of its submission in a payable format. It is fair and rational to place that same 45-day time frame for the medical provider, pharmacy or prescription plan to submit a medical bill. Reconsiderations should have a limit of 90 days from the date the check is cashed and/or receipt of the Explanation of Review to request a reconsideration.

It is my understanding that the Commission plans on monitoring the fee schedule each year and we also believe that is a good idea and commend the efforts.

Thank you again for your time and consideration of our comments and recommendations.

Respectfully,

Jerry Whorton, CEO

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Michael Strong, MSHCA, MBA, CPC, CEMC
7480 Halcyon Pointe Drive, Suite 300
Montgomery, AL 36117

February 13, 2020

Jerry Whorton, CEO
Consolidated Benefits Resources
PO Box 581630
Tulsa, OK 74158-1630

RE: Proposed 2020 Oklahoma Fee Schedule

Dear Jerry Whorton, CEO:

Equian remains a committed business partner to Consolidated Benefits Resources and thanks you for the opportunity to review the proposed 2020 State of Oklahoma Workers' Compensation Commission Medical Fee Schedule. Equian recognizes the expertise and time required to assemble the proposed schedule. After a thorough evaluation of the FAIR Health Executive Summary as well as the proposed fee schedule, Equian has identified some areas of opportunities that it would like to share for consideration with the State of Oklahoma Workers' Compensation Commission for inclusion in the proposed fee schedule.

Inpatient Hospital Stop-Loss Threshold:

In the previous 2012 State of Oklahoma Workers' Compensation Commission Medical Fee Schedule (hereafter, "2012 Fee Schedule"), the inpatient hospital stop-loss threshold was established at $70,000.00. The proposed 2020 State of Oklahoma Workers' Compensation Commission Medical Fee Schedule (hereafter, "2020 Proposal") reaffirms the stop-loss threshold at $70,000.00.

Since stop-loss is based on the charges of a hospital and not on the fee schedule reimbursement, then the 2020 Proposal assumes that the cost of healthcare or the charges by the hospitals have not changed since the 2012 Fee Schedule. Such an argument would indicate that the cost of living, wages, population growth, and economic growth did not occur in the last eight years.

Each year, the Centers for Medicare and Medicaid Services (hereafter, "CMS") updates the inpatient impact files to adjust the cost-to-charge ratio (hereafter, "CCR"). The CCR is assembled yearly based on each facility's health cost reports filed with the state and federal government. When assembled, the CCR creates the hospital's breakeven point. This is the point at which the hospital's costs to provide care are fully covered and each dollar above that become profit. For example, the 2019 Oklahoma CCR was established as 24.10% for the urban area and 33.00% for the rural area. In 2020, the Oklahoma CCR was changed to 23.00% for the urban area and 30.30% for the rural area. This means that the hospitals charged more for the care, resulting in the lower CCR established for 2020. If the 2020 Proposal keeps the stop-loss threshold unchanged, the ability for a facility to exceed the stop-loss threshold becomes easier. This means more and more facilities and inpatient

bills will trigger the stop-loss threshold. In doing so, the ability to contain medical cost growth diminishes.

When looking at other states, California, Texas, West Virginia, Minnesota, Indiana, North Carolina, Connecticut, and Washington DC all price their inpatient hospital bills as a percentage above Medicare. These states all recognize that the inpatient rate for each hospital will be different because the CCR, number of hospital beds, direct medical education, disproportionate share, and other factors affect the reimbursement of the hospital for the inpatient care. For states, that do not follow Medicare, there are other states that recognize the disparity in the costs of the inpatient care by hospitals and have their thresholds established differently. Nebraska sets the stop-loss threshold for the inpatient care according to each hospital and each diagnosis related group (hereafter, "DRG"). No two hospitals receive the same rate for the same DRG. Illinois and Virginia, on the other hand, establish DRG reimbursement on the region with the stop-loss threshold being a mark-up above that DRG for the region at a multiplier of 2.857 and 300% respectively. Other states take a different approach. They recognize the hospitals do not charge their care equally and provide reimbursement through a CCR methodology. These states include Washington, Michigan, New Mexico, Kentucky, and Massachusetts.

In Oklahoma, this affects many hospitals. Lindsay Municipal Hospital has a CCR of 99%. This means that the hospital will likely never trigger the stop-loss threshold established by the state. However, O U Medicine has a CCR of 15.50%. Claremore Indian Hospital, for example, is an urban hospital with a CCR of 23.00%. This means $100,000 in charges at this hospital would be equal to $148,387.10 at O U Medicine. From this, it is easier for O U Medicine to trigger the stop-loss more quickly than Claremore Indian Hospital. Consequently, Equian requests that the 2020 Proposal consider both the fact that the charges for hospitals have changed since the 2012 Fee Schedule and the fact that the charges by each hospital will never be equal.

Physician Dispensed Drugs:

Over the years many states have started examining physician dispensed medication. Many have established formularies. Others have restricted the ability for physicians to dispense generic only medication. Others have limited the number of days certain medication may be dispensed by the physician before future dispensing needs to be done through a pharmacy. Others have begun the process of banning physician dispensed medication completely.

While the dispensing of medication to patients directly via physicians may result in direct access to more timely care and treatment, it comes with significant risks and costs. Physicians will not have the same pharmacology background as a pharmacist who will be able to determine drug interactions that could inherently cause greater harmer to a patient. Additionally, the medication carried by a physician is often the most expensive that is not generally first line treatment options considered by major medical insurance carriers, Medicare, Medicaid, the United States Department of Labor Office of Workers' Compensation Programs, and other workers' compensation jurisdictions with formularies.

For example, when looking at Diclofenac Sodium 1.5%, a patient could obtain 150mL through their physicians for $1,314.23 since most physicians will carry the most expensive manufacturers in their office. In comparison other bioequivalent cheaper alternatives carried in the retail pharmacies or mail order pharmacies include the same drug with the same active and inactive ingredients for a

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fraction of the price. Meaning that same medication can be obtained through a retail pharmacy or mail order pharmacy for $234.63. These prices are based on the 2012 Fee Schedule and the rules for the 2020 Proposal. Lidopro is the brand name of 4% lidocaine. This same medication can be obtained over the counter for a fraction of the cost at local pharmacies or even through online retailers as 4% lidocaine patches, topicals, or creams. Physician dispensing does not reduce medical costs. It raises them and does little to promote patient care.

Physicians are often susceptible to pharmaceutical representatives marketing their drugs without knowledge by the physician of the cheapest alternatives or even bioequivalence per the United States Food and Drug Administration. Since Medicare and most major medical insurance carriers do not allow physician dispensed medication, physicians are often unaware of the costs of the medication being dispensed or the availability of cheaper alternatives. This greatly increases the cost of care in Workers' Compensation both within the state and in those states that have not regulated this area to date.

Some states have attempted to control this by banning the distribution of brand name medication or creating a formulary. Kentucky for example has a formulary. Wisconsin has forbidden the dispensing of brand name medication unless brand name is the only option available. However, if the patient requests brand name, then the employer is only liable for the cost of the generic version and the patient must pay the difference to obtain the brand name equivalent. Other states require physicians to dispense or prescribe the cheapest alternative before proceeding to more expensive medication. Some states have even controlled the costs by limiting the reimbursement to physicians as a mark-up above their costs for the medication after proof of invoice.

One compromise would be to limit the dispensing of medication by a physician to a 10 day supply in order to allow the injured worker to obtain the medication through a retail pharmacy or a mail order pharmacy for the most cost-effective bioequivalent version in stock at the pharmacy. The pharmacy would have authority to substitute from a brand to a generic version of the medication or from generic to other generic alternatives if bioequivalence is maintained in accordance with state and federal substitution laws.

The state should also consider treatment guidelines and/or a formulary on approved medications and treatment options for generic medication before moving to more expensive generic medication or brand name medication for the same active ingredients targeted to the injured workers' diagnosis.

Assistant-at-Surgery:

Assistant-at-surgery is a growing issue currently within the nation. Many physicians utilize nurse practitioners (hereafter, "NPs"), clinical nurse specialists (hereafter, "CNS"), or physician assistants (hereafter, "PAs"). The 2020 Proposal takes great strides in providing clarity on surgical codes based on Medicare assistant-at-surgery indicators to determine when an assistant may be allowed. However, in order to properly use the indicators correctly, one must understand the Medicare language behind the indicators.

When billing for a physician acting as an assistant-at-surgery with modifiers 80 or 82, the Medicare claims processing manual limited "assistant-at-surgery for surgical procedures in which a physician is used as an assistant-at-surgery in fewer than five percent of the cases for that procedure

nationally."[1] As for the PAs, NPs, and CNS, the requirement is that the assistant "actively assists a physician in performing a surgical procedure and furnishes more than just ancillary services."[2]

Documentation must indicate the role and necessity of the assistant-at-surgery for each surgical procedure performed. Given the 2020 Proposal has indicators next to each procedure, then basic coding guidelines and industry accepted documentation practices must be followed to demonstrate that the assistant actively participated in each surgical procedure performed to support the applicable assistant-at-surgery indicator in the 2020 Proposal. It must also support the necessity of the service if required by the indicator. Ancillary services or insufficient documentation should not be permissible. Often many of the services performed by these assistants can be done by the operating room staff or hospital staff at no additional cost to the payer as it would be included in the overall facility reimbursement rate. Providers typically utilize their personal PAs, NPs, and CNS out of convenience, trust, direct knowledge of the procedure, and for increased revenue. The direct knowledge of the procedure limits the surgeon from having to give instructions throughout the procedure to the hospital staff about the instruments needed or the technique provided. The assistant accompanying the surgeon would have been trained by the surgeon to perform the same services with greater efficiency and speed. This is the reason the documentation requirements were initiated by Medicare on assistant-at-surgery along with the indicators. This promotes payment integrity by eliminating payment for billing errors where a biller may simply bill the same codes reported by the surgeon and adding the applicable modifier for the assistant when there were no documentation other than the name of the assistant on the operative report, which would not substantiate the assistant's active participation in the surgical procedure.

Evaluation and Management Services:

Starting in 2021 the American Medical Association Current Procedural Terminology (hereafter, CPT®) in conjunction with CMS will drastically reshape how evaluation and management services (hereafter, "E/Ms") are coded. Since medical necessity remains the overarching criteria for services and workers' compensation is limited liability, the fee schedule should indicate that while the current CPT manual guidelines should be used for coding their E/Ms the final coding determination is limited to the medical necessity for the liable compensable injury.

Beginning in 2021, CPT® will require E/Ms to be coded based on the medical decision-making of the services or time as the controlling factor. However, medical-decision making is affected by the nature of the presenting problem, the compensable injury, and medical necessity. The guidelines should indicate that providers must not code for a level higher than was medically necessary to treat and/or diagnose the compensable injury and as based on the nature of the presenting problem as defined in the CPT® manual.

Reconsideration Limitation:

While the regulations require an employer or carrier to pay charges within 45 days, neither the 2012 Fee Schedule nor the 2020 Proposal address reconsideration time limits for providers to file reconsiderations or disputes. Providers should not have unlimited time limits for such disputes. Employees could change employers. Policyholders could change for carriers. Workers'

[1] Medicare Claims Processing Manual, Chapter 12, Section 20.4.3
[2] Medicare Claims Processing Manual, Chapter 12, Sections 110.2 and 120.1

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compensation claims could become closed or settled. These all can impact reserves and create surprise medical bills. The 2020 Proposal General Ground Rules, Section 8, should establish a reasonable time limit for providers to submit reconsiderations for unpaid medical charges. Reconsiderations should be limited to 6 months from the initial determination by the employer or carrier with disputes limited to 1 year from the initial determination by the employer or carrier where the provider has full knowledge of the workers' compensation initial determination.

Should you have any additional questions regarding the outcome of this review, please contact Equian via phone at (334) 290-4739 or email at mstrong@equian.com.

Sincerely,

Michael Strong, MSHCA, MBA, CPC, CEMC,
Operations Manager, Clinical & Coding Logic

CC: Rhonda Miller, RN, CMAS, CPC, CCS, Vice President of Audit Operations

Lauren Hammonds Johnson

From: Treva Overstreet <toverstreet@enablecomp.com>
Sent: Wednesday, February 26, 2020 4:42 PM
To: WCC Fee Schedule Comments
Subject: [External] Comments on Proposed Oklahoma Workers' Compensation Fee Schedule 2020
Attachments: EnableComp - Comments on Proposed Oklahoma Fee Schedule -02262020.pdf

Importance: High

Good afternoon,

Please see attached written comments on the proposed 2020 Oklahoma Workers' Compensation Fee Schedule. We do appreciate the opportunity to respond.

If you have additional questions, please feel free to reach out. We are happy to discuss further.

Best regards,

Treva

Treva Overstreet
Director of Quality & Training
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enablecomp
complex claims revenue solutions

February 25, 2020

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

RE: Proposed 2020 Medical Fee Schedule Changes

Dear Commissioners;

EnableComp appreciates the ability to offer our comments on the proposed changes to the Medical Fee Schedule effective this year, 2020. With over 800 hospitals nationwide including 19 facilities in Oklahoma, EnableComp has a unique and focused level of expertise that exclusively deals with hospital-based workers' compensation reimbursement. EnableComps' rules-engine accurately models reimbursement based on every Workers' Compensation Fee Schedule jurisdiction in the United States including Department of Labor. As a company we process over $1.6 Billion in workers' compensation hospital bills annually.

We give high praise to Oklahoma for reviewing the fee schedules and implementing much needed updates. A couple of the positive changes include the 15% increase in the Inpatient MAR Reimbursement conversion factor and updating the CPT codes in the fee schedule. As you are aware, there have been many medical code changes since the 2012 fee schedule was implemented, bringing those codes current and giving them value will make reimbursement easier to understand for both the provider and payer communities.

In reviewing the proposed fee schedule changes there are still some areas of opportunity and need clarification. The rules and the fee schedule allowable go together when determining reimbursement. In order to complete the knowledge of the expected allowance for both providers and payers our recommended changes are as follows:

INPATIENT REIMBURSEMENT:

Page 415 – Section 1 - Definitions:

a. Definition of: "Audited Charges":

Current:

Audited charges means those charges that remain after deducting charges for services which are not documented as rendered during the admission and charges for items and services which are not related to the compensable injury or occupational disease. The formula to obtain audited charges is as follows: Total Charges - Deducted Charges = Audited Charges. The payer may have the bill audited at its own expense.

Recommended:

Audited charges mean:

(a) Those charges that remain after deducting charges for services which are not documented as rendered during the admission and, or;

(b) Charges for items and services which are not related to the compensable injury or occupational disease.

The formula to obtain audited charges is as follows:

Total Charges - Deducted Charges = Audited Charges.

The payer may have the bill audited at its own expense and must provide the detailed results of the audit to the provider upon request

It is important that the results of such an audit be made available to the provider so that any potential appeals are appropriately addressed, or any unnecessary appeals are avoided.

b. Definitions of: "Inpatient"

Current:

Inpatient means being confined to a hospital setting for a stay that crosses two or more midnights. An inpatient stay does not require official admission to the hospital.

Recommended:

Inpatient services are services rendered to a person who is formally admitted by physician order (or order of other qualified practitioner by State licensure whose privileges include hospital admission) to a hospital for evaluation and treatment and whose length of stay is defined as:

(a) Expected to include at least two midnights, or;
(b) The medical record supports the admitting physician's determination/expectation that the patient requires inpatient care despite the lack of a two-midnight length of stay based on:
    a. Patient's history, co-morbidities & current medical needs
    b. Severity of signs and/or symptoms

Recognizing Oklahoma has adopted a Medicare reimbursement methodology for inpatient stays, the recommended definition aligns with Medicare guidelines. It also supports uniform billing guidelines and one that is familiar to all RAC auditors.

Page 415 Section 3 – Computation of Maximum Allowable Reimbursement

Current Example:

MAXIMUM ALLOWABLE REMBURSEMENT=
Medicare MS DRG Relative Weight x $4,619.07

Recommended:

MAXIMUM ALLOWABLE REIMBURSEMENT=
Current Medicare MS DRG Relative Weight based on Date of Service x 4,619.07

Defining the MS DRG Relative Weight solidifies to both the provider and payer the specific number to be used in the calculation, thereby creating consistency in expected maximum allowable reimbursement. Also, by utilizing this methodology, the fee schedule will stay relatively current until it is time to update the conversion factor.

OUTPATIENT/ASC REIMBURSEMENT:

Under this section we recommend providing additional rules that cover the following topics as they are not currently addressed under the Hospital Outpatient and Ambulatory Surgery Center heading.

- **Medicare Status Indicators:**
  - The rules define how the maximum allowable reimbursement should be calculated for services provided that are identified with a J1 status indicator. We recommend verbiage that defines how other Status Indicators are recognized during the payment calculation. Examples:
    - How will the Imaging family status indicators be reimbursed? (Q1, Q2, Q3, Q4)
    - How will J2 services be reimbursed?
    - Does Oklahoma recognize Comprehensive APC(C-APC) reimbursement calculations?
- **OP MAR Column Blank:**
  - There are many services under the OP MAR column that are blank. Items such as laboratory, physical therapy, some surgical codes, etc. do not have an allowable in the OP MAR Column. There needs to be a definition of how these services will be reimbursed since there isn't a published rate. Otherwise it is left up to the readers' interpretation which can vary between provider and payer.
    - Bill types impacted: Pre-op Testing, Emergency Room Visits, Outpatient Clinic, bills with Physical Therapy charges only, etc.
- **Add-On codes:**
  - Under this section there isn't a definition as to how the reimbursement rate for Add-on codes will be calculated. Also, under the OP MAR column the recommended allowance is blank.
- **By Report Codes:**
  - There isn't a definition as to how By Report codes are to be reimbursed. Recommending adding a rule so that the OP MAR is defined and not left up to interpretation.
- **Lesser of Language:**

  Current:

  Hospitals and ASC's will be reimbursed the lesser of billed charges or the fee schedule MAR

  Recommended:

  Hospitals and ASC's will be reimbursed the lesser of billed charges or the fee schedule MAR. <u>This lesser of comparison is done on the bill or amount due, not a line-by-line comparison of items.</u>

The thought process around the "Lesser of" language being made at the line level verses total billed charges, potentially reimburses hospital facilities at an unintended extremely low reimbursement rate and one that does not even cover the hospitals costs for treating the injured worker.

When reviewing reimbursement methodologies for hospital facilities, an item that should be factored in, is the way hospital charge masters are built. One of the most important facts to know about hospital chargemaster listings is that their rates for individual services provided do not necessarily reflect the true costs of healthcare. For hospitals, creating accurate chargemasters is the catalyst to their revenue cycle as well as an important record for purposes of public reporting and compliance.

Many factors play into what is charged for an individual item or service. Such factors include what items and services are currently in use, how popular they are and if they are listed for discontinuation or other modifications. Also, chargemaster teams must navigate complex ICD-10 coding systems and look for inaccuracies in charge-to-cost ratios for Medicare services. This means while one service may be billed at a higher rate another may be below the cost of care. Typically, Workers' Compensation reimbursement is not factored in during the chargemaster creation, as for most hospital facilities workers' compensation claims only amount to 1-2% of their total operating revenue. However, treating injured workers' is more complex compared to all other services provided including additional paperwork, authorizations, patient compliance, etc.

There are many instances where the provider charges on a line may show an extreme variation to the Oklahoma Workers' Compensation Fee Schedule. This can lead to a loss as the reimbursement is less than the cost of care. Other Workers' Compensation Fee Schedules recognize the complexities of hospital billing and have defined the lesser of language in their fee schedule to be calculated at the bill level.

We recommend that Oklahoma look further into the "lesser of" thought process. By incorporating "lesser of" language at the bill level instead of the line level this would ensure facilities are reimbursed at a rate that will appropriately cover the costs of medical care when based on the total billed charges.

GENERAL GROUND RULES:

- **Modifiers:**
  - Current:

    "When applicable, the circumstances should be identified by a modifier code; a two-digit number, alpha, or alpha-numeric combination placed after the usual procedure code, separated by a hyphen."

  - Concern:

    Requiring the "hyphen" will cause EDI issues as the 837 files do not have a place holder for a hyphen which would make this directive non-HIPAA compliant.

- **Physician Assistant, Nurse Practitioner and Registered Nurse, First Assistant:**

  - Current:

    Evaluation and Management Services:

    > *A certified physician assistant shall be allowed eighty-five (85%) of the fee schedule allowance for evaluation and management services provided a signed report details the findings of the examination and the CPT code level billed is supported by the signed report.*

  - First Concern:

    What about reimbursement to Nurse Practitioners? These are recognized by other payers including Medicare as reimbursable professionals. By not specifying Nurse Practitioners in the reimbursement definition it could be assumed that their services do not warrant separate reimbursement.

  - Second Concern:

    Does Oklahoma recognize "Incident To" billing for Physician Assistants & Nurse Practitioners? If so, what is the reimbursement rate?

- **Modifiers and Payment Guidelines:**

  - Recommend further defining TC Technical Component to state that the TC modifier is not required on facility billings (UB04)

- **Multiple Procedures:**
    - Current:

      When multiple procedures, unrelated to the major procedure and adding significant time or complexity are provided at the same operative session, reimbursement for the major procedure is at 100% of the MAR listed in the rate tables and 50% for the additional procedure(s). Multiple procedure guidelines do not apply to procedure codes that appear in the rate table with a pound (#) sign. These services are Modifier 51 exempt. See Surgery Ground Rule 13.

    - Recommendation:

      The word "unrelated" is not a defined term and has the potential to be a point of contention between providers and payers as it will be left up to individual interpretation. Because the Oklahoma fee schedule already states that it recognizes NCCI edits, we recommend removing the underlined wording. NCCI is the set a national standard for determining these types of situations and is a recognized source utilized by insurance payors, physicians and coding professionals.

Lastly, we would like to suggest one way to keep Oklahoma's Medical Fee Schedule current between rule changes is to publish addendums that include excel spreadsheets directly to their website and list only the added/deleted/changes codes or reimbursement methodologies. There are several states that do this on a regular basis. It helps clarify reimbursement rates and mitigates potential disputes especially when important large updates in the coding world have taken place.

Thank you for allowing us to present our thoughts as Oklahoma continues to strive to create rules and reimbursement rates that make sense to both providers and payers thereby eliminating administrative burdens. Should you have questions, my information is listed below, and I would be happy to connect with you.

Best regards,

Treva G Overstreet

Treva Overstreet
Director of Quality & Training
(615)850-1970
toverstreet@enablecomp.com

Lauren Hammonds Johnson

From: Isabel Hernandez <ihernandez@healthesystems.com>
Sent: Thursday, February 20, 2020 12:51 PM
To: WCC Fee Schedule Comments
Cc: Sandy Shtab; Tracy Euler
Subject: [External] Healthesystems Fee Schedule Comments
Attachments: Healthesystems_OK Proposed Medical Fee Schedule Comments.pdf

Good afternoon,
On behalf of Healthesystems, please accept the attached commentary letter in response to the Oklahoma Workers' Compensation Commission proposed Medical Fee Schedule. We appreciate the opportunity to provide input on the proposed fee schedule and are happy to answer any questions related to our recommendations.

Thank you,

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000026

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February 20, 2020

Oklahoma Workers Compensation Commission
1915 North Stiles Avenue
Oklahoma City, Oklahoma 73105
feeschedulecomments@wcc.ok.gov

Re: Oklahoma Proposed Medical Fee Schedule Stakeholder Comment

To whom it may concern:

Please accept these comments from Healthesystems as it relates to the Oklahoma Proposed Medical Fee Schedule. We appreciate the opportunity to provide input on the proposed changes and thank the Oklahoma Workers Compensation Commission for its consideration. Our comments will focus on Pharmaceutical Services Ground Rules including physician dispensing practices, Physical Medicine Ground Rules, and General Ground Rules with respect to provider billing and dispute procedures.

Pharmaceutical Services Ground Rules
Section 1 Definitions
Average Wholesale Price (AWP) – The amount determined from the latest publication of the RED BOOK®, published by IBM Micromedex, unless otherwise designated by the Oklahoma Workers' Compensation Commission.

Healthesystems recommends expanding the definition of Average Wholesale Price to include Medispan as a source for AWP drug price data. MediSpan is published by Wolters Kluwer Health and incorporates a proprietary generic product indicator which helps PBMs and pharmacies to standardize drugs by class, an efficiency which supports the application of formulary rules and selection of the lowest cost therapeutic equivalent drug, as is currently required in the Commissions' payment methodology for Repackaged Drugs (*c. REPACKAGED DRUGS: 85A O.S. §50(H)(8)*). RedBook has never published this type of information and for this reason many entities are required to use both RedBook and MediSpan to adjudicate medical bills. In the spirit of administrative simplification, we recommend replacing RedBook with Medispan, or in the alternative allowing payers to use either compendia for AWP data. Because Redbook and MediSpan both publish AWP data which is reported by the drug manufacturer, drug pricing should be identical between both compendia; however, in the event of a fee dispute based on a price difference between the MediSpan and Redbook Price, the provider may request the higher price between the two, as of the date of dispensing.

Section 3 Reimbursement Methodology for Pharmaceutical Services
c. REPACKAGED DRUGS: 85A O.S. §50(H)(8) requires that If the National Drug Code, or "NDC", for the drug product dispensed is for a repackaged drug, then the maximum reimbursement shall be the lesser of the original labeler's NDC and the lowest-cost therapeutic equivalent drug product.

We recommend a slight change to the language to ensure there is no ambiguity on reimbursement in the new fee schedule as follows:

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> *c. REPACKAGED DRUGS: 85A O.S. §50(H)(8) requires that if the National Drug Code, or "NDC", for the drug product dispensed is for a repackaged drug, then the maximum reimbursement shall be the lesser of the (AWP-10% of the) original labeler's NDC and the lowest-cost therapeutic equivalent drug product.*

e. COMPOUNDED DRUGS: 85A O.S. §50(H)(8) requires that compounded medications shall be billed by the compounding pharmacy at the ingredient level, with each ingredient identified using the applicable NDC of the drug product, and the corresponding quantity. Ingredients with no NDC area are not separately reimbursable (e.g., distilled water will not be reimbursed). Payment shall be based on a sum of the allowable fee for each ingredient plus a dispensing fee of Five Dollars ($5.00) per prescription.

In comparison to the current reimbursement methodology for compound drugs, the proposed language is problematic because it omits discussion of how repackaged ingredients within a compound should be reimbursed and does not define the "allowable fee". We find the reimbursement methodology for compounds which is currently in place is adequate and do not suggest any changes at this time.

> *COMPOUND DRUGS: Compound drugs shall be billed by the compounding pharmacy. Compound drugs shall be billed by listing each ingredient, the corresponding NDC, and quantity. If there is no NDC for an ingredient (e.g. distilled water), it will not be reimbursed. If the NDC for the compound ingredient is a repackaged drug, the maximum allowable fee for the repackaged drug is determined per subparagraph d of this ground rule. The maximum allowable reimbursement for the compound medication shall be based upon the sum of the allowable fee for each ingredient plus a dispensing fee of Five Dollars ($5.00) per prescription for the compound medication.*

f. PHYSICIAN-DISPENSED DRUGS: When medical care includes prescription drugs dispensed by a physician or other medical care provider and the NDC for the drug product dispensed is for a repackaged drug, then the maximum reimbursement shall be the lesser of the original labeler's NDC and the lowest cost therapeutic equivalent drug product. Payment shall be based upon a sum of the allowable fee for each ingredient plus a dispensing fee of Five Dollars ($5.00) per prescription. Compounded drugs shall be billed by the compounding pharmacy.

As noted above, the absence of AWP and the undefined term "allowable fee" can lead to misunderstandings on expected reimbursement rate, which could be avoided by considering the following language:

> *f. PHYSICIAN-DISPENSED REPACKAGED DRUGS: When medical care includes prescription drugs dispensed by a physician or other medical care provider and the NDC for the drug product dispensed is for a repackaged drug, then the maximum reimbursement shall be the lesser of the original labeler's NDC and the lowest cost therapeutic equivalent drug product. Payment shall be based upon a sum of ninety percent (90%) of the average wholesale price of the applicable NDC for each ingredient plus a dispensing fee of Five Dollars ($5.00) per prescription. Compounded drugs shall be billed by the compounding pharmacy.*

With regard to Subsection *(g) Reimbursement for Pharmaceutical Services, Medications, Other than repacked medication, Dispensed by a Provider* we understand that the proposed Medical Fee Schedule has not made amendments and must say we agree with the current reimbursement language; however, we

encourage consistency in the terminology utilized within this section. Alternating between "medication" and "prescription drug" can be confusing. Since the Commission has defined "prescription drug" within the Pharmaceutical Services Ground Rules we suggest this term be applied consistently throughout the rule and specifically within this section.

Our last recommendation on Pharmaceutical Services Ground Rules is with respect to physician dispensing. Physician dispensing has bloomed into a profit center for a very small number of providers, and while not prevalent throughout the system, it is costing employers far more than is necessary in claim and premium dollars. With such a strong focus on drug cost and utilization through the formulary process, we see this as an issue the Commission can address by restricting payment for any physician dispensed medications to the first seven days of a work injury, and only for a one time, seven-day fill.

We acknowledge that physician dispensing is very convenient for the injured worker, however that convenience creates waste and abuse within the system; so much so that most commercial group health and all government funded programs like SoonerCare do not allow any physician dispensing except in very limited circumstances and only for rare diseases and only with prior approval. Many of the workers' compensation programs across the nation have placed strict limits on reimbursement of physician dispensed medications. In 2019, Arizona and Colorado updated their fee schedules to address this issue. Texas has long prohibited more than a three-day supply to be physician dispensed, and only when there is no pharmacy accessible to the patient and the patient is in imminent harm without the medication. With more than 3,700 in state pharmacies licensed in Oklahoma, it would seem there is broad access to a retail pharmacy in the areas where we see those few providers dispensing on a regular basis.

We further recommend preauthorization be required for any prescriptions which do not conform to common dosages and formulations which are widely available in pharmacies which are "accessible to the general public." "Accessible to the general public" means a pharmacy which is readily accessible and provides pharmaceutical services to all segments of the general public - without restricting services to a defined or exclusive group of consumers who have access to services because they are treated by or have an affiliation with a specific entity or medical practitioner.

These recommendations do not constitute a total ban on physician dispensing; physicians may still dispense the initial fill of medication, if they choose to do so. Injured workers will still have ample time to obtain their subsequent prescription(s) at any local or mail order pharmacy of their choosing, so long as it is reasonably accessible to the public.

<u>Physical Medicine Ground Rules</u>

For Time-Based Physical Medicine services, we have noticed inconsistency in billing practices and therefore recommend adding clarification on billing and payment requirements for physical therapy, occupational therapy, and chiropractic services provided in an outpatient setting. The Centers for Medicare and Medicaid Services (CMS) allows reimbursement to therapy providers for cumulative treatment time when more than one service is provided for less than 8 minutes each.

We recommend the following language to be considered:

> *Billing for any time-based codes shall require the practitioner to be directly engaged with the patient for a minimum of 8 minutes (also known as the midpoint). If this 8-minute time threshold is met, then the provider may bill the appropriate time-based code. For example, if the sum of two*

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services that are provided is 8 minutes or more, then the service provided for the greater amount of time will be billed as one unit. For services exceeding 8 minutes up to and including 127 minutes, units shall be calculated as documented in the following chart:

Units	Number of Minutes
0	< 8 minutes
1	≥8 minutes and ≤ 22 minutes
2	≥23 minutes and ≤ 37 minutes
3	≥38 minutes and ≤ 52 minutes
4	≥53 minutes and ≤ 67 minutes
5	≥68 minutes and ≤ 82 minutes
6	≥83 minutes and ≤ 97 minutes
7	≥98 minutes and ≤ 112 minutes
8	≥113 minutes and ≤ 127 minutes

We are concerned that lack of guidance unnecessarily increases cost and are requesting the Commission address this topic while the Medical Fee Schedule is under review. We would like to recommend the Commission consider language which makes it clear for both providers and payers for these services by adopting CMS billing guidelines under the medical fee schedule. The addition of clarifying language in the Physical Medicine Ground Rules section would eliminate ambiguity and reduce payment disputes and delays for providers and payers alike.

General Ground Rules

We propose the Commission establish a timely filing and dispute resolution period for providers as it relates to submission of medical bills. Currently, there are only requirements placed on payers to process a medical bill within 45 days of the date the bill was received per Okla. Stat. tit. 85A, § 50(H)(11). However, there is no time limitation the provider to submit their bill or to request a reconsideration or an appeal of a medical bill. Many states have standardized these timeframes, allowing providers and carriers to both have clear expectations on the handling of medical bills. Our recommended language is as follows:

A healthcare provider shall submit a complete medical bill to the carrier not later than the 95th day after the date on which the health care services were provided to the injured employee. Failure by the provider to timely submit constitutes a forfeiture of the provider's right to reimbursement for that medical bill. If the carrier requests additional documentation about the bill, the health care provider must provide the requested documentation not later than the 15th day after the date of receipt of the carrier's request. The health care provider may dispute the carrier's determination not later than the 45th day after the date of the insurance carrier's determination. The carrier must act on the determination not later than the 45th day after the date on which the dispute is received.

This is in keeping with the existing language throughout the Medical Fee Schedule regarding documentation to support the provider's charge (i.e By Report codes). Most states' workers' compensation fee schedules or ground rules describe a specific timeline for submission of bills, and timelines to appeal. This cuts down on the frictional costs associated with old medical bills being submitted years after the date of service, or requests for reconsideration of a medical bill received years after the claim file has been closed.

Healthesystems supports the Oklahoma Workers Compensation Commission in its mission to ensure a fair and balance system and praise their efforts in reviewing the Medical Fee Schedule. Again, we thank the Commission in allowing the opportunity to submit feedback to the proposal and we are happy to answer any questions related to our recommendations.

Sincerely,

Isabel Hernandez
Analyst, Advocacy and Compliance
Healthesystems, LLC.

INTEGRIS

John B. Vera, JD
Direct Line: 405•951•4786
Email Address: john.vera@integrisok.com

February 26, 2020

Workers' Compensation Commission
Fee Schedule Comments
1915 N. Stiles Ave
OKC, OK 73105

Dear Commissioners:

These are some comments and suggestions for the proposed Fee Schedule. My comments come from the perspective of having both prosecuted and defended thousands of Form 19 claims and the areas of disagreement that might be avoided with more clarity.

Foreword States that it "outlines maximum reimbursement levels" it should also reaffirm that it does NOT set how much the provider can bill. I have had some judges and bill audit companies claim that it sets the limit on what a medical provider may bill/charge and then they apply the discounts in the Fee Schedule. In effect, this is a double-dipped discount.

Introduction

1. PROCEDURE CODES: in accordance with current procedural terminology codes and descriptions listed in CPT, copyright 2019 by the AMA. Should this be changed to in accordance with . . . the CPT codes in effect on the date of the medical procedure? This has become an issue with the continued use of the 2012 Fee Schedule which often does not match up well with current coding rules, which are mandated by Federal Law to be those in effect on the date of the procedure. Wording it to continue following current CPT codes would negate that potential result.

General Ground Rules

10. IMPLANTABLE MEDICAL DEVICES:
    a. Address whether "implantables" includes or doesn't include items that are implanted and then removed, for whatever reason, and whether it includes single-use items that are billed per revenue codes 274, 275, 276, or 278 but are not actually implanted into the body. The language says, billed under revenue code and "which involve an item or device intended for permanent placement. . . " and I interpret that to mean that such single-use items ARE implantables and should be reimbursed per implantables rules. I just think it would be very helpful to make it clear, to avoid future litigation on the matter.

Hospital outpatient & ambulatory surgery Center Ground Rules

1. DEFINITIONS

a. . . .
b. . . .
c. Implantables – See above comments under "General Ground Rules." Please clarify the addition of Revenue Code 624, FDA investigational devices. Why is this in the outpatient and inpatient ground rules, but not in the General ground rules? Is this a complete bar to reimbursement for any FDA investigational devices? Also, address the single-use items per above

Inpatient Ground Rules

1. DEFINITIONS
   a. . . .
   b. Same as above comments

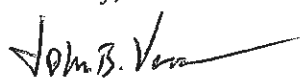
Other comments: I would ask for clarity on some issues that arise frequently when presenting Form 19s for determination. The Outpatient/ASC ground rules require the bills to include the CPT codes etc. on the bill. They specifically state that the professional charges will be paid separately pursuant to the specific MARs in other sections of the Fee Schedule. Only the facility charges will be paid per the MARs in the Outpatient/ASC section. In the past, I have had many bill review companies pay Outpatient/ASC bills by applying the CPT technical components from other sections of the Fee Schedule, even though it was, pay the lesser of these 3 options. I've also had judges rule that the CPT technical component MAR is the most that the facility can bill, and then apply the lesser of 3 options formula (the aforementioned double-dipping discount). It appears clear to me that reimbursement for Outpatient/ASC facilities is intended to reimburse ONLY by that ground rule, per the method in paragraph 5. Could we have clarifying language to that effect?

In addition to the above, there is a lack of clarity about non-FDA approved items, particularly implantables, use of biologic implants and similar items. The standard has long been whether the item/procedure was reasonable and necessary medical care for the work-related injury. It has never been whether these items/procedures are FDA approved, ODG approved, or such arguments. This could easily be cleared up by reiterating any such devices used during a procedure that was reasonable and necessary, are to be reimbursed. The Outpatient/ASC rules seem to brush on the subject in ¶4(b) by mentioning "drugs, biologicals, . . . " but then states that implantables will be separately reimbursed. Some biologicals are implants.

Finally, there should be a link to or incorporation of CMS OPPS as well as APC group reimbursements if the Fee Schedule is going to use them to determine MAR.

Thank you for allowing me to weigh in on the proposed Fee Schedule

Sincerely,



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State of Oklahoma Worker's Compensation Commission Schedule of Medical and Hospital Fees

Feedback to Summary of Proposed Changes

INTEGRIS Health – Oklahoma City

January 30th, 2020

Inpatient Hospital Changes:

It has been eight years since there has been an increase to the Oklahoma Worker's Compensation fee schedule. The average DRG base rate for Oklahoma hospitals is $5,935.69, and the Commission is proposing a new base rate of $4,619.07. While this is a 15% increase from the 2012 base rate, this is only 77.8% of the Medicare rate.

The average hospital would have to get paid 110% of the Medicare rate to break even. In other words, hospitals lose about 10% on each Medicare patient. Thus, getting reimbursed at 77.8% of Medicare means each hospital is losing significant dollars for each patient treated.

INTEGRIS recommends that the Commission increase reimbursement for inpatient hospital services to 100% of each hospital's specific Medicare rate, which would still be a loss on each patient served.

Outpatient Hospital Changes:

The proposed changes to outpatient hospital services makes financial modeling very difficult. Taking an APC and removing the implant cost, and then marking each up at a different percentage can not be done using our modeling system. This leaves us not knowing if the Commission is proposing an increase or a decrease under the new methodology.

INTEGRIS recommends both providing examples of the new methodology calculations, and beyond that, we believe Fair Health should obtain actual claim examples from 2019, and then run models for each hospital which shows how we were paid in 2019, and how we would be paid going forward, so we know the financial impact of the new proposed changes.

One other option would be to follow CMS' OPPS methodology exactly, and then increase the percent of the proposed Medicare rate. If this route is taken, we can more easily model to determine the financial impact. We've seen other state organizations use 200% of Medicare if following the Medicare methodology exactly.

Physician Rate Changes:

Since rates have not increased in eight years, and the Physical Medicine conversion factor is proposed to remain flat, INTEGRIS recommends a 10% increase in this category.

MEDICAL CLAIMS REVIEW SERVICES

57450 E Highway 125 Unit 526
Monkey Island, Oklahoma 74331

Phone 866-611-6633 Fax 866-611-4573

Oklahoma Workers' Compensation Commission
Fair Health

Comments Regarding the Proposed
Oklahoma Workers' Compensation Fee Schedule

February 26, 2020

I have reviewed the proposed 2020 Oklahoma Workers' Compensation Fee Schedule. Having worked with all the different versions of the Oklahoma Workers' Compensation Fee Schedule, I can appreciate the thought and hard work that went into this revision. My comments today will be directed to the Ground Rules associated with the 2020 Fee Schedule.

If the actual dollars allowed in the Fee Schedule are the body of the Oklahoma Workers' Compensation Fee Schedule, then the Ground Rules are the Heart and Soul. Without good, clear, and precise ground rules it does not matter what the allowed dollars are. Ground Rules that are not clear will do nothing but cause additional work on all parties and lead to conflict and Commission hearings. In most cases the Ground Rules in the 2020 Proposed Fee Schedule have stayed the same. There are a couple of questions and comments I would like to make.

Modifiers and Payment Guidelines:

Page 14 addresses the Two Surgeon modifier. The language on page 14 states "This modifier is reimbursed at the provider's usual and customary rate up to **75%** of the MAR for each surgeon". Page 37 of the Surgery Ground Rules under the Two Surgeon Heading states, "When two surgeons work together as **primary** surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding the modifier "-62" to the procedure code and any associated add-on code(s) for that procedure **as long as both Surgeons continue to work together as primary surgeons**." The rule further states, "
Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s), including add-on procedure(s), are performed during the same surgical session, separate code(s) may also be reported with the modifier "-62" added. Under these circumstances, the MAR may be increased by twenty-five percent (25%) in lieu of the assistant's charges. By prior agreement, the total MAR for the procedure(s) may be apportioned in relation to the responsibility and work
done."

The modifier definition seems to say that each Surgeon could receive up to 75% of the MAR which would be calculated at 50% above the actual MAR. The Surgery Ground Rule says the Modifier -62 will allow the MAR to be increased by 25%. I feel the Commission needs to clarify these two ground rules. Is it 50% increase on the main procedure and then 25% on every other procedure, or is it supposed to be 50% increase of the MAR for each procedure performed as co-surgery?

Surgery Ground Rules:

Surgery Ground Rule 5 page 35. This rule has changed significantly. There has always been a limit on the amount that can be collected for any single surgery. This rule has never limited the number of procedures but has always limited the amount that can be reimbursed. Add on procedures needed to perform complex comprehensive surgeries are exempt from this rule and should be exempt. As someone who reviews medical bills daily, this rule is used every day. Without some sort of cap, this will become an area of major contention between Providers and Payors. It will also cause a rise in the cost of some surgeries. In some cases, significant increases will be seen. There is an additional ground rule that could be used along with Ground Rule 5 that allows for a payor such as an insurance company or TPA to disallow services if they are deemed to be excessive. This seems to be a conflict ready to occur. In the case of surgery, no adjuster, or Fee Schedule evaluator has the credentials to question the number of surgery procedures used during surgery. I would encourage the Commission to look at Ground Rule 5 again and come to some type of consensus that will prevent excessive billing and conflict between the Payor and the Provider.

Page 12 of the Payment and Modifiers Guidelines lists the modifier 50 Bilateral Procedure. This payment guideline specifically addresses payment of these procedures. It states," *Oklahoma guideline: Procedures performed with a bilateral modifier are reimbursed at 150% of the MAR listed in the rate tables".* In the 2012 Fee Schedule a bilateral procedure was treated in the same way as other surgery procedures under Ground Rule 5. There was no special consideration for a bilateral procedure. In the 2020 Proposed Fee Schedule Guidelines I have not found anything in the Surgery Ground Rules that addresses how the bilateral procedure will be handled. The only mention is in the Payment and Modifiers Guidelines. Is the bilateral procedure with the 50% increase in the MAR now the new, single most expensive code, and treated as a single CPT code for purpose of the multiple procedure ground rule? What about multiple bilateral procedures? Will they be treated in the same way? I would encourage the Commission to make sure this section is much clearer so there is less chance for conflict.

Page 407 Hospital Outpatient and Ambulatory Surgery Center Ground Rules:

This is a new payment system for Oklahoma Workers' Compensation. This set of ground rules uses the Medicare Ambulatory Payment Classification System (APC) for payment for Outpatient Services and Ambulatory Surgery. All services performed by a hospital that are not for an inpatient, by definition, will be classified as Outpatient procedures and paid using the MAR associated with the APC system. This works great for outpatient surgeries in both Hospital and Ambulatory Surgery Center settings. This also works great and takes the guesswork out of payment for such services as ER and Radiology.

Hospitals, especially Rural Hospitals, use many of their ancillary services in treating employees that have been injured on the job. They especially use the Rehabilitation (Physical and Occupation) Therapy along with Laboratory and Pathology services. Most hospitals in Oklahoma bill these services as any other outpatient service, such as an ER visit. Under this Ground Rule, these services do not have APC codes to allow reimbursement. It seems the hospitals need to be reminded that all the billing for these services should be done using the HCFA 1450 or similar form and not the UB92 form. These services are outpatient hospital services, but by instituting the above system should now only be billed using any form other than the UB92. This is another place where conflict could arise quickly.

Respectfully Submitted
Medical Claims Review Services, Inc
Bob Altmiller

Lauren Hammonds Johnson

From: Medical Claims <Bob@mcaudit.com>
Sent: Wednesday, February 26, 2020 5:31 PM
To: WCC Fee Schedule Comments
Subject: [External] Proposed 2020 Fee Schedule
Attachments: 02262020 WCC 2020 Fee Schedule Comments.pdf

Please see the attached comments

Thank You

--

Bob Altmiller
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a: 57450 E Highway 125 Unit 526 Afton, Oklahoma 74331

MCRS

Lauren Hammonds Johnson

From: Brian Allen <Brian.Allen@mitchell.com>
Sent: Wednesday, February 26, 2020 6:08 PM
To: WCC Fee Schedule Comments
Subject: [External] Comments on Fee Schedule
Attachments: Mitchell Comments on OK Proposed Fee Schedule 02-26-20.pdf

Please see our comments on the proposed fee schedule rule attached to this email. Thank you!

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February 26, 2020

Oklahoma Workers' Compensation Commission (WCC)
1915 North Stiles Avenue
Oklahoma City, Oklahoma 73105

Delivered via email to: feeschedulecomments@wcc.ok.gov

Re: 2020 Proposed Fee Schedule Comments

Dear Chairman Mark Liotta:

Thank you for the opportunity to provide feedback on the proposed fee schedule. Before getting into specific comments, we want to commend you, the Commission, and Fair Health for the time and effort expended to investigate best practices from around the country and to include input and commentary from the various stakeholders. It is greatly appreciated.

Our comments will primarily be focused on the Pharmaceutical Services Ground Rules, beginning on page 411. Mitchell International is a leading provider of services to the workers' compensation industry, providing solutions starting with the first report of injury through the claims process to settlement. Our Pharmacy Solutions division helps employers, insurance carriers, and pharmacies appropriately manage and process pharmacy claims as we ensure injured workers have convenient access to medications prescribed in accordance with the Oklahoma drug formulary. We are constantly seeking ways to deliver better results related to drug costs and drug utilization in the workers' compensation space. We generally support the fee schedule as proposed and appreciate the open process the Commission has allowed for providing feedback on the proposal.

We do have some concern about the disparate reimbursement schedule for pharmaceuticals dispensed as compounds or by physicians when compared to the reimbursement paid to a retail pharmacy. As a result of extensive research and experience, we've found uniform rules should exist among the various dispensing options. Retail pharmacies are generally electronically connected to the pharmacy benefit manager and as such can obtain real-time information on whether or not the drug prescribed conforms to the drug formulary and is related to the claim. That type of real-time verification is not available when medications are dispensed by physicians. Since compounds require prior authorization, there is some ability to ensure adherence to the drug formulary and treatment guidelines in the authorization process. That said, the local, retail

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pharmacy is the best outlet for managing adherence to the state-adopted guidelines and formularies because of the connectivity to the pharmacy benefit manager.

Additionally, over time we have found that repackagers and compounders have moved to more expensive original ingredients than found in a retail pharmacy setting. The Workers' Compensation Research Institute (WCRI) released a report in January of 2015 (Are Physician Dispensing Reforms Sustainable) detailing how repackagers have circumvented pricing controls by working with manufacturers to create "boutique" strength drugs with artificially inflated average wholesale prices. These boutique drugs are not dispensed in retail pharmacies and create additional and unnecessary expenses in the workers' compensation system.

We recommend, for purposes of the proposed fee schedule, that all pharmaceuticals being dispensed in any setting be reimbursed at 90% of the average wholesale price of the original manufacturer's product. This creates parity and does not disadvantage the local, retail pharmacies while rewarding settings, where the drugs are already more expensive, with higher reimbursement.

We also recommend that the Commission consider changes to the formulary rule the next time it is open to require prior authorization for physician-dispensed medications, except for an initial fill of formulary medications dispensed at an initial visit to the physician within seven (7) days following the date of injury. Other formulary states have taken this approach and it has proven to be a cost-saving provision while still allowing for the convenience of the first fill at the initial visit to the treating physician.

Thank you for considering our comments. Should you have any questions or need further clarification, please contact me at Brian.Allen@mitchell.com or at 801-903-5754.

Sincerely,

Brian Allen
Vice President
Government Affairs

000041

ANALYSIS OF OKLAHOMA MEDICAL FEE SCHEDULE CHANGES PROPOSED TO BE EFFECTIVE JULY 1, 2020

NCCI estimates that the changes to the fee schedule in Oklahoma, proposed effective July 1, 2020, would result in an estimated impact of +0.4% (+$3.0M[1]) on overall workers compensation system costs.

SUMMARY OF PROPOSED CHANGES TO MEDICAL FEE SCHEDULE

The current Oklahoma Schedule of Medical and Hospital Fees, published by the Oklahoma Workers' Compensation Commission (OWCC), has been in effect since January 1, 2012. The proposed Oklahoma Medical Fee Schedule, to be effective July 1, 2020, contains various revisions. The impacts of quantifiable revisions are summarized below:

Physician Services:

- Currently, the maximum allowable reimbursements (MARs) for physician services are as listed by physician practice category in the 2012 fee schedule.
- The proposal updates the MARs as listed in the 2020 fee schedule.

Hospital Inpatient Services:

- Currently, MARs for hospital inpatient services are based on the 2012 Medicare Severity Diagnosis-Related Group (MS-DRG) weights as published by Centers for Medicare and Medicaid Services (CMS). Additionally, a stop-loss payment is provided for inpatient stays with total audited charges exceeding the stop-loss threshold of $70,000.
- The proposal updates the MARs to be based on the 2020 MS-DRG weights as published by CMS and proposes to maintain the current stop-loss provision.

Hospital Outpatient and Ambulatory Surgical Center (ASC) Services:

- Currently, MARs for hospital and ASC services are based on either the usual and customary charge, 60% of audited charges, or the MAR under the hospital inpatient services fee schedule.
- The proposal updates the MARs to be based on Medicare's 2020 Hospital Outpatient Prospective Payment System (OPPS).

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[1] Overall system costs are based on NAIC Annual Statement data and data on self-insurance approximated using the National Academy of Social Insurance's October 2019 publication "Workers' Compensation: Benefits, Coverages, and Costs, 2017." The estimated dollar impact is the percentage impact(s) displayed multiplied by 2018 written premium of $662M from NAIC Annual Statement data for Oklahoma and an estimated $132M of losses for self-insureds. These figures do not include the policyholder retained portion of deductible policies or adjustments for subsequent changes in premium levels. The use of premium as the basis for the dollar impact assumes that expenses and other premium adjustments will be affected proportionally to the change in benefit costs.

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E-mail: Carla_Townsend@ncci.com

ANALYSIS OF OKLAHOMA MEDICAL FEE SCHEDULE CHANGES PROPOSED TO BE EFFECTIVE JULY 1, 2020

ACTUARIAL ANALYSIS

NCCI's methodology to evaluate the impact of proposed medical fee schedule changes includes three major steps:

1. Calculate the percentage change in maximum reimbursements
    - Compare the current and proposed maximum reimbursements by procedure code and determine the percentage change by procedure code.
    - Calculate the weighted-average percentage change in maximum reimbursements for the fee schedule using observed payments by procedure code as weights.

2. Determine the share of costs that are subject to the fee schedule
    - The share is based on a combination of fields, such as procedure code, provider type, and place of service, as reported on the NCCI Medical Data Call, to categorize payments that are subject to the fee schedule.
    - The share is calculated as the greater of the percent of observed payments with a maximum allowable reimbursement (MAR) or 75%. NCCI assumes no change for the share of costs not subject to the fee schedule.

3. Estimate the price level change as a result of the revised fee schedule
    - NCCI research by David Colón and Paul Hendrick, "The Impact of Fee Schedule Updates on Physician Payments" (2018), suggests that approximately 80% of the change in maximum reimbursements for physician fee schedules is realized on payments impacted by the change. For non-physician fee schedule changes, a price realization factor of 80%is assumed.

In this analysis, NCCI relies primarily on two data sources:

- Detailed medical data underlying the calculations in this analysis are based on NCCI's Medical Data Call for Oklahoma for Service Year 2018.
- The share of benefit costs attributed to medical benefits is based on NCCI's Financial Call data for Oklahoma from Policy Years 2016 and 2017 projected to the effective date of the benefit changes.

Physician Fee Schedule

In Oklahoma, payments for physician services represent 34.6% of total medical costs. The overall change in maximums for physician services is a weighted average of the percentage change in MAR by procedure code (Proposed MAR/Current MAR). The weights are based on Service Year 2018 observed payments by procedure code for Oklahoma, as reported on NCCI's Medical Data Call. The overall weighted-average percentage change in maximums for physician services is estimated to be +3.3%. The estimated impact by category is shown in the following table.

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ANALYSIS OF OKLAHOMA MEDICAL FEE SCHEDULE CHANGES PROPOSED TO BE EFFECTIVE JULY 1, 2020

Physician Practice Category	Share of Physician Costs	Percentage Change in MAR
Anesthesia	5.1%	+4.1%
Surgery	21.2%	+3.2%
Radiology	9.9%	-25.4%
Pathology & Laboratory	0.7%	-6.8%
Evaluation & Management	22.1%	-13.4%
General Medicine	0.2%	+4.4%
Physical Medicine	23.5%	+8.8%
Physician Payments with no specific MAR*	17.3%	-
Total Physician Costs	**100.0%**	+3.3%

*Includes codes with a proposed MAR, but no MAR under the current fee schedule.

A price realization factor of 80% was applied. The impact on physician payments after applying the price realization factor is estimated to be +2.6% (= +3.3% x 0.80).

The above impact of +2.6% is then multiplied by the percentage of medical costs attributed to physician payments in Oklahoma (34.6%) to arrive at an estimated impact of +0.9% on medical costs. This is then multiplied by the percentage of benefit costs attributed to medical benefits in Oklahoma (51%) to arrive at an estimated impact of +0.5% on overall workers compensation costs.

Hospital Inpatient Fee Schedule

In Oklahoma, payments for hospital inpatient services represent 18.4% of total medical costs. Of these payments, 77.8% have a MAR. The overall change in maximums for hospital inpatient services is a weighted average of the percentage change in MAR by episode (Proposed MAR/ Current MAR). The weights are based on Service Year 2018 observed payments by episode for Oklahoma, as reported on NCCI's Medical Data Call. The overall weighted-average percentage change in maximums for hospital inpatient services is +3.7%.

A price realization factor of 80% was applied. The impact on hospital inpatient payments after applying the price realization factor is estimated to be +3.0% (= +3.7% x 0.80).

The above impact of +3.0% is then multiplied by the percentage of medical costs attributed to hospital inpatient payments in Oklahoma (18.4%) to arrive at an estimated impact of +0.6% on medical costs. This is then multiplied by the percentage of benefit costs attributed to medical benefits in Oklahoma
(51%) to arrive at an estimated impact of +0.3% on overall workers compensation costs.

Note that episodes with audited charges greater than $70,000 are eligible for stop loss reimbursement. For catastrophic procedures, the maximum reimbursement is calculated as 70% x audited charges. For non-catastrophic procedures, the stop loss reimbursement formula for the maximum reimbursement is:

[Total Audited Charges – (MS-DRG Reimbursement) x 50%)] x 65%

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ANALYSIS OF OKLAHOMA MEDICAL FEE SCHEDULE CHANGES PROPOSED TO BE EFFECTIVE JULY 1, 2020

Hospital Outpatient Fee Schedule

In Oklahoma, payments for hospital outpatient services represent 19.6% of total medical costs. Of these payments, 75% would be subject to the proposed fee schedule, if implemented. The overall change in reimbursements for hospital outpatient services is a weighted average of the percentage change in reimbursement by procedure code. The weights are based on Service Year 2018 observed payments by procedure code for Oklahoma, as reported on NCCI's Medical Data Call. The current and proposed reimbursements for each relevant procedure code are calculated as follows:

Current Reimbursement = Prior Average Payment x Trend Factor

The payments by procedure code were adjusted to the price levels projected to be in effect on July 1, 2020. The trend factor is based on the U.S. hospital outpatient services component of the medical producer price index (MPPI)[2].

Proposed Reimbursement = Maximum Fee x (1 + Price Departure)

A price departure of -10% was assumed.

The overall weighted-average percentage change in reimbursements for hospital outpatient services is estimated to be -6.9%. A price realization factor of 80% was applied. The impact on hospital outpatient payments after applying the price realization factor is estimated to be -5.5% (= -6.9% x 0.80).

The above impact of -5.5% is then multiplied by the percentage of medical costs attributed to hospital outpatient payments in Oklahoma (19.6%) to arrive at an estimated impact of -1.1% on medical costs. This is then multiplied by the percentage of benefit costs attributed to medical benefits in Oklahoma
(51%) to arrive at an estimated impact of -0.6% on overall workers compensation costs.

Note that Medicare rules for outpatient services contain a comprehensive payment policy that packages payment for adjunctive and secondary items, services, and procedures into the primary procedure under certain circumstances. For this analysis, the experience is aggregated according to the packaging rules reflected under Medicare, where applicable.

Ambulatory Surgical Centers (ASC) Fee Schedule

In Oklahoma, payments for ASC services represent 1.9% of total medical costs. Of these payments, 75% would be subject to the proposed fee schedule, if implemented. The impact on ASC services is calculated in an analogous manner to the hospital outpatient fee schedule implementation. The overall weighted-average percentage change in reimbursements for ASC services is +26.7%.

[2] Source: Bureau of Labor Statistics, series ID WPU511104.

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A price realization factor of 80% was applied. The impact on ASC payments after applying the price realization factor is estimated to be +21.4% (= +26.7% x 0.80).

The above impact of +21.4% is then multiplied by the percentage of medical costs attributed to ASC payments in Oklahoma (1.9%) to arrive at an estimated impact of +0.4% on medical costs. This is then multiplied by the percentage of benefit costs attributed to medical benefits in Oklahoma (51%) to arrive at an estimated impact of +0.2% on overall workers compensation costs.

Additional Considerations

Maximum reimbursement for dental, ambulance, home health, durable medical equipment, supplies, orthotics and prostheses, and inpatient rehabilitation services are also governed by the medical fee schedule in Oklahoma. The share of these payments with a MAR makes up a small portion of medical costs. Therefore, the impact on overall costs due to updating the fee schedule for these services, if adopted, would be realized in future loss experience and reflected in subsequent NCCI loss cost filing in Oklahoma.

Summary of Impacts

The estimated impacts from the fee schedule change in Oklahoma, proposed to be effective July 1, 2020, are summarized in the following table:

Type of Service	(A) **Estimated Impact on Type**	(B) **Share of Medical Costs**	(C) = (A) x (B) Estimated Impact on Medical Costs
Physician	+2.6%	34.6%	+0.9%
Hospital Inpatient	+3.0%	18.4%	+0.6%
Hospital	-5.5%	19.6%	-1.1%
Outpatient ASC	+21.4%	1.9%	+0.4%
Combined Estimated Impact on Medical Costs (D) = Total of			+0.8%
(C) Medical Costs as a Share of Overall Costs (E)			51%
Combined Estimated Impact on Overall Costs (F) = (D) × (E)			+0.4%

THIS DOCUMENT AND ANY ANALYSIS, ASSUMPTIONS, AND PROJECTIONS CONTAINED HEREIN PROVIDE AN ESTIMATE OF THE POTENTIAL PROSPECTIVE COST IMPACT(S) OF PROPOSED/ENACTED SYSTEM CHANGE(S) AND IS PROVIDED SOLELY AS A REFERENCE TOOL TO BE USED FOR INFORMATIONAL PURPOSES ONLY. THIS DOCUMENT SHALL NOT BE CONSTRUED OR INTERPRETED AS PERTAINING TO THE NECESSITY FOR OR A REQUEST FOR A LOSS COST/RATE INCREASE OR DECREASE, THE DETERMINATION OF LOSS COSTS/RATES, OR LOSS COSTS/RATES TO BE REQUESTED. THE ANALYSIS CONTAINED HEREIN EVALUATES THE DESCRIBED CHANGES IN ISOLATION UNLESS OTHERWISE INDICATED; ANY OTHER CHANGES NOT INCLUDED IN THIS ANALYSIS THAT ARE ULTIMATELY ENACTED MAY RESULT IN A DIFFERENT ESTIMATED IMPACT. I, CAROLYN WISE, ACAS, MAAA, AM AN ASSOCIATE ACTUARY FOR THE NATIONAL COUNCIL ON COMPENSATION INSURANCE, INC. AND THE ACTUARY RESPONSIBLE FOR THE PREPARATION OF THIS DOCUMENT. THIS DOCUMENT IS PROVIDED "AS IS" ON THE DATE SET FORTH HEREIN AND INCLUDES INFORMATION AND EVENTS AVAILABLE AT THE TIME OF PUBLICATION ONLY. NCCI'S FINAL ESTIMATED IMPACT MAY DIFFER FROM WHAT IS PROVIDED IN THIS ANALYSIS IF ADDITIONAL INFORMATION BECOMES AVAILABLE OR IF DATA NECESSARY TO ANALYZE PROVISIONS THAT WERE NOT EXPLICITLY QUANTIFIED PREVIOUSLY BECOMES AVAILABLE.

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Lauren Hammonds Johnson

From: austen@neurosurg.org
Sent: Wednesday, February 19, 2020 5:17 PM
To: WCC Fee Schedule Comments
Subject: [External] Workers Compensation Fee Schedule Comments
Attachments: image001.jpg; Workers Compensation Fee Schedule Comment.pdf

Good evening,
Please see the attached document containing comments regarding the proposed fee schedule changes.

Thank you,
Austen

Austen Peeler
Director of Human Resources
Neuroscience Specialists
Direct: (405) 748-3171 | Cell: (405) 245-8034 | Fax: (405) 748-3172
4120 West Memorial Road, Suite 300 | Oklahoma City, OK 73120
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[300 DPI NSS Long Logo With Gold Spine]
Neuroscience Specialists

COMMENTS REGARDING OKLAHOMA WORKERS COMPENSATION MEDICAL FEE SCHEDULE REVIEW
COMMONLY PERFORMED NEUROSURGERY CODES
NEUROSCIENCE SPECIALISTS, P.C.

	DESCRIPTION	CPT CODES	EFFECTIVE *1-1-2005* FEE SCHEDULE	2005 VS CURRENT FEE SCHEDULE $ INCREASE (DECREASE)	2005 VS CURRENT FEE SCHEDULE % INCREASE (DECREASE)	EFFECTIVE 1-1-2012 *CURRENT* FEE SCHEDULE	INCREASE (DECREASE)	FAIR HEALTH FEE SCHEDULE	NEUROSCIENCE SPECIALISTS RECOMMENDATION DOLLAR	PERCENT	VS CURRENT	VS TX	VS AR	VS KS	VS NM
1	Insert spine fixation device	22845	1,808.46	(435.86)	-32%	1,372.60	-	1,372.60	1,441.23	5%	68.63	(161.34)	(40.67)	(193.75)	(231.40)
2	Neck spine fuse&remov bel c2	22551	N/A	N/A	N/A	3,692.29	-	3,692.29	3,876.90	5%	184.61	138.84	420.30	70.11	(299.06)
3	Lumbar spine fusion	22612	3,191.40	(431.07)	-16%	2,760.33	-	2,760.33	2,898.35	5%	138.02	(583.85)	(321.65)	(631.99)	(589.19)
4	Remove spine lamina 1 lmbr	63047	3,715.38	(895.46)	-32%	2,819.92	-	2,819.92	2,960.92	5%	141.00	546.09	727.92	510.36	(335.83)
5	Insj biomechanical device	22853	N/A	N/A	N/A	@ 737.04	(289.98)	447.06	773.89	5%	36.85	204.63	247.49	215.62	188.71
6	Insert spine fixation device	22842	1,914.84	(461.50)	-32%	1,453.34	-	1,453.34	1,526.01	5%	72.67	(153.02)	(26.59)	(182.49)	(689.59)
7	Spine fusion extra segment	22614	957.42	(230.75)	-32%	726.67	-	726.67	763.00	5%	36.33	(98.46)	(33.60)	(112.31)	(123.06)
8	Lumbar spine fusion combined	22633	N/A	N/A	N/A	@ 5,526.43	(2,335.75)	3,190.68	5,802.75	5%	276.32	1,739.93	2,045.85	1,677.39	1,614.85
9	Addl neck spine fusion	22552	N/A	N/A	N/A	700.62	-	700.62	735.65	5%	35.03	(138.68)	(72.85)	(155.74)	(248.22)
10	Low back disk surgery	63030	3,184.61	(767.53)	-32%	2,417.08	-	2,417.08	2,537.93	5%	120.85	410.01	570.23	379.14	(325.35)
11	Lumbar spine fusion	22558	2,978.64	(320.50)	-12%	2,658.14	-	2,658.14	2,791.05	5%	132.91	(569.28)	(316.25)	(619.82)	(578.30)
12	Neck spine fusion	22600	2,765.88	(575.40)	-26%	2,190.48	26.41	2,216.89	2,300.00	5%	109.52	(522.85)	(310.30)	(567.92)	(534.05)

@ - New Code to Oklahoma Fee Schedule

Lauren Hammonds Johnson

From: Rick Snyder <rsnyder@okoha.com>
Sent: Wednesday, February 26, 2020 9:53 PM
To: WCC Fee Schedule Comments
Subject: [External] OK Hospital Association comments
Attachments: 2020 Medical fee schedule proposal comments - OHA.pdf

Please find our comment letter attached.

Rick Snyder, FHFMA
VP/Finance & Information Services
Oklahoma Hospital Association
4000 Lincoln Blvd.
Oklahoma City, OK 73105
405-427-9537
rsnyder@okoha.com

000049

Rick Snyder, FHFMA
Vice President, Finance & Information Services

February 26, 2020

Oklahoma Workers' Compensation Commission VIA email: feeschedulecomments@wcc.ok.gov
1915 North Stiles Avenue
Oklahoma City, OK 73105

RE: Proposed Medical Fee Schedule

Greetings:

On behalf of our more than 110 member hospitals, the Oklahoma Hospital Association offers the following comments on the proposed medical fee schedule.

Inpatient hospital payment rates

We appreciate the proposal of a 15 percent increase in the inpatient DRG base rate, as it is a larger increase than the10 percent guideline on rate increases. Unfortunately, the proposed base rate of $4,619.07 would still be far below that of other payers. The Oklahoma workers' comp inpatient base rate was woefully inadequate at the time the Commission was created, and of course has fallen farther behind while the fee schedule maximum allowable reimbursements have remained at their 2012 levels.

As the consultants' report acknowledges, Medicare MS-DRG base rates in Oklahoma are at least 14 percent higher than the proposed $4,619.07, and range up to 77 percent higher than the proposed base rate. Medicaid, widely known as the lowest of all payers, now has MS-DRG base rates in Oklahoma ranging from $4,823.51 to $6,170.13.

A reasonable increase in the inpatient base rate would be at least twice that of the increase proposed. A 30 percent increase, rather than 15 percent, would still be a low rate in comparison to other payers.

Otherwise, Oklahoma's extremely low inpatient base rate will create a significant disadvantage for Oklahoma hospitals and for the injured workers needing hospital care.

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

The summary report from FAIR Health discusses three options for stating and updating the MS-DRG weights to be multiplied by the base rate to determine the inpatient MAR (exclusive of implant and stop-loss considerations).

We believe 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. The proposed inpatient ground rule does not say anything about the grouper version, which typically is updated by CMS each October 1, and this should be made clear. Specifying the CMS grouper version that is in effect for the date of service would be the preferred approach.

Please clarify payment policy for short inpatient stays

The inpatient ground rule 1.c defines an inpatient as a hospital confinement that crosses two midnights. This is patterned after Medicare policy changes that have taken place since the 2012 edition of the fee schedule. This implies that a confinement that does not cross two midnights should be considered an outpatient service and that the hospital outpatient ground rule is to be applied instead. It would be helpful to say so. It would also be appropriate to state exceptions for inpatients who do not cross two midnights because of transfer to another hospital, or because they die in the hospital.

Thank you for considering these comments on the proposed medical fee schedule.

Sincerely,

Rick Snyder
Vice President, Finance and Information Services

Lauren Hammonds Johnson

From: Pam Dunlap <pdunlap@osahq.org>
Sent: Wednesday, February 26, 2020 7:36 AM
To: WCC Fee Schedule Comments
Subject: [External] OK Society of Anesthesiologist Comments

To Whom it May Concern:

The proposed fee schedule for anesthesia covers several areas. While most updates are positive for providers and the patients they serve, the overall plan is a net loss for anesthesia providers. The biggest impact on the rates is the change in methodology of the time units in cases over 2 hours. This singular change has a dramatic impact on rates.

Data from two of the largest groups in the state (one in OKC and the other in Tulsa) indicates that about 26% of cases are two hours or longer. This is inconsistent with the FAIR health database:

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.

These two groups took their 2019 work comp cases and applied the new, proposed rate along with the new time methodology. The impact is a net decrease of 5.6% - 6%. If the new time methodology is kept in place, the per unit rate would need to be $51.80 just to break even with current reimbursement. For the 2.5% provider rate increase (as proposed), the rate would need to be $53.10 and for a 5% increase $54.39.

The reduction of the time to 4U across the board doesn't take into account that longer cases do not add any additional base units. Also, the calculation on $/U time units after 2 hours is incorrect. Traditionally the first two hours are counted at 4/U per hour in the overall $/U calculation. So, for hour 3 the unit value would be $54.20, the fourth hour $58.08, the fifth hour $60.41.

We respectfully request that the time unit methodology be reevaluated. Specifically, we request that the time unit calculations remain the same 4/U under 2 hours and 6/U over 2 hours. This is consistent with private insurers and has a significant impact on work comp cases.

Thank you for your consideration.

Sincerely,

Pam Dunlap

Pam Dunlap, CAE
Executive Director
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February 24, 2020

Oklahoma Workers Compensation Commission

1915 North Stiles Avenue

Oklahoma City, OK 73105

RE: Oklahoma Workers Compensation Medical Fee Schedule/FAIR Health Report

Dear. Commissioners;

After careful review of the FAIR Health report and proposed fee schedule our practice has some concerns. As you know the current fee schedule has been stagnant since 2011. This comes on the heels of concurrent reductions to the medical fee schedule dating back to 2005. As we have previously voiced concerns regarding new, bundled and replacement CPT codes and how careful consideration must to made in valuating them as the same work product and utilization is required. Most of our common neurosurgical codes remained flat with no increase at all and new codes came in considerably low.

FAIR Health gives a recommendation that you "consider making exceptions for selected codes based on customized rates from prior fee schedules. They further go on to say that you "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." We are respectfully requesting that the Commission consider this provision and propose a 5% increase to these common codes.

- 22853 was created to replace 22851 however the description of these two codes is very similar and their surgical purpose is the same.
- Further, we request the MAR for 22853 be established at 105% of the current MAR for 22851.

- 22633 involves a lumbar interbody spine fusion. Previously we billed various codes together to better define the work product performed and more appropriately reimburse for the procedure. AMA/CPT has issued guidance that states that the decompression is separately reportable "when in addition to removing the disc and preparing the vertebral endplate, the surgeon removes posterior osteophytes and decompresses the spinal cord or nerve root (s), which requires work in excess of that normally performed when doing a posterior lumbar interbody fusion. The AMA is the author of CPT and therefore their interpretation and guidance should govern. It is our position that the AMA's guidance was not taken into consideration which has resulted in the surgeon doing additional work for not only no reimbursement but less reimbursement.
- The current fee schedule allows a practice to bill 63047, 22612 and 22630 with 63047 being reimbursable. We respectfully request the current reimbursement for these various codes not receive the proposed decrease found in 22633 but receive a 5% increase to the current reimbursement rate of $5,526.43 bringing the valuation of 22633 up to $5,802.75.
- Additionally, there are new codes for a percutaneous kyphoplasty that many neurosurgeons perform. The proposed reimbursement for these codes are much lower than our neighbors in Kansas and Arkansas. This is an all-inclusive code which means that the surgeon has certain hard cost involved in purchasing the product and supplies as well as the anesthesia required. We would propose at least a 105% increase to the current proposed MAR. With this adjustment we will still be well below neighboring states in reimbursement for this procedure. These codes are 22513, 22514 and 22515.
- The common neurosurgical codes that we are requesting an exception for are 22845, 22551, 22612, 22614, 63047, 63030, 22853, 22842, 22633, 22552, 22558, 22600, 22513, 22514 and 22515. With the proposed exception and MAR increase most neurosurgeons would be agreeable with moving forward with the proposed fee schedule.

We are seeing a trend across the nation but recently in Oklahoma where many specialty physicians are now being absorbed by the larger hospital systems and are no longer independent practices. It is our belief that we must protect our most qualified specialists that are the treating physicians in the system so that we do not create further physician shortage areas in the workers compensation system.

Respectfully,

Sheila Harless

Director of Workers Compensation

Lauren Hammonds Johnson

From: Madonna Burton <mburton@oksurg.com>
Sent: Wednesday, February 26, 2020 7:59 AM
To: WCC Fee Schedule Comments
Subject: [External] Written Comments for OK WC Fee Schedule
Attachments: Workers Compensation Proposed 2020 Inquiries.pdf

Please see attached comments from Oklahoma Surgical Hospital.
Thanks,
Madonna

Madonna Burton | Executive Director of Revenue & Information Technology
Oklahoma Surgical Hospital
2408 E 81st St, Suite 300 Tulsa, Ok 74137-4230
Phone 918-477-5010 | Fax 918-477-5930
Email: mburton@oksurg.com | Website: www.oklahomasurgicalhospital.com

Workers Compensation Proposed 2020

Medical Fee schedule Inquiries

Outpatient:

1) Clarification regarding certain codes that are billed to Medicare as a 'G' code. These codes are not listed in the proposed fee schedule. Non-Medicare payers are billed crosswalk codes for some 'G' codes
   Medicare Addendum B of the Outpatient payment prospective system includes all Healthcare common procedure coding system codes which includes all Common procedure codes and level 11 codes.

Example:

G0260 *Injection procedure for sacroiliac joint* (Billed to Medicare)
* Per Medicare Ambulatory Payment Classification Group 5442. Code is not located in the WC fee schedule.

27096 *Injection procedure for sacroiliac joint* (Crosswalk code for Non-Medicare Payers)
* Per Medicare procedure code does not group to an Ambulatory Payment classification. There is no allowable listed in the WC fee schedule for facility

Example:

G0379 *Direct admission of patient for hospital observation care* (Billed to Medicare and Non-Medicare Payers)
* Per Medicare Ambulatory Payment Classification group 5025. Code is not located in the WC fee schedule.

Inpatient:

1) Further detailed Inpatient definition changes from previous fee schedule stating "Inpatient stay is 24 hours" to proposed definition.

   Inpatient hospital services ground rules page 415 1.c states "Inpatient means being confined to a hospital setting for a stay that crosses two or more midnights. An inpatient stay does not require official admission to the hospital"

   Will Medical Necessity be taken into consideration vs length of stay or will it be 2 midnights only?

2) Further explanation of Intent regarding 2 Midnights.

   Per Medicare the two Midnight Rules states "IP admission and payment are appropriate when the treating physician expects the patient to require a stay that crosses 2 midnights and admits the patient based on that expectation."

   If physician expects patient to require a stay that crosses 2 midnights but the patient leaves prior to 2 midnights how will that be handled?

Workers Compensation Proposed 2020

Medical Fee schedule Inquiries

3) Clarification regarding procedure codes that Medicare groups as Inpatient Only (C Status Indicator). These are procedure codes that the patient is required to be admitted to the facility and are not reimbursed if performed in an outpatient setting. There are no rates listed on the proposed fee schedule for Current Medicare Inpatient only codes.

   Will Inpatient only procedures require IP admission and reimbursed as Inpatient or will there be exceptions to this rule?

   Example:
   Procedure code 27269

   Consider adopting an unlisted or unassigned group for those Medicare considers Inpatient only codes. Most of working age are healthy enough to not be required to be inpatient unless the physician feels an inpatient stay is necessary.
   As per the Workers compensation fee schedule in Kansas outpatient surgery Unmapped codes are identified as "UM" in the fee schedule and are reimburse at billed charges less the variable discount rate

4) There was a 15% increase is to the Base rate only from $4016.58 to $4619.07 this does not calculate to a direct increase in the IP revenue due to the decrease of some DRG relative weights . For OSH this resulted in a 1.32% increase from previous WC fee schedule.

5) Inpatient DRG weights
   In the Fair Health Summary under Inpatient hospital (pg10) last section, it discusses alternatives to consider ensuring the currency of fee schedule. OSH would like for the 3rd option to be considered. Remove the MS-DRG relative weights from the table from the ground rules but adopt it by reference. This would ensure that the most recent MS-DRGs are being used if the fee schedule is not updated as planned.

Diagnostic:

1) Clarification regarding Radiology rules and definitions for facility billing.
   Per the Proposed fee schedule introduction (page 4) the following definitions are listed:

   PC (PROFESSIONAL COMPONENT)

   MAR: The PC column shows the maximum allowable reimbursement amount for the professional services portion of the procedure and does not include the technical component of the procedure. The total maximum allowable reimbursement should never be more than the professional and technical components combined.

   TC (TECHNICAL COMPONENT)

Workers Compensation Proposed 2020

Medical Fee schedule Inquiries

MAR: The TC MAR column shows the maximum allowable reimbursement amount for that portion of the procedure that is technical. The total MAR should never be more than the professional and technical components combined.

MAR (MAXIMUM ALLOWABLE REIMBURSEMENT):
A MAR is listed for each code excluding Anesthesia codes, HCPCS codes, MS-DRGs and CMG codes. The MAR column lists the maximum allowable reimbursement for a particular service or procedure performed.

OP MAR:
The OP MAR column shows the maximum allowable reimbursement amount for the facility service performed in a hospital outpatient or ambulatory surgery center setting.

The radiology columns listing the radiology rates do not coincide with the above definitions.

Radiology

CODE	MOD	DESCRIPTION	PROF MAR	FUD	ASST	APC	SI	OP MAR
70491		CT SOFT TISSUE NECK W/CONTRAST MATERIAL	$425.85	XXX	0			
70491	26	CT SOFT TISSUE NECK W/CONTRAST MATERIAL	$127.37	XXX	0			
70491	TC	CT SOFT TISSUE NECK W/CONTRAST MATERIAL	$298.48	XXX	0	5571		$318.89

2) If facility bills for the PC Professional Component (26 Modifier) will the reimbursement be the OP MAR total and the Professional Mar Total for Modifier 26 as with Medicare.

Example:

70491 (Billed on UB)
OP Mar $318.89

70491 – 26 (Billed on 1500)
Prof Mar $127.37

Total Facility Reimbursement $446.26

Lauren Hammonds Johnson

From: Thomas Novelli <Thomas_Novelli@onecallcm.com>
Sent: Wednesday, February 26, 2020 9:10 PM
To: WCC Fee Schedule Comments
Subject: [External] Comments on Medical Fee Schedule
Attachments: 2020-02-27 OC comment letter.pdf

Please find attached comments for the proposed medical fee schedule on behalf of One Call. Thank you in advance.

Thomas Novelli

Thomas C. Novelli
Vice President, Government Relations and Public Affairs

One Call
C: 202.731.0624
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841 Prudential Dr., Suite 200 | Jacksonville, FL 32207

000059

February 26, 2020

Oklahoma Workers' Compensation Commission (WCC)
1915 North Stiles Avenue
Oklahoma City, Oklahoma 73105

Dear Commissioners Liotta, Russell, and Tilly,

One Call appreciates the opportunity to provide comments with respect to the proposed modifications of the medical fee schedule for workers' compensation ("the proposal"). We commend the State of Oklahoma Workers' Compensation Commission ("the Commission"), in collaboration with FAIR Health, to ensure the proposed fee schedule is designed to ensure that injured workers receive the best and most appropriate care possible.

One Call is the nationwide leader of care management services in the workers' compensation industry. Our mission is to ensure that injured workers receive timely access to the highest quality possible providers. We have a longstanding commitment and relationship with the state of Oklahoma. In 2019 alone, we assisted over 14,000 injured Oklahomans in receiving the best care possible through our diverse network of providers.

We commend the Commission for the effort in updating the medical fee schedule for medical providers. After reviewing the updated fee schedule, we **request one point of clarification regarding payment rates for radiological services**.

In the proposal, it appears that a single payment methodology is being applied to all radiological procedures regardless if the procedure meets the definition for accreditation or Medicare requirements for payments. FAIR Health states, "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." However, the statute also potentially infers a different rate standard for magnetic resonance imaging ("MRI") procedures. Specifically, the statute appears to differentiate between accredited MRI procedures or those that meet Medicare requirements and "all other radiology procedures," which would be subject to the rate defined in statute. The proposal appears to apply the statutory single payment methodology rationale for all radiological procedures, regardless if the procedure meets Medicare requirements and accreditation standards.

One Call would greatly appreciate if the Commission could further clarify if the payment methodology in the proposal applies to radiological procedures, such as MRIs, that meet the statutory Medicare requirements and accreditation standards as well as "all other radiological procedures" that do not meet the aforementioned statutory requirements.

Thank you for your consideration in providing this clarification.

Sincerely,

Thomas C. Novelli
Vice President
Government Relations & Public Affairs
One Call

Lauren Hammonds Johnson

From: Pati Swain <pswain@aelcs.com>
Sent: Thursday, February 27, 2020 9:52 AM
To: WCC Fee Schedule Comments
Subject: [External] Fee Schedule Comments - Laboratory

In the laboratory ground rule #2 allows for the treating physician to charge for handling a specimen. Can the descriptor and payment schedule be expanded allowing the laboratory to bill for this charge (99000) when the person collecting, prepping and transporting the specimen is an employee of the laboratory and working the physician's office as a Lab Tech?

Thank you,

Pati Swain, CPC, CPPM
Billing and Coding Manager
(405) 724-1035 phone
(405) 445-7525 fax

Lauren Hammonds Johnson

From: Valerie Lavender-Little <valerie@spinesurgeryinc.com>
Sent: Wednesday, February 26, 2020 9:57 AM
To: WCC Fee Schedule Comments
Subject: [External] Fee schedule Comment

Hello,

In regards to Ground rule 12 (PHYSICIAN ASSISTANT, NURSE PRACTITIONER AND REGISTERED NURSE FIRST ASSISTANT SERVICES), within the rule it only mentions the PA and the RNFA, can you also define the Nurse Practitioner's roles as well as which modifier to use for surgery assists as an NP?

Thank you for your time.

Valerie S. Lavender-Little
Office Manager

Spine Surgery, Inc.
Dr. James M. Odor, MD
Brandi R. Dickey, APRN, CNP

14100 Parkway Commons Dr, Ste 200
Oklahoma City, OK 73134

Ph: 405.242.4345
Fx: 405.242.4333

February 15, 2020

Oklahoma Workers Compensation Commission
1915 North Stiles Avenue
Oklahoma City, OK 7305

Re: Oklahoma Workers Compensation Medical Fee Schedule / FAIR Health Report

Dear Commissioners:

On page two of the above referenced report FAIR Health explains their proposed methodology for calculating MAR values (Maximum Allowed Values). The fourth bullet point of that explanation is a recommendation that you "consider making exceptions for selected codes based on customized rates from prior fee schedules ..." On page six of the FAIR Health report the last bullet point under the Surgery heading suggests that you "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." We agree that the general methodology employed by FAIR Health to value certain commonly used neurosurgery codes is inappropriate and that these codes should be made exceptions to that methodology.

Attached is a schedule of twelve codes commonly used by neurosurgeons to bill for certain spine surgeries. Other specialists appropriately complain that the Workers Compensation MAR for codes they use have not increased in many years. However, as demonstrated on the attached schedule, the MAR for the listed codes has actually decreased from 12% to 34% since January 1, 2005. For the listed codes that are not new the FAIR Health methodology results in no increase. Two codes listed are new to the Workers Compensation Medical Fee schedule. As further explained below, these new codes are valued by FAIR Health at substantially less than the codes they replace. These results clearly demonstrate why Fair Health admits these codes should be made exceptions to their general methodology. We recommend that these twelve codes be increased by five percent over the existing MAR.

In 2017 CPT Code 22853 was created to replace CPT Code 22851. However, the scenario and description for 22851 and 22853 are very similar and for neurosurgery purposes have not changed in regards to utilization and use. Therefore, the MAR for CPT Code 22853 should be established at 105% of the current MAR for 22851 as indicated on the attached schedule.

The other "new" code on the attached schedule is 22633 which involves interbody spine fusion. In 2012 when 22633 was established, the vignette was written to state that laminectomy for decompression is separately reportable when performed. The code 22633 for the combined posterior lumbar arthrodesis has an edit established by CMS (Medicare) that will not pay for the decompression. Furthermore, the

RVU valuation of 22633 did not account for a decompression, therefore, the AMA/CPT has issued guidance that states the decompression is separately reportable "when in addition to removing the disc and preparing the vertebral endplate, the surgeon removes posterior osteophytes and decompresses the spinal cord or nerve root(s), which requires work in excess of that normally performed when doing a posterior lumbar interbody fusion." Since the AMA is the author of the CPT, its interpretation and guidance should control. Based on the MAR assigned by FAIR Health to 22633 they have apparently disregarded the AMA's guidance which results in the surgeon doing the additional work for no reimbursement.

Based on the current reimbursement methodology, in which Workers Comp currently pays for the decompression in addition to the fusion, the expected fee schedule reimbursement is as follows:

	Current		Proposed New		Difference
1 Level PLIF w/ Decompression	63047	7,381.23	22633	4,834.28	(-2,546.94)
	22630-51		22840		
	22612-51		22853		
	22840				
	22851				
2 level PLIF w/ Decompression	63047	10,499.52	22633	6,394.81	(-4,104.71)
	22612-51		22634		
	22630-51		22842		
	22632		22853 x2		
	22614				
	63048				
	22842				
	22851 x2				

While 22633 is not listed in the 2012 fee schedule, the comparative codes that make up the 22633 would be 22612 and 22630, with 63047 also being reimbursable. It is our position that the current fee schedule value of 22633 as it is being reimbursed today is $5,526.42 when a decompression is performed. FAIR Health's proposed rate for 22633 is undervalued in that it discounts the decompression work, which is commonly performed.

Aside from the decompression and CMS edit issue, looking at just the fusion codes, we contend the service is still grossly undervalued compared to the fee schedule. The fusion codes that were combined to make up 22633, are listed in the fee schedule as follows:

22612	2760.33
22630	2652.68

The reimbursement expected for these two codes, with multiple procedure rules applied (which reduces 22630 reimbursement to half), totals 4,086.67, which is comparable to the fee schedules of Texas, Kansas, and New Mexico.

Essentially, there are two separate issues at hand, and two separate values for the Combined Interbody Fusion (PLIF) code, one that values the work of the decompression, and the other that only values the work for elements of the fusion, which are as follows:

	Current	**Proposed New**	**Difference**
Fusion codes Only	4,086.67	3,190.68	(-895.99)
Fusion and Decompression	5,526.43	3,190.68	(-2,335.75)

In conclusion, the CPT Codes on the attached schedule have been assigned inadequate MAR values by utilizing the FAIR Health general methodology. Even FAIR Health admits this in their report and FAIR Health recommends that these CPT Codes should be treated as exceptions to their general methodology. We request and recommend that these services which have actually been devalued by as much as 34% since 2005 receive at least a 5% increase in their corresponding MAR's.

Robert Remondino, M.D.

Kevin Blaylock, CPA *

Enclosure: Fee Schedule Comparison Worksheet and Addendum

Mr Blaylock is currently out of the country

Addendum:

When valuing and determining the reimbursement for CPT 22633 in comparison to the surrounding states, it's imperative to look at not only the fee schedule allowable, but also the coding edits that are implemented within the states guidelines. The states that follow AMA's CPT guidelines allow for reimbursement of the decompression in addition to the PLIF, in comparison to a state that requires the use of NCCI edits which would not allow for separate reimbursement. Assuming multiple procedure guidelines, the reimbursement by state would be as follows:

	Texas	Arkansas	Kansas	New Mexico	Oklahoma
22633	4,062.82	3,756.90	4,125.36	4,187.90	5,526.43
63047	1,679.03	2,233.00	2,450.56	3,296.75	2,819.92
NCCI	Yes	No	No	No	Yes
Total	**4,062.82**	**4,873.40**	**5,350.64**	**5,836.28**	**5,526.43**
	1,463.61	653.03	175.79	(309.84)	

Lauren Hammonds Johnson

From: Richard L Foster, CPO <richard@tggpo.com>
Sent: Wednesday, February 26, 2020 10:08 AM
To: WCC Fee Schedule Comments
Subject: [External] Request For Fee Schedule Review - Written Comments
Attachments: Oklahoma Workers Compensation Commission Review Request.pdf; VA Announcement to the Field X3-Genium- Update August 2013.pdf

Please find attached the request for fee schedule review public comment period.

1) Formal Statement
2) Veteran's Administration Field Announcement

Best Regards,

Richard L Foster, CPO, LP, LO, BSME
Owner / Certified Prosthetist Orthotist

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Oklahoma Workers Compensation Commission

Reimbursement Fee Schedule – Request for Review
Prosthetic and Orthotic "Not Otherwise Classified Codes"

Richard L Foster, CPO, LP, LO, BSME
February 26, 2020

The Issue:

OWCC regulations are denying amputees and other individuals with mobility impairments access to medically necessary and appropriate prosthetic and orthotic technologies.

The Request:

Reconsider the OWCC's approach to "not otherwise classified" (NOC) codes," which has the practical effect of precluding patient access to devices described by these codes. Adopt the Veterans Administration's approach to reimbursement of these codes.

Background:

Prosthetic and orthotic devices are described by alpha-numeric codes, each with an assigned reimbursement value. The Centers for Medicare and Medicaid Services (CMS) develop and maintain these codes and set their reimbursement amounts.

A small number of new prosthetic and orthotic devices have functional characteristics that are not described by any currently-existing alpha-numeric code. However, in order to ensure appropriate beneficiary access to all available devices, CMS created NOC codes. These codes are "catch-all" codes with no set description or reimbursement amount. When a prosthetist/orthotist submits a claim using one of these codes, he/she is responsible for specifically describing the device/feature at issue and selecting the applicable reimbursement amount. There are three NOC codes describing prosthetic/orthotic devices that OWCC recognizes: L5999 (lower extremity prosthetics), L7499 (upper extremity prosthetics), and L2999 (lower-extremity orthotics).

Unfortunately, OWCC limits providers to "the lesser of the provider's usual and customary charge or 10 percent (10%) above the manufacturer's invoice price plus reasonable and customary acquisition costs of the item(s) to the provider" when NOC codes are involved. This effectively limits prosthetists' and orthotists' ability to provide devices described by NOC codes to their patients. The margins are so thin as to make delivery of NOC devices financially non-viable for the prosthetist and orthotist. That is not a complaint – it is simply a statement of fact. But the provider is not the one who suffers as a result – it is *the patient* who cannot obtain the medically appropriate device.

The OWCC approach to NOC codes is significantly more restrictive than other payers' – most notably, the Veterans Administration. In 2013, the VA issued guidelines for prosthetic devices utilizing NOC codes as follows:

> For an item that is not otherwise classified in the CMS HCPCS, and for which VA assigns L5999 or L7499, the Contractor shall be paid ***1.5 times the Contractor's purchase invoice price from the manufacturer for the item, minus any applicable discounts***. [emphasis added]

The VA's approach to NOC reimbursement represents a more balanced approach to the issue, establishing a hard ceiling on payment for NOC codes on the one hand, while also creating a viable financial pathway for new technology to find its way to amputees when medically appropriate.

The OWCC might ask, "Why is this our issue? Why not simply wait until Medicare creates a new code and sets a specific reimbursement amount for it?" The short answer is that Medicare's process for submitting and obtaining a new code is dependent on a minimum threshold of device sales as a predicate to submission. In order for a device manufacturer to file a new code application, it must demonstrate based upon historical sales data that it has sold the device at issue to at least 3% of the "affected patient population" and receive a favorable reimbursement rate. Crossing this threshold with only Medicare beneficiaries receiving the device is an impossibility. Rather, manufacturers need other payers – the VA, private insurance, and workers compensation – to process and approve claims as well in order to satisfy the 3% requirement.

And OWCC is similar to the VA in that its beneficiaries are tied to it for the long-term. Therefore, up-front investment in newer, more effective technologies is likely to reduce overall health care costs to the program. For example, a Retrospective Cohort Study of the Economic Value of Orthotic and Prosthetic Services Among Medicare Beneficiaries (Dobson DaVanzo, 2013) found the following:

> [P]atients who received O&P services were more likely to receive the physical therapy and rehabilitation required for them to remain in the community and avoid facility-based care. The goal of restoring function is emphasized in many of Medicare's covered services (i.e., skilled home health care and inpatient rehabilitation facilities), and therefore supports the targeted use of O&P services for patients who are able to benefit from and receive the requisite therapy. The increased physical therapy among O&P users allowed patients to become less bedbound and more independent, which may be associated with higher rates of falls and fractures, but fewer emergency room admissions and acute care hospital admissions. This reduction in health care utilization ultimately makes O&P services cost-effective for the Medicare program and increases the quality of life and independence of the patient.

Put simply, investing up front in appropriate prosthetic and orthotic care saves money. The existing fee schedule for "Not Otherwise Classified" codes for prosthetics and orthotics is the beginning of the end of future investment and research in the field.

Summary:

We are requesting that the OWCC Physician Advisory Board adopt the VA's approach with respect to NOC codes. Specifically, OWCC should modify its current payment methodology and permit reimbursement of 1.5 times the provider's purchase invoice price for the item.

With the increased prevalence of diabetes, dysvascular disease and stroke-related disabilities, no one – me, or anyone reading this request – is immune from requiring prosthetic or orthotic treatment. (As I've heard many of my patients say, "Everyone else is just temporarily able-bodied.") I hope you agree with me that the State of Oklahoma and the OWCC specifically should be part of a solution that offers amputees and individuals with other mobility impairments the opportunity to receive the best patient care and the best possible tomorrow.

Prosthetic & Sensory Aids Service
Maximizing Veteran Independence

Instructions to the Field: L Code Usage for Otto Bock X3 and Genium Knee Units
August 2013

ANNOUNCEMENT: VHA Prosthetic and Sensory Aids Service in conjunction with Patient Care Services and VHA Procurement & Logistics Office make the following recommendations for appropriate L Code usage with the Otto Bock X3 and Genium knee units.

NIF Item numbers and descriptors:
451319 PROSTHETIC COMPONENT, LOWER EXTREMITY, GENIUM KNEE OTTO BOCK HEALTHCARE LP 3B1
NO NIF for the X3

RECOMMENDATION:

- Use one miscellaneous code L5999 for the Genium knee unit with the description of "Genium", added to the end of the code. (see below)
- ***L5999- Lower extremity prosthesis, not otherwise specified-Genium***

- Use one miscellaneous code L5999 for the X3 knee unit with the description of "X3", added to the end of the code. (see below)
- ***L5999- Lower extremity prosthesis, not otherwise specified-X3***

- The miscellaneous code will replace all other associated knee unit L Codes (5856, 5828, 5848, 5845 and 5930).
- L7368- Lithium Ion Battery Charger, replacement only: Is not allowable on initial purchase.

- At the present time, VHA can purchase the Genium and X3 knee units directly from the manufacturer for use by VHA Prosthetists for Veterans at the below approximate costs.
- Part# 3B1: Genium- Bionic Prosthetic System: $33,280.00

3B1 or 3B1=ST-Genium Bionic Prosthetic System
4X350-Remote control
4E60-Induction charger
2R20 or 2R11-AXON Tube Adapter
Software-Provided during initial training or downloadable

- Part# 3B5-X3: X3 Bionic Prosthetic System: $41,500.00
  X3 system includes:

2R19-AXON Tube Adapter (standard pylon)
757L16-3-Wall Charger
4E60-Inductive Charger
4X350-X3-Remote Control
4X194-Wrist Band
4X193-Protector
Software X- Soft Version 1.2

If procurement is from a VHA Contracted Vendor (CV) who is providing the care and service, the local contracted rate methodology established in the local VHA contract will determine the amount of reimbursement to the CV.

If this is not addressed in the local contract the following methodology is recommended:

A. ($16,100.00 minus the VA contract discount rate) plus the CV invoice from the manufacturer depicting purchase price.

Example: *CV has a VA Contract discount rate of 10%. CV purchases item from manufacturer for $34,000.00. $16,100.00 - $1,610.00(10% CV discount) = $14,490.00 plus $34,000.00 (vendor/manufacturer invoice) = $48,490.00*

VA would reimburse $48,490.00

B. **How was the $16,100.00 determined?**

1. The methodology for determining the $16,100.00 fee is calculated by review of similar products assigned a HCPCS code(s) and reimbursement fee schedule(s).
2. L5856, L5828, L5848, L5845, and L5930 were selected as the appropriate L Codes. Associated Floor/Ceiling averages were calculated = ($32,602.33).
3. The VHA estimated purchase price for the predicate product (Otto Bock C-Leg) was determined= $16,493.00
4. Methodology: The VHA purchase price for the predicate product (Otto Bock C-Leg) was subtracted from the averaged Floor /Ceiling rate. (See below)
   $32,602.33 (Average of CMS HCPCS FY2013 Ceiling/Floor for L5856, L5828, L5848, L5845, and L5930) minus $16,493.00 (VA estimated purchase price from manufacturer) = **$16,109.33 rounded to $16,100.00**

A record of the transaction should be maintained and should include invoices and related documents (if any) to support reimbursement.

Implementation of these recommendations should be coordinated between departments at local sites. If you have any questions related to this announcement, please contact the local PSAS service for more information and/or communications via the VACO PSAS 10P4K Action Workgroup.

** VA is granted broad statutory authority under 38 U.S.C.S. 8123 to procure prosthetic items and services. The Comptroller General acknowledged the broad scope of this authority and has determined that using L Codes and related Medicare pricing is an appropriate exercise of this discretionary authority. Purchases must be made at fair and reasonable prices.*

**The VA Prosthetic and Sensory Aids Service, Orthotics and Prosthetics L Code Committee was created to help clarify the use of L Codes for orthotic and prosthetic limb products (e.g. documenting AND/OR invoicing of those products) for which it is not clear or appropriate. The committee is not responsible for determining cost formulary, clinical merit or appropriate use of the products reviewed. Contracts for the provision of orthotic and prosthetic services require review prior to implementation of this recommendation.*

** The VA Prosthetic and Sensory Aids Service, Orthotics and Prosthetics Service do not determine or define industry terminology for products or services.*

** The VA Prosthetic and Sensory Aids Service, Orthotics and Prosthetics Service recommend that manufacturers and/or commercial partners seek guidance through the CMS HCPCS Coding Determination process. END*

Lauren Hammonds Johnson

From: Theresa Johnston <TJohnston@johnstonandassoc.com>
Sent: Thursday, January 23, 2020 11:32 AM
To: WCC Fee Schedule Comments
Subject: [External] Fee Schedule Comments

Hello Hopper,

I will not be able to attend the open forum but would like to submit written comments.

As a claims carrier and payor I know that Medicare rates are freely accessible to everyone and the states that base their Work Comp rates on the CMS rates, that also include calculations for Inpatient/Outpatient hospitals, it works very well and we have free access to CMS rates. We don't currently have to purchase any third party data, such as Fair Health data to calculate rates, so here's my comments:

Are you using Fair Health to gage the UCR 80th percentile for your state, then you will establish a set fee schedule rate based on their data, along with CMS data to come up with percentages based on CMS data that all payors will have free access to use for calculations?

Since data changes over time, if we had to purchase third party data for FS calculations, it could drive up costs significantly, especially if the third party charges by the zip code.

Thanks

Theresa Johnston
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Franklin, TN 37068
Mobile 615-554-3830
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From: TERRELL PHILLIPS
To: WCC Fee Schedule Comments
Subject: [External] Pharmaceutical Services Ground Rules of the 2020 Proposed Medical Fee Schedule
Date: Tuesday, February 25, 2020 4:14:07 PM
Attachments: OWCC Medical Fee Schedule Changes 02252020.docx

Dear OWCC

I'm writing to submit written comment to the OWCC regarding a proposed change to the Pharmaceutical Services Ground Rules of the 2020 Proposed Medical Fee Schedule. Please see the below attached document in Word format laying out a recommended change to the 2020 Proposed Medical Fee Schedule.

Sincerely,
Terrell R. Phillips, D.O.

OWCC Medical Fee Schedule – Pharmaceutical Services Ground Rules
Physician Dispensed Medications

The State of Oklahoma Workers' Compensation Commission (OWCC) proposed Medical Fee Schedule that is set to be effective on July 1, 2020, **needs one change** to the Pharmaceutical Services Ground Rules in order to provide clarity and certainty on the costs to the workers' compensation insurance carriers for medications dispensed by a physician.

In the new proposed Medical Fee Schedule, important language clarifying the reimbursement methodology **is left out** of the section applicable to medications dispensed by physicians. In Section 3f of the proposed Pharmaceutical Services Ground Rules, it states, in pertinent part, that:

> PHYSICIAN-DISPENSED DRUGS: When medical care includes prescription drugs dispensed by a physician or other medical care provider and the NDC for the drug product dispensed is for a repackaged drug, then the maximum reimbursement shall be the lesser of the original labeler's NDC and the lowest-cost therapeutic equivalent drug product.

This proposed section does NOT contain the language necessary to set the reimbursement methodology for medications dispensed by a physician. Section 3f of the Pharmaceutical Services Ground Rules needs to be changed to add the words **"ninety percent (90%) of the average wholesale price"** to the language. Therefore, the proposed Pharmaceutical Ground Rules, Section 3f, should be revised to read as follows (new language underlined):

> PHYSICIAN-DISPENSED DRUGS: When medical care includes prescription drugs dispensed by a physician or other medical care provider and the NDC for the drug product dispensed is for a repackaged drug, then the maximum reimbursement shall be the lesser of <u>ninety percent (90%) of the average wholesale price of</u> the original labeler's NDC <u>or ninety percent (90%) of the average wholesale price of</u> the lowest-cost therapeutic equivalent drug product.

By revising Section 3f of the Pharmaceutical Services Ground Rules, it will provide the needed clarity and continuity for the reimbursement methodology for medications dispensed by a physician. Additionally, it is important to note that by implementing this revision to Section 3f it will act to mirror the average wholesale price reimbursement methodology applicable to medications dispensed by a pharmacy. In Section 3a of the proposed Pharmaceutical Services Ground Rules, it states, in pertinent part, that "charges for prescription drugs dispensed by a pharmacy shall be limited to ninety percent (90%) of the average wholesale price of the prescription. . ." By making this revision to Section 3f, it will alleviate the ambiguity created by the omission of the "average wholesale price" language from the proposed Pharmaceutical Services Ground Rules.

Lauren Hammonds Johnson

From: Terry Shaw <tshaw@ccrs-inc.com>
Sent: Thursday, January 30, 2020 8:19 AM
To: WCC Fee Schedule Comments
Subject: [External] follow-up to yesterday's comment on fee schedule

I posted a comment yesterday on the extremely low rates suggested for neuropsychological assessment and indicated that I would provide references if needed. Rather than wait for your request for additional information, I went ahead and pulled up the primary reference. It is the 2015 Practice Survey authored by Dr. Jerry Sweet and constitutes Volume 29, Number 8 of The Clinical Neuropsychologist. The survey was sponsored by the National Academy of Neuropsychology as well as Division 40 of the American Psychological Association (Society for Neuropsychology). It is a practice survey of 1,777 neuropsychologists across the US and in it you will find on page 1096 a chart that notes the average hourly fee for clinical neuropsychological assessment is $240/hr while forensic neuropsychological assessments charge on average $320/hr. This is of course using the old 96118 code but you are basically proposing to pay $178.68 for the first hour of NP work and $134.25 for each subsequent hour (96132 and 96133 respectively). Both of these figures are below the average clinical rate across the US (in 2015 dollars) and woefully short of the forensic rate. It is obvious that the company that is proposing these new reimbursement figures have not done their homework and have basically disregarded published data on a sample of 1,777 neuropsychologists surveyed in the above referenced article from across the US. That same article notes that the average length of a forensic neuropsychological examination is 13. 5 hours (see page 1110 of the article). Unless there is a massive amount of records to review prior to the exam, I rarely bill for more than 12 hours. Again, I feel as thought your proposed rates may well bring to an end my willingness to provide services for the WCC system in the future as I will likely opt to just do clinical work instead. Why would I want to do forensic evaluations and get reimbursed below the national average for a basic clinical evaluation.

Sent from Mail for Windows 10

Lauren Hammonds Johnson

From: Terry Shaw <tshaw@ccrs-inc.com>
Sent: Wednesday, January 29, 2020 2:29 PM
To: WCC Fee Schedule Comments
Subject: [External] New rates

I just reviewed the newly proposed rates of reimbursement for a neuropsychological assessment. I have to say, the suggested rates are well below market. This includes 96116, (and add on 96121) as well as 96131 (and add on code of 9612) in addition to 96136 (and add on code 96137). These codes are woefully below rates posted for a forensic neuropsychological assessment. If you would like a reference, I would be more than happy to provide you with a reference regarding average fees for forensic work for neuropsychologists across the country (published by Jerry Sweet and sponsored by the National Academy of Neuropsychology).

For the record, when I evaluate an injured worker (ordered by the court or by legal counsel), it is not run of the mill clinical work; It is a forensic examination, one that I know I have to read extensive records, perform exhaustive testing, explore all avenues of explanation and be prepared to defend my opinion in court (or in a deposition). While current reimbursement for neuropsychological codes is below forensic market value, I have been willing to do these at a lower rate compared to personal injury work.

When you announced that you were hiring a national firm to review reimbursement rates, I suspected that they would disregard the forensic nature of the work and simply provide you with suggested reimbursement figures based on non-litiginiouis work. I was right.

Finally, using the proposed rates would now result in a nearly 29% reduction in payment for the service (which is already below market value). I don't mind tightening my belt for the good of all but 29% is a big number compared to current reimbursement. If the newly proposed fees aren't adjusted for the forensic nature of the service, I may well have to decline future referrals. Why would I want to be involved in litigation and get paid at a rate I can earn for non-litiginiouis work. …Dr. Terry Shaw.

Sent from Mail for Windows 10

Lauren Hammonds Johnson

From: Yvonne Redington <yredington@tulsapain.net>
Sent: Friday, February 7, 2020 2:09 PM
To: WCC Fee Schedule Comments
Subject: [External] Presumptive Urine Drug Screens

Creating a spread sheet for the codes we use the most. In our office we use a urine drug screen cup that shows us if a patient is positive or negative for their prescribed medications or any illicit substances. Codes in the proposed 2020 fee schedule do not give any monetary reimbursement. The codes it states to use are 80305, 80306 and 80307 and when you go to that section it states see rules. We only send out the urine for laboratory confirmation if the prescribed medications do not show or an illicit is detected. In the past we were challenged by numerous work comp insurance companies on why were doing both. When a patient is here in the office we want to know right then if there are any issues. Also, most of the laboratories cannot give us a definitive amount of the medications in the patient or when the patient last took their medications. The lab company response is always that all patient's metabolize the medications differently.
So, how are we going to be reimbursed for an office urine analysis using CPT Code 80305 with a 12 panel cup?
Yvonne Redington
Office Manager
Tulsa Integrated Pain Services
918-477-5942 (direct)
918-688-3857 (cell)
918-477-5951 (fax)

Lauren Hammonds Johnson

From: Chali Stevens <chalis@unitedsafety.com>
Sent: Wednesday, February 26, 2020 4:47 PM
To: WCC Fee Schedule Comments
Subject: [External] Fee Schedule Stakeholder Feedback

To Whom It May Concern:

I would like to comment on item #3 in the letter from Sheila Harless, dated December 20, 2019. We are a Third Party Administrator for self-insured employers. We have a contract with a PPO network for access to their contracted physicians and PPO discounts. We handle all bill review and adjudication in-house for our self-insured clients. We have confirmed with the PPO Network that this is a permissible us of their network.

I feel this is a contract issue not a fee schedule issue. My understanding is the intent of the statement was clarified and it was about contracts for health insurance PPO's that included workers' compensation claims at the same discounted fees as the health. I wanted to make sure it doesn't have an impact on the Third Party Administrators to have the ability to lease a PPO network and complete bill review and adjudication in-house.

I appreciate your time and consideration.

Best Regards,

Chali Stevens
President/Chief Financial Officer
918-664-8816

US&C
United Safety & Claims Inc.

Lauren Hammonds Johnson

From: Samantha Watkins <samantha.watkins@walmart.com>
Sent: Thursday, February 27, 2020 1:23 PM
To: WCC Fee Schedule Comments
Subject: [External] 22020 Fee Schedule Comments

Good Afternoon,

Questions/comments regarding the 2020 Oklahoma Fee Schedule:

Per page 7. By report codes are to be reimbursed at the medical providers usual and customary charge. Could By reports be paid at a comparable code? Example: Per GA Fee Schedule "usual, customary, and reasonable charges shall be limited to such charges as prevail in the State of Georgia for similar treatment."

Can you clarify how J-codes (injectables) would be reimbursed? Will these be paid by Medicare part B Drug Fee Schedule, or if the J code is not listed will they be denied for invoice plus markup per rule 5. Unlisted Items of the Durable Medical equipment and supplies?

Per page 412- OTC Drugs are to be reimbursed at retail price. Does this mean an invoice can be requested for any billed charges over $15.00 and reimbursement will be invoice cost plus mark up?

The Fee Schedule does not mention skilled nursing facilities. Will Skilled nursing be reimbursed at Medicare?
Per 408- It states that ASC will be paid at the APC rate subtracting the implant cost from the APC rate before applying the Oklahoma multiplier. My concern with this is extensive programing or not being able to program this at all and requiring manual calculation. If we have to manually calculate every bill with implants this will cause these types of bill to take longer for the provider to be reimbursed. Could implants be reimbursed at Medicare, then any dispute we can request invoice of cost and pay the difference if any? Also, please clarify if Outpatient Hospitals will be reimbursed per OPPS Addendum A and B, plus Markup and Ambulatory Surgery Centers be reimbursed by Addenda AA-EE, plus Mark up?

The Fee Schedule mentions how long the insurance carrier or employer has to pay, however, it does not mention how long the provider has to submit initial bill or disputes/reconsiderations to the insurance carrier or employer. Will the initial bills have a timely filing limit after Date of service? Will Disputes/Reconsiderations have a timely filing limit from the payment date of the last received bill?

Thank you,

Samantha Watkins
Analyst l, Specialty Compliance and Ethics
OK, TN, DC, WV, GA

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