

**Workers' Compensation
Medical Services Review Committee
Meeting Minutes
March 16, 2015**

I. Call to order

The Medical Services Review Committee was called to order at 9:02 am on Monday, March 16, 2015, in Anchorage, Alaska.

II. Roll call

The following Committee members were present, constituting a quorum:

Dr. Mary Ann Foland	Jane Griffith	Dr. Robert Hall
Tammi Lindsey	Dr. William Pfeifer	Pamla Scott
Kevin Smith		

Member Vince Beltrami joined the committee after lunch

III. Approval of Agenda

A motion to adopt the agenda was made by member Scott and seconded by member Foland. The agenda was adopted unanimously.

IV. Approval of Minutes

A motion to adopt the minutes from the January 15-16, 2015 meeting was made by member Smith and seconded by member Foland.

- Member Pfeifer recommended that the word "initially" be inserted in between the words "would" and "be" at p. 7, item IV, second bullet. The recommendation was unanimously accepted.
- Member Pfeifer recommended that the word "budget" be removed from the first bullet at p. 8, to read "...from UCR to RBRVS fee schedule neutral..." He recommended that similar change be made wherever "budget neutral" appears. The recommendation was unanimously accepted.
 - *At the last bullet on p. 2, "...retain budget neutrality..." was changed to "...fee schedule neutrality..."*
 - *At the second bullet of XIII on p. 6, "...overall budget neutral..." was changed to "...overall fee schedule neutral..."*
- Member Pfeifer recommended that the word "addressed" be amended to "reviewed" in the second bullet at p. 8, to read "There was general consensus that utilization will need to be reviewed as part of medical reform in workers' compensation." The recommendation was unanimously accepted.

The January 15-16, 2015 minutes, as amended, were unanimously adopted by the committee.

A motion to adopt the minutes from the January 29, 2015 meeting was made by member Smith and seconded by member Scott.

- Member Pfeifer noted an incorrect date under I at p. 1. The date should read "Thursday, January 29, 2015". The correction was unanimously accepted.

- Member Pfeifer recommended clarification at the first bullet on p. 4. He requested the following be added, “Member Pfeifer reiterated his objection to multiple conversion factors, but the proposed transitory conversion factors are acceptable.” Member Foland requested the following be added, “The Academy of Family Physicians also supports the proposed transitory conversion factors.” The recommendations were unanimously accepted.

The January 29, 2015 minutes, as amended, were unanimously adopted by the committee.

A motion to adopt the minutes from the February 23, 2015 meeting was made by member Smith and seconded by member Scott. There were no corrections or recommended changes noted. The February 23, 2015 minutes were unanimously adopted by the committee.

V. Chair’s Report

The chair distributed an action item list and a summary of draft recommendations through the February 23, 2015 meeting.

The Workers’ Compensation Board has a meeting scheduled for May 14-15, 2015. The chair would like to see the committee’s recommendations wrapped up in time to have the Commissioner review and to the Board in time for that meeting.

VI. Fee Schedule Development Discussion

The committee discussed and reviewed the methodology for inpatient implants.

- If the inpatient procedure does not include an implant, or includes an implant but the billed charge is not an outlier case, the amount to be paid is the DRG weight times the hospital specific conversion factor.
- If the stay involves an implant, and the case is an outlier case (\$30,000 threshold)
 1. The implant charge is removed from the amount billed.
 2. The Alaska conversion factor is applied to the adjusted balance.
 3. The implant reimbursement is calculated at invoice plus 10%
 4. The amounts calculated in #2 and #3 are added together to determine the final reimbursement.
 5. Eric Anderson from Optum will send a worksheet demonstrating how this methodology would work.

VII. Review of Optum Analysis of Medical Data for ASP, CLAB, DMEPOS, & PEN

Carla Gee reviewed Optum’s analysis of ASP, CLAB, DME, & PEN.

- Definitions
 - ASP – Average sale price fee schedule from CMS. These are mainly HCPCS drug and vaccination (J) codes
 - CLAB – Clinical laboratory fee schedule from CMS
 - DMEPOS – Durable medical equipment, prosthetics, orthotics and supplies fee schedule from CMS
 - PEN – Parenteral and Enteral Nutrition Items and Services (PEN) fee schedule from CMS. These are mainly HCPCS dietary and nutritional supply (B) codes.

- CMS does not produce relative values for these fee schedules, so Optum calculated multipliers that would establish maximum allowable reimbursement rates at the 75th percentile of the FairHealth data.
- Optum calculated the following percentages above Medicare
 - ASP - 3.375
 - CLAB - 6.33
 - DMEPOS - 1.84
 - PEN - 3.55
- Optum stated that neither NCCI nor FairHealth included any PEN data. Members Scott and Lindsey stated they rarely see billings for these items. The committee's consensus was to not establish a multiplier for PEN, and instead cover it under the general rule adopted for payment of unlisted codes and procedures.
- Optum also stated that Medicare does produce an ambulance fee schedule, but they did not calculate a multiplier for ambulance fees pending direction from the committee.
- The chair noted that Optum's multipliers for these categories were projected to be at the 75th percentile of the FairHealth data. He notes that the committee may want to re-evaluate the draft conversion factors for evaluation and management, medicine, radiology and surgery to see what percentile of FairHealth data these categories calculate to when making a final decision. Ms. Gee noted that the reason the surgery conversion factor is low is because the difference in relative values for surgical services provided in a facility setting, which are significantly lower than surgical services provided in an office setting.

Break 10:20am-10:36am

VIII. Fee Schedule Development Discussion (continued)

The chair opened the floor for motions on adopting the following draft conversion factors.

- Physician Fee Schedule
 - Evaluation & Management - \$85
 - Medicine - \$85
 - Surgery - \$205
 - Radiology - \$280
 - Laboratory - \$142
 - Pathology & Clinical Lab - CMS x 6.33
 - Durable Medical Equipment - CMS x 1.84
 - ASP - CMS x 3.375
 - Utilize separate CMS physician fee schedule relative values for facilities and non-facilities
- Outpatient - \$221.79
 - Outpatient based on CMS Outpatient Prospective Payment System
 - ASC Payments at 95% Outpatient allowance
 - Implants @ invoice plus 10%
 - Adopt state rule for status codes C, E, & P

- Inpatient Acute Care (Based on 13% case outlier and 7% implant outlier)
 - Inpatient based on MS-DRG
 - CF adjustment for disproportionate share, case outlier, and implants
 - On outlier cases, implants backed out of MS-DRG and paid at invoice plus 10%
 - Providence Alaska Medical Center \$17,085.40
 - Mat-Su Regional Medical Center \$15,326.64
 - Bartlett Regional Hospital \$14,615.18
 - Fairbanks Memorial Hospital \$15,972.59
 - Alaska Regional Hospital \$15,413.63
 - Yukon Kuskokwim Delta Regional Hospital \$28,315.11
 - Central Peninsula General Hospital \$14,385.49
 - Alaska Native Medical Center \$22,681.05
 - Mt Edgecumbe Hospital \$19,621.32
- Anesthesia \$121.82, based on the Relative Value Guide, produced by the American Society of Anesthesiologists.
- Prescription Drugs
 - MFG average wholesale price + \$5 dispensing fee for brand/\$10 dispensing fee for generics
 - For compound drugs, limited to medical necessity, MFG AWP for each drug included in the compound (listed separately by NDC) plus a \$10 compounding fee.

Member Scott moved to adopt the draft conversion factors. The motion was seconded by member Pfeifer.

- Member Pfeifer moved to amend the draft conversion factor for evaluation and management from \$85 to \$80 and the conversion factor for medicine from \$85 to \$80. The motion was seconded by member Smith. After discussion, the committee unanimously approved the motion to amend.
- Member Foland moved to amend the draft conversion factor for radiology from \$280 to \$257. The motion was seconded by member Smith. After discussion, the committee unanimously approved the motion to amend.

IX. Public Comment

Misty Steed, PACBLU

- Ms. Steed spoke in support of adopting the National Correct Coding Initiative edits. In 2005, the Office of the Inspector General issued a report on the use of modifier 59. CMS sets coding standards in collaboration with the American Medical Association in consultation with medical associations and medical providers.
 - *Modifier 59 is used to indicate that a procedure or service was distinct or independent from other services performed during the same session on the same day. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. AMA CPT Coding System© description.*
 - *The report can be found online at <https://oig.hhs.gov/oei/reports/oei-03-02-00771.pdf>*

Sheila Hansen, Corvel

- Ms. Hansen spoke in support of a rule for unlisted procedures or procedures for which there is no relative value to be paid at 80% of billed charge.

X. Fee Schedule Development Discussion (continued)

The committee continued discussion of the motion to adopt conversion factors.

- Member Pfeifer moved to amend the draft fee schedule recommendation for compound prescription drugs to read, "For compound drugs, limited to medical necessity, MFG AWP for each drug included in the compound (listed separately by NDC), plus a \$10 flat compounding fee, with no dispensing fee." The motion was seconded by member Smith. After discussion, the committee unanimously approved the motion to amend.
- The committee discussed the outpatient conversion factor of \$221.79. Member Hall said he is hearing from his constituency group that the current workers' compensation fee schedule rate is over 300% of Medicare, but the proposed conversion factor is 218% of Medicare. He stated the combination of lower conversion factors for both the physician and outpatient facility fee schedules, plus the 5% reduction in the maximum allowable reimbursement rate for ambulatory surgical centers, concerns his members. The chair noted that Optum's analysis assumed a base rate of \$101, which was determined using a straight average wage index. However if a weighted average wage index is used, the base rate calculates to \$88.86, which puts the \$221.79 to 249.6% of Medicare. If the urban wage index is used, the base rate calculates to \$87.77, which puts the \$221.79 to 252.7% of Medicare.
- Member Hall moved to amend the draft conversion factor for outpatient from \$221.79 to \$245.77, which would set the percentage at 280% of Medicare. The motion was seconded by member Griffith. After discussion, member Hall changed his motion, amending the conversion factor from \$221.79 to \$237.0, and eliminating the 5% outpatient fee schedule reduction for services provided at an ambulatory surgical center. Member Griffith agreed to the change. After further discussion, the amendment failed, with only 3 members voting in favor.

Lunch Break 11:55am-1:32am

XI. Fee Schedule Development Discussion (continued)

- Copies of Eric Anderson's Outlier/Implantable examples were distributed to committee members.
- Member Hall distributed a spreadsheet containing the top twenty procedure codes, based on frequency, performed at the Alpine Surgery Center. Member Hall would like to see a similar analysis for the conversion factors being proposed.
- The committee continued its discussion of the outpatient conversion factor.
- Member Foland moved to pull the outpatient conversion factor from the main motion, and decide it at a later date. The motion includes having Optum and the Division put

together a spreadsheet similar to what member Hall had put together for the committee to review before the next meeting.

- Member Smith moved to amend member Foland's motion, providing that the proposed spreadsheet display conversion factors ranging from \$221.79 to \$245.77, in \$3.0 increments. The motion was seconded member Pfeifer. After discussion the committee unanimously approved the motion.
- Returning to member Foland's motion, after additional discussion, the committee unanimously approved the motion to exclude the outpatient conversion factor from the main motion.
- The committee discussed acute care hospital conversion factors. Member Pfeifer recommended developing a narrative explaining why individual conversion factors were developed for each of the 9 acute care hospitals. The chair stated the goal is to have a narrative report developed which will be vetted by the committee. The chair, working with Optum, will draft a summary report with findings and recommendations for review by the committee and submission to the Commissioner and Workers' Compensation Board.
- Returning to the main motion, the motion as amended – which excludes the outpatient conversion factor – was unanimously approved by the committee.

Having voted on conversion factors, the committee next took up proposed fee schedule rules.

- The committee postponed the decision on whether to adopt a rule reducing outpatient maximum allowable reimbursement rates for ambulatory surgical centers by 5%, pending further analysis of the proposed outpatient conversion factor.
- Member Foland moved to recommend a rule providing that implants in outpatient facilities be paid at invoice plus 10%. The motion was seconded by member Griffith. After discussion, the committee unanimously approved the motion.
- The committee discussed a rule dealing with status codes C, E, & P. There may also be procedures that CMS does not pay in an outpatient setting. Optum had recommended adopting a rule providing that these procedures be paid under the professional fee schedule, or at a percentage of billed charge. The committee requested a survey from Optum to see how these codes are being handled by other states.
- Member Pfeifer moved to recommend a rule providing that separate CMS relative values be utilized for physician services provided in facilities and in non-facilities. The motion was seconded by member Smith. After discussion, the committee unanimously approved the motion.
- Member Smith moved to recommend a rule adopting CMS ICD-10 codes effective October 1, 2015. The motion was seconded by member Lindsey. After discussion, member Smith amended his motion, adopting a rule requiring providers to comply with CMS prescribed ICD codes. Member Lindsey agreed to the amended motion. After discussion, the committee unanimously approved the motion.
- The committee discussed adopting billing rules and modifiers. The chair said he will work with Optum to produce "boilerplate" billing and payment rules and modifiers for the committee's consideration at the next meeting.

- The committee discussed adopting a rule to address unlisted procedures, procedures with no CMS relative values, and procedures that are not covered by CMS. The decision point is whether these will be paid “by report” or as a percentage of billed charges. The general consensus from the payer side is that a defined percentage of billed charges is preferable. The chair recommended that whatever method is chosen, it should be consistent with the rule adopted for status codes. As with status codes and modifiers, the committee recommended Optum produce a survey of how this is handled by other states.
- The committee will need to recommend a rule for HCPCS III codes.
- The committee discussed adopting an ambulance fee schedule. Optum stated that CMS does have an ambulance fee schedule, which includes both ground and air miles. The committee would have to decide what multiplier (percentage above CMS) they wish to recommend. Member Pfeifer suggested looking at the numbers presented to the committee by LifeMed and calculate what the multiplier would be to match their fees. The chair noted that the committee also has a regional analysis by NCCI and state Medicaid rates.
- Member Griffith stated that a rule needs to be proposed for inpatient rehabilitation facilities and long term acute care facilities. There are two inpatient rehabilitation facilities and one long term acute care facility in Alaska. These inpatient facilities are exempt from the CMS inpatient prospective payment system. Member Griffith recommended developing a distinct conversion factor for these types of hospitals, similar to the methodology the committee has recommended for acute care hospitals. The committee recommended Optum provide some additional information.
- Member Pfeifer asked what happens when an acute care patient is transferred to an out-of-state hospital. The chair noted that out-of-state treatment is governed by the fee schedules and payment rules in the state where the treatment was provided. Member Griffith noted that CMS payment rules allow two inpatient prospective payment system hospitals to “split” billing.
- Member Foland asked whether the committee wants to recommend a rule for lab testing, similar to what has been done in California and Washington State. The chair referenced public comment at the January 15th meeting. He noted that with the legalization of marijuana in Alaska, there may be an increase in drug testing, and this might be a rule the committee wants to recommend.
- Member Scott asked if the committee is going to adopt a rule for critical access hospitals. The chair noted that these hospitals are exempt under HB316, therefore the committee doesn’t have authority to regulate them.

The committee selected April 20th as their next meeting date.

Meeting Adjourned 3:17 pm

Appendix I – Communication from member Pfeifer on known issues with NCCI edits for chiropractic care.

Below are a few of the common NCCI edit conflicts that could negatively impact chiropractic coverage if implemented.

Issue 1-NCCI Edit involving CMT

- **NCCI Edit Manual January 2015**

S. Chiropractic Manipulative Treatment

Medicare covers chiropractic manipulative treatment (CMT) of five spinal regions. Physical medicine and rehabilitation services described by CPT codes 97112, 97124 and 97140 are not separately reportable when performed in a spinal region undergoing CMT. If these physical medicine and rehabilitation services are performed in a different region than CMT and the provider is eligible to report physical medicine and rehabilitation codes under the Medicare program, the provider may report CMT and the above codes using modifier 59. NCCI edits define when two procedure HCPCS/CPT codes may not be reported together except under special circumstances. If an edit allows use of NCCI-associated modifiers, the two procedure codes may be reported together when the two procedures are performed at different anatomic sites or different patient encounters. Modifier 59 and other NCCI- associated modifiers should NOT be used to bypass an NCCI edit unless the proper criteria for use of the modifier are met. [emphasis added]

- **CPT® & ACA Policy**

CPT Assistant May 2010 page 9

Medicine: Physical Medicine and Rehabilitation, 97110, 98940 (Q&A)

Question: Is it appropriate to report codes 97110-97124, if the procedure were performed at the same region as Chiropractic Manipulative Treatment (CMT)?

Answer: *Yes. The physical medicine and rehabilitation procedure codes, 97110-97124, represent distinctly separate and unrelated procedures, which are not considered inclusive of CMT as described by codes 98940-98943. Therefore, when the procedure is distinct from the manipulation, it would be appropriate to report codes 97110-97124 in addition to CMT, when performed at the same anatomic site (ie, separate body regions are not required). [emphasis added]*

- **ACA's FAQ:**

Q. Can you tell me if it is appropriate to bill CPT codes 97110-97124 when they have been performed in the same region as CMT?

A. *It is absolutely appropriate to perform these services to the same region as CMT when clinically indicated and properly documented. Contrary to some interpretations, the modifier -59 is not required with these services when billed on the same date or same region as CMT. CPT Assistant: March 2006; Vol. 16, Issue 3, Page 15.*

- **ACA's Coding Clarification 97112, Neuromuscular Reeducation**

CPT Code 97112 Neuromuscular reeducation, does not describe chiropractic manipulative treatment and the services are not mutually exclusive. Chiropractic manipulation (CMT) is described by codes 98940, 98941, 98942, and 98943. **From a CPT coding perspective, in certain circumstances it may be appropriate to report CMT procedures and CPT code 97112 on the same date of service.** For example, if separate therapeutic procedures are being addressed by different techniques, then it is appropriate to report these services separately.

http://www.acatoday.org/content_css.cfm?CID=1136

The aforementioned comparison of NCCI and CPT® is a clear representation of how sometimes NCCI edits differ from CPT® and could impact a doctor of chiropractic who provides a service such as 97112 or 97124 in the same area as CMT.

Issue 2: NCCI Edit Physical Medicine and Rehabilitation

- NCCI Edit Manual January 2015

P. Physical Medicine and Rehabilitation

1. With one exception providers should not report more than one physical medicine and rehabilitation therapy service for the same fifteen minute time period. (The only exception involves a “supervised modality” defined by CPT codes 97010-97028 which may be reported for the same fifteen minute time period as other therapy services.) Some CPT codes for physical medicine and rehabilitation services include an amount of time in their code descriptors. Some NCCI edits pair a “timed” CPT code with another “timed” CPT code or a non-timed CPT code. These edits **may be bypassed with modifier 59 if the two procedures of a code pair edit are performed in different timed intervals even if sequential during the same patient encounter.** NCCI does not include all edits pairing two physical medicine and rehabilitation services (excepting “supervised modality” services) even though **they should never be reported for the same fifteen minute time period.** The NCCI edit with column one CPT code 97140 (Manual therapy techniques, one or more regions, each 15 minutes) and column two CPT code 97530 (Therapeutic activities, direct patient contact, each 15 minutes) is often bypassed by utilizing modifier 59. Use of modifier 59 with the column two CPT code 97530 of this NCCI edit is **appropriate only if the two procedures are performed in distinctly different 15 minute intervals. The two codes cannot be reported together if performed during the same 15 minute time interval.** [emphasis added]

CPT® & ACA Policy

- CPT Assistant March 2014 page 15

Frequently Asked Questions: Medicine: Physical Medicine and Rehabilitation

Question: When reporting the Physical Medicine and Rehabilitation time-based codes

(97110-97548), is it appropriate to report these services with modifier 52, Reduced Services, if less than 15 minutes was spent treating the patient, or when the treatment lasts less than eight minutes?

Answer: When codes do not contain specific language in the guidelines, code descriptors, or parenthetical statements other than an increment of time, the guidelines for time in the introduction section of the CPT code set provide the following instructions: "A unit of time is attained when the mid-point is passed. Therefore, in response to the first question and based on the time guidelines provided in the CPT code set, it is not appropriate to append modifier 52, Reduced Services, to codes 97110-97546. Multiple units may be reported on a date of service for one or more procedures based on the aggregate amount of time spent by a qualified health care professional in direct (one-on-one) contact with the patient. [emphasis added]

With the aforementioned NCCI edit, it could be understood that if a doctor of chiropractic were to perform 97140 manual therapy for seven minutes and 97530 for eight minutes in the same visit, the codes could not be reported or combined together in order to meet the aggregated time of 15 minutes, required for one unit. Yet CPT® states codes 97110-97546 could be reported based on aggregated time. This may impact DCs who provide a number of physical medicine services for less than the required time to report a unit during a single encounter and depend on stacking the times in order to meet the timed code requirement.

Other ACA Coding Clarifications involving NCCI edits

- Coding Clarification: Proper Use of Testing and Measurement CPT® codes: 95831, 95832, 95851, and 95852

The American Chiropractic Association fields numerous questions concerning CPT codes 95831 and 95832, Muscle testing, manual, and CPT codes 95851 and 95852, range of motion measurements, and report. Questions relate to when it's appropriate to bill these codes in conjunction with other CPT codes such as E/M codes or Chiropractic Manipulative Treatment (CMT) codes. **Recent software edits in place for the Medicare Correct Coding Initiative (CCI) state that the above testing and measurement codes are "Mutually exclusive" with CMT codes.** http://www.acatoday.org/content_css.cfm?CID=1099

CPT Assistant August 2013 page 7: *MMT and ROM testing procedures are considered separate test and measurement procedures, and are separately reported when each is performed. The need for each individual service must be documented in a separate, distinctly-identifiable, written and signed report. In addition, MMT and ROM testing services **may be reported in addition to evaluation and management (E/M) services if the E/M services performed are significant and separately identifiable from the MMT and ROM testing services.** [emphasis added]*

Finally, If the Workers' Comp plan were to adopt or align themselves with all Medicare guidelines, this may impact coverage for any services outside of CMT and should be clarified up front.

97112 – Neuromuscular Reducation /15min

97124 – Massage / 15min

97140 - Manual Therapy /15min mobilization, manip, myofacial release -59 different area from CMT

97110-97124 physical medicine and rehab codes

97530 –Therapeutic activities / 15min functional activities to address functional needs. bending,lifting etc

95831, 95832 – muscle testing w/ report

95851, 95852 – range of motion w/ report