

DWC 23rd Annual Educational Conference: Fee Schedule Updates

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Medical Treatment Schedules

- Access on the DWC website
<http://www.dir.ca.gov/dwc/OMFS9904.htm#7>
- Labor Code §5307.1(g)(2) requires updates through Administrative Director posting order
- Updates announced by Newslines - subscribe



Physician and Non-Physician Practitioner Fee Schedule

- RBRVS-based fee schedule implemented 2014
- 2016 - 3rd year of 4-year transition from old to new
- 2016 Update adopts relevant Medicare changes
 - Title 8, Cal. Code Regs. §9789.19 - annual updates
 - Medicare Economic Index = 1.1% increase
- Conversion Factors

	2015	2016
Anesthesia	\$31.5290	\$29.3852
Surgery	\$51.6570	\$48.2013
Radiology	\$50.1900	\$47.4598
Other Services	\$40.2970	\$42.4599

Inpatient Hospital Fee Schedule

- Labor Code §5307.1 requires IHFS no more than 120% of Medicare, adjusted by inflation factors
 - Applies to acute care hospitals
 - Other inpatient facilities exempt (LTC, Critical Access Hospitals, Cancer Hospitals, Rehabilitation hospitals, out of state hospitals)
- 2016 IHFS annual update effective for discharges on or after March 1, 2016
 - Hospital-specific composite factors & outlier factors updated
 - Market basket increase (operating 2.4% / capital 1.3%)
 - MS-DRG relative weights updated
 - Cost-to-charge ratio updated (used for outlier eligibility and payment; and transfer case payment rate)

Hospital Outpatient Departments Fee Schedule

- Maximum allowable facility fees for surgical and ED services rendered to hospital outpatients are set at 120% of Medicare's outpatient prospective payment system (OPPS).
- Facility fees for services to outpatients that are not an integral part of surgical or ED ("Other Services") is based on whether the service is payable under Medicare's OPPS, and if so, the maximum allowable fee would be set according to the OMFS RBRVS Physician Fee Schedule relative values.
- Using two Medicare payment systems to determine maximum allowable payments for Other Services has resulted in conflicts and inconsistencies.
- To address this issue, a rulemaking has been initiated to amend the payment methodology for determining maximum allowable facility fees for Other Services. Information related to the rulemaking may be accessed at: http://www.dir.ca.gov/dwc/rulemaking/dwc_rulemaking_proposed.html

Ambulatory Surgical Centers

- Fees not to exceed 80% of the Medicare fee for the procedure under the Hospital Outpatient Department Fee Schedule (HOPD)
- Ambulatory Surgery Centers may be reimbursed for surgery services and services that are "an integral part of a surgical service" (title 8, CCR § 9789.32 subdivision (d))
- ASC fees will be updated with the HOPD 2016 update

Pathology and Clinical Laboratory Fee Schedule

- L.C. §5307.1 no more than 120% of Medicare
- 2016 Update effective for services 1/1/2016
- Substantial changes to drug testing: new codes
 - Presumptive (“screening”) drug testing (any number of drug classes, per date of service)
 - G0477 presumptive, direct optical observation
 - G0478 presumptive, instrument-assisted direct optical observation
 - G00479 presumptive, instrumented chemistry analyzers
 - Definitive (“confirmation”) drug testing (1 code per day)
 - G0480 per day 1-7 drug classes
 - G0481 per day 8-14 drug classes
 - G0482 per day 15-21 drug classes
 - G0483 per day 22 or more drug classes
 - Not using the AMA CPT drug testing codes (Presumptive 80300 – 80304; Definitive 80320 – 80377); Deleted HCPCS codes G0431, G0434, G6030 through G6058

DMEPOS

Durable Medical Equipment, Prosthetics, Orthotics, Supplies

- Labor Code §5307.1 requires DMEPOS no more than 120% of Medicare
- 2016 Medicare DMEPOS update
 - Routine update of HCPCS codes
 - New for 2016 – Rates from “Competitive Bidding Program” are adopted for selected codes
 - New for 2016 – For codes priced at competitive bidding program rate, rural zip codes have higher rates

Ambulance Fee Schedule

- The maximum reasonable fee for ambulance services shall not exceed 120% of the applicable California fees set forth in Medicare's ambulance fee schedule (Public Use file), which is accessible at:
<http://www.dir.ca.gov/dwc/OMFS9904.htm#1>
- 2016 annual update effective for services on or after 1/15/2016
- The inflation factor for 2016 is negative 0.40% (-0.40%)

Interpreter Regulations Current Thinking

- Preparing for Rulemaking
- *NEW FIXED FEE STRUCTURE*
- Based upon Federal Court Rates.
- Parties can still negotiate different fee.
- No distinction in fees based upon language.
- Billing Codes and Detailed Invoices.
- Double Billing Reduced.
- Use of IBR to resolve disputes, reduction of lien litigation.

Interpreter Regulations Current Thinking

- *EMPHASIS ON CERTIFIED INTERPRETERS*
- Higher rates are paid for certified interpreters over provisionally certified.
- Expansion of the languages requiring certified interpreters.
- Stringent restrictions on use of provisionally certified interpreters when a certified interpreter “cannot be present”.

Copy Service Regulations

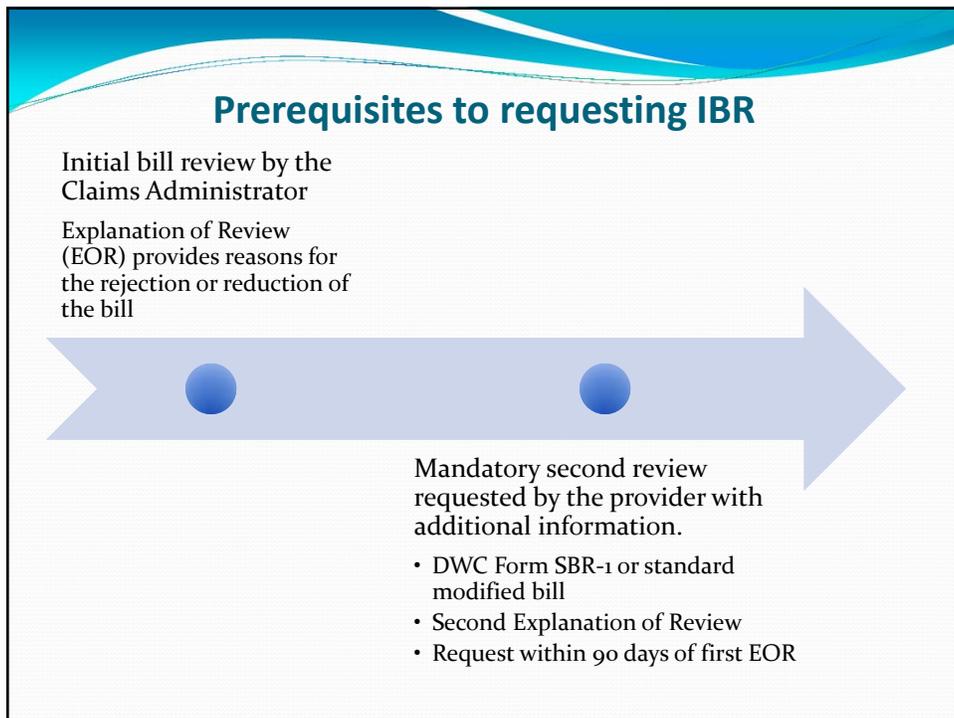
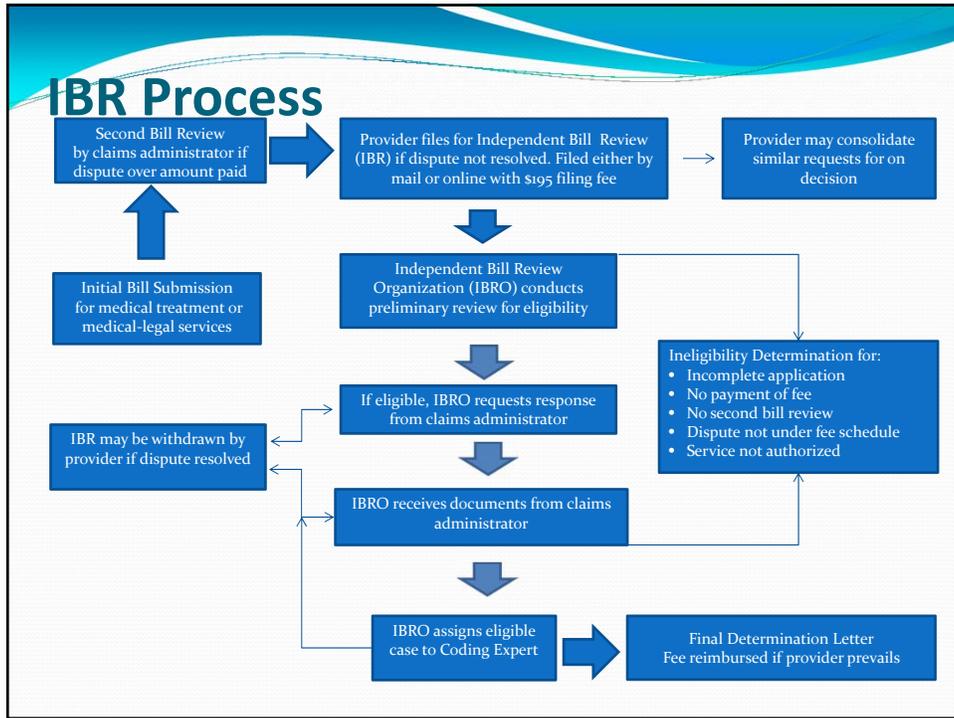
- The copy service fee schedule became effective July 1, 2015.
- Copy service fee schedule is a flat \$180 fee for a set of records from a single custodian.
- Bills for copy services must include provider tax ID numbers, professional photocopier numbers, and claim numbers and may include newly-created billing codes.
- Fees for Transcripts have changed.
- Disputes now handled through IBR.

Home Health Care Regulations

- Rulemaking in Progress – Public Comment Period
- Home health care services provided as medical treatment if reasonably required to cure or relieve the injured worker from the effects of his or her injury, if such treatment is prescribed by a licensed physician or surgeon, in accordance with Labor Code section 4600, subdivision (h) and the Medical Treatment Utilization Schedule.
- Home health care services are subject to the utilization review and independent medical review processes.
- In-home assessment of the injured worker's need for home health care.
- Provisions for evaluations of needs for rehabilitation services in the areas of speech language pathology, physician therapy or occupational therapy.

Home Health Care Regulations

- Pre-existing home health care prior to work injury not covered.
- Fixed fee schedules and billing codes.
- Fee schedule exclusion of some caregivers.
- Parties can negotiate rates different from fee schedule.
- Fee disputes over amount of fee subject to IBR.



Explanation of Review

Under Labor Code section 4603.3, an EOR must include:

- A statement of the items or procedures billed and the amounts requested by the provider to be paid.
- The amount paid.
- The basis for any adjustment, change, or denial of the item or procedure billed.
- The additional information required to make a decision for an incomplete itemization.

Explanation of Review

- If a denial of payment is for some reason other than a fee dispute, the reason for the denial.
- Information on whom to contact on behalf of the employer if a dispute arises over the payment of the billing. The explanation of review shall inform the medical provider of the time limit to raise any objection regarding the items or procedures paid or disputed and how to obtain an independent review of the medical bill pursuant to Section 4603.6.


State of California
Division of Workers' Compensation
Provider's Request for Second Bill Review
California Code of Regulations, Title 8, section 1002.36

The Medical Provider signing below seeks reconsideration of the denial and/or adjustment of the billed charges for the medical services or goods, or medical legal services, provided to the injured employee.

Employee Information						
Employee Name (Last, First, Middle): _____						
Date of Birth (MM/DD/YYYY): _____			Claim Number: _____			
Date of Injury (MM/DD/YYYY): _____			Employer Name: _____			
Provider Information						
Provider Name: _____			Contact Name: _____			
Address: _____						
Phone: _____			Fax Number: _____			
Email Address: _____			NPI Number: _____			
Claims Administrator Information						
Claims Administrator Name: _____			Contact Name: _____			
Address: _____						
Phone: _____			Fax Number: _____			
Bill Information						
Provider's or Claims Administrator's Bill Identification Number (if any): _____						
Date Explanation of Review Received by Provider: _____						
List of disputed services or goods (attach additional pages if necessary):						
Date of Service	Service/Good in Dispute (include modifier, if any)	Service/Good Authorized?	Amount Billed	Amount Paid	Amount in Dispute	Supporting Documentation Attached?
		<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Service	Service/Good in Dispute (include modifier, if any)	Service/Good Authorized?	Amount Billed	Amount Paid	Amount in Dispute	Supporting Documentation Attached?
		<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No
Provider Signature: _____			Date: _____			

IBR: Who and What?

- Providers File for IBR
 - Includes hospitals and billing agents
 - Must use the AD form (DWC Form IBR-1)
 - Can be completed online or mailed
 - Provider must pay a fee (\$195)
 - Reimbursed by claims administrator if provider prevails
 - May request consolidation of separate requests
- There must be a fee schedule for service billed

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State of California
 Division of Workers' Compensation
Request for Independent Bill Review
California Code of Regulations, Title 8, Section 9792.1.8

Employee Information	
Employee Name (Last, First, Middle):	Claim Number:
Date of Injury (MM/DD/YYYY):	Employer Name:
Date of Bill (MM/DD/YYYY):	Contract Name:
Provider Information	
Provider Name:	Contract Name:
Address:	Phone Number:
Phone:	NPI Number:
E-mail Address:	
Provider Type:	
<input type="checkbox"/> Ambulance <input type="checkbox"/> Clinical Laboratory <input type="checkbox"/> DMEPOS Supplier <input type="checkbox"/> Impaired Hospital <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Interceptor <input type="checkbox"/> Ambulatory Surgical Center <input type="checkbox"/> Pharmacy <input type="checkbox"/> Qualified Medical Evaluator <input type="checkbox"/> Agreed Medical Evaluator <input type="checkbox"/> Treating Physician <input type="checkbox"/> Other Practitioner – specify: _____	
Provider Specialty:	
Claims Administrator Information	
Claims Administrator Name:	Contract Name:
Address:	Phone Number:
Phone:	
E-mail Address:	
Bill Information	
Applicable Fee Schedule(s):	
<input type="checkbox"/> Physician Services <input type="checkbox"/> Impaired Hospital Services <input type="checkbox"/> Hospital Outpatient Departments and Ambulatory Surgical Centers <input type="checkbox"/> Pharmacy <input type="checkbox"/> Pathology and Laboratory Services <input type="checkbox"/> DMEPOS <input type="checkbox"/> Ambulance Services <input type="checkbox"/> Medical Legal Fee Schedule <input type="checkbox"/> Interceptor <input type="checkbox"/> Other – specify: _____ <input type="checkbox"/> Contract for Rehabilitation/Return to Work	
Date of Second Bill Review Decision (MM/DD/YYYY):	Was Bill Subject to Audit? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Service (MM/DD/YYYY):	
Service/Control Code in Dispute (include modifier, if any):	
Amount in Dispute:	Amount in Dispute:
Reason for Disputing Provision or Denial of Full Payment:	
Consolidation	
Should this Request be Consolidated with Other Unpaid Bill(s) or Control? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Reasons for Consolidation:	
Disputed Service/Control to be Consolidated (if all, use either/and if necessary):	
Date of Service (MM/DD/YYYY):	
Service/Control Code in Dispute (include modifier, if any):	
Amount in Dispute:	Amount in Dispute:
Reason for Disputing Provision or Denial of Full Payment:	
Documents to Accompany Request (Must be Indexed and Separated)	
The original billing itemization and original supporting documentation.	
The explanation of review provided in response to the original billing.	
The request for second bill review and original documentation supporting second review.	
The explanation of review provided in response to the second bill review request.	
If applicable, the relevant contract provisions for reimbursement rates.	
Provider Signature:	Date:
If mailed, send to: DWC-IBR c/o Mission Federal Services, Inc., 625 Coolidge Drive, Suite 100, Folsom, CA 95630. Concurrently send a copy of this request to the Claims Administrator.	

IBR Procedure

- Provider must submit with IBR request:
 - DWC Form IBR-1 and filing fee.
 - Original billing itemization, supporting documents, and EOR;
 - Second review request, supporting documents, and EOR;
 - Relevant provisions of Labor Code section 5307.11 contract, if applicable;
 - Documents must be indexed and arranged.
- Consolidation and Disaggregation of IMR requests (section 9792.5.12).

IBR – Eligibility

- Eligible? Consider timeliness, completion of second review, authorization of treatment, payment of fee, dispute under existing fee schedule.
- If request ineligible, provider reimbursed portion of fees. Claims administrator given opportunity to contest eligibility and IBR request.
 - 15 days to respond.

IBR – Procedure

- Provider may withdraw IBR request at any time prior to determination.
 - \$147.50 is reimbursed if withdrawal is prior to assignment of the request to IBRO.
- IBR reviewer may request additional documents.
 - Must be received 35 days after request.

IBR – Consolidation

- Up to 20 individual requests may be consolidated.
- Grounds for consolidation:
 - Multiple dates of services, one employee, one claims administrator, one billing code, one fee schedule, \$4,000 limit;
 - Multiple billing codes, one employee, one claims administrator, one date of service;
 - Pattern and practice of underpayment: multiple employees, one claims administrator, one billing code, one or multiple dates of service, (aggregate amounts up to \$4,000 or individual amounts less than \$50 each).
- IBRO may disaggregate an IBR request.

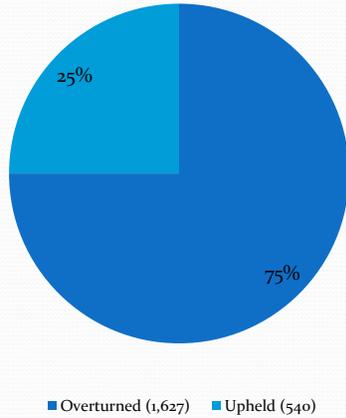
Independent Bill Review

- IBR Reviewer will apply OMFS, Medical-Legal fee schedule, or contract rates to determine if additional amounts owed.
- Will apply as necessary all billing, payment, and coding rules.
- Decision within 60 days of assignment.
- Limited appeal to WCAB.

Independent Bill Review (IBR) 2015

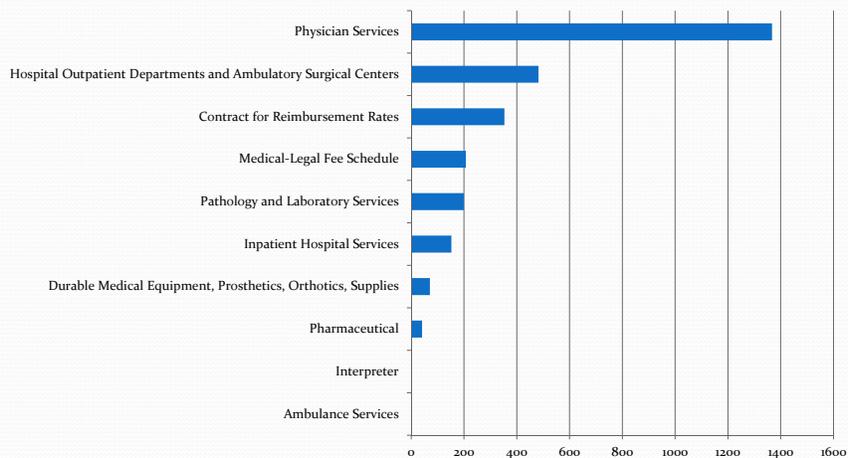
2,310 applications filed

2,167 decisions issued



- 15% increase in filings from 2014 (N=1,964)
- 3 of every 4 IBR determinations results in at least a partial overturn of disputed billing denial.
- In December 2015, the average number of days to complete IBR determinations = **4.8**

IBR Service Categories 2015



IBR v. Liens

- IBR - Labor Code §4603.6
 - For medical provider services clearly described in a fee schedule adopted by the DWC
 - Physician fee schedule
 - Medical-legal fee schedule
 - Official Medical Fee Schedule (OMFS).
 - Copy Service Fee Schedule L.C. §5307.9
 - Statute of Limitations to file IBR application. L.C. §4603.6(a)
 - If only dispute is amount of payment, 30 days of service of second bill review.
 - If liability is contested for any issue other than reasonable payment of bill, 30 days from date of resolution of contested liability issue or WCAB order finding in favor of compensation.

IBR v. Liens

- Liens – Labor Code §4903.5
 - For medical provider services either (a) not described in a fee schedule or (b) uncertainty that the service is included in a described fee schedule service.
 - Home health care (Fee schedule rulemaking pending)
 - Transportation
 - Interpreting services (Fee schedule being drafted)
 - Newer medical procedures.
 - Statute of Limitations to file a lien with the WCAB. L.C. 4903.5
 - 18 months from date of service.

Dual Track Issues of IBR & Liens

When to file IBR, Lien, or both?

- IBR
- SOL- 30 days date of 2nd bill request except if liability has not been decided, in which case, 30 days from date of liability decision or WCAB order finding in favor of compensation.
- Is the medical treatment clearly covered by a fee schedule? If so, file only IBR.
- Liens
- SOL- 18 months from last date of service.
- If the medical treatment is not covered by a fee schedule, file a lien.
- File both IBR and Lien
- If liability has not be determined and it is unclear whether a fee schedule definition includes the medical service provided, the medical treatment provider should file both a lien within 18 months of the service and an IBR request to protect the lien statute of limitations.