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 Newsline - 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

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
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<tr>
<td>Anesthesia</td>
<td>$31.5290</td>
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<td>Surgery</td>
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<td>Radiology</td>
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<td>Other Services</td>
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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](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.
**IBR Process**

- **Initial Bill Submission for medical treatment or medical-legal services**
- **Second Bill Review by claims administrator if dispute not resolved**
- **Provider files for Independent Bill Review (IBR) if dispute not resolved. Filed either by mail or online with $195 filing fee**
- **Provider may consolidate similar requests for one decision**

**Independent Bill Review Organization (IBRO)** conducts preliminary review for eligibility:

- **Ineligibility Determination for:**
  - Incomplete application
  - No payment of fee
  - No second bill review
  - Dispute not under fee schedule
  - Service not authorized

- **If eligible, IBRO requests response from claims administrator**
- **IBRO receives documents from claims administrator**
- **IBRO assigns eligible case to Coding Expert**
- **Final Determination Letter**
  - Fee reimbursed if provider prevails

**Prerequisites to requesting IBR**

- **Initial bill review by the Claims Administrator**
- **Explanation of Review (EOR) provides reasons for the rejection or reduction of the bill**

**Mandatory second review requested by the provider with additional information.**

- DWC Form SBR-1 or standard modified bill
- Second Explanation of Review
- Request within 90 days of first EOR
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.

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.
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
**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 9792.512).
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

- Physician Services
- Hospital Outpatient Departments and Ambulatory Surgical Centers
- Contract for Reimbursement Rates
- Medical-Legal Fee Schedule
- Pathology and Laboratory Services
- Inpatient Hospital Services
- Durable Medical Equipment, Prosthetics, Orthotics, Supplies
- Pharmaceutical
- Interpreter
- Ambulance Services

Overtorn (1,627)  Upheld (540)
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.