

Appendix 1:

Detailed State Interviews Concerning Their Use of Relative Value Scales for Workers Compensation

Colorado

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Fee schedule approach

Colorado adopted the Relative Values for Physicians (RVP), published by St. Anthony, in 1995. Currently the state is using the July 1997 version and is in the process of an update.

State goals

The fee schedule was adopted to:

- create a uniform and complete medical billing code system for all providers working in the system;
- facilitate automation of billing and payment of medical bills;
- establish a clearly written and less interpretative billing code system to try and minimize coding disputes; and
- establish an easy-to-update billing system, which allows reasonable methods to evaluate and control medical costs in workers compensation.

The Colorado workers compensation fee schedule and conversion factors were legislatively frozen during the period prior to the adoption of the RVP. Overall health care rates were high in 1989/90 when the freeze was placed on the fee schedule. However, during the freeze period health care costs leveled, minimizing the impact of implementing the RVP. According to the Workers Compensation Research Institute's (WCRI) comparison of state fee schedules, Colorado's fees are in the middle range. The ultimate goal is to keep providers happy while minimizing premium cost increases to employers.

Reason for selecting payment method

Colorado adopted the RVP for the following reasons:

- The RBRVS did not have complete medical billing CPT codes in one book. There were no pathology codes.
- The RBRVS fee schedule from the Federal Register was more difficult to read and understand than the RVP.
- The RBRVS RVUs were manipulated by HCFA from the original created RVUs. This caused concern regarding validity of the RVUs
- Adopting the RBRVS would require maintaining all code and policy decision made by Medicare to keep the fee schedule current and complete. Medicare is a single payer system and makes their decisions based upon their budgetary and operational needs. Medicare can limit payable benefits. In Colorado, the regulatory agency cannot say a service is not a benefit if it is determined to be "reasonable and necessary" care to cure and relieve the effects of the injury. This may be in disagreement with some of Medicare's policy decisions about what is paid for, such as certain alternative medicine types of care, e.g., rolfing or acupuncture.

- The RBRVS was developed for Medicare’s older chronic disease patient population. Worker’s compensation patients are young adults with mostly acute injuries. RVP is designed more for the general population.
- The RBRVS had a negative stigma among physicians. There was concern about maintaining access to specialty providers.

Conversion factors and adjustments

<u>RVP and Colorado Defined Sections</u>	<u>CFs</u>	<u>CPT Code Ranges</u>
Evaluation & Management	\$6.51	99201-99499
Medicine	\$6.51	90770-96999 and 98925-99199
Physical Medicine and Rehabilitation	\$3.20	97000-97999
Anesthesia	\$33.45	00100-01999
Surgery	\$77.36	10000-69999
Radiology	\$16.12	70000-79999
Pathology	\$12.34	80000-89999

All Conversion factors are determined based on an evaluation of the overall workers compensation system cost impact on the medical dollar component and premium dollars to employers, a low and high fee benchmark, and community task force recommendations and comments. First, paid workers compensation medical bill data are collected and the frequency of billing codes are determined. The collected code frequencies are applied to the current codes and values to develop the probable cost impact of the last fee schedule change. Then, the code frequencies are mapped to the new updated codes and values to determine the projected “budget neutral” conversion factors.

The “budget neutral” conversion factors are determined by dividing the total new fee schedule RVUs for each section by the total dollars allowed for that section under the old fee schedule. After the budget neutral conversion factors are completed, then two benchmark evaluations are completed. A Medicare benchmark is done using the RBRVS dollar values multiplied by the mapped code frequencies to determine an overall dollar value of the medical fee schedule section, then the difference between Medicare and the budget neutral dollars values are compared. The second benchmark uses the same process to compare Usual, Customary, and Reasonable (UCR) dollar values at the 70th percentile. The billed dollar amounts are determined by a large data base of paid medical bills from various sources of general health, managed care, indemnity, etc.

Before the community is brought in for comment, an evaluation of all the gathered information is completed. Not only are cost evaluations and benchmarks evaluated, but other economic and access to care indicators need to be evaluated. The Colorado Consumer Price Index (CPI) and letters or phone calls from the public are considered when making a final draft determination of the fees and/or rules. In addition, physician participation is needed to ensure injured workers can access care and quality of care is promoted. Emphasizing higher fees for E&M services may be one way to encourage physicians to spend more time with injured workers for accurate diagnosis, and to plan and coordinate treatment. Emphasizing care management and coordination should lessen the possibility of provider misdiagnosis and unnecessary duplication of care, which results in cost control.

Once the proposed conversion factors are created and all rule adjustments are done, task forces are convened. Task forces are asked for their comments, recommendations, and alternatives to the proposed draft fee schedule rules. However, it is important to convey to the task force members their task parameters and limitations, including any cost considerations, unless they provide evidence to the contrary.

After a survey analysis of provider fees was completed in 1993/94, no significant overall geographical difference warranted a maximum fee differentiation by region.

Updates

Conversion factors are updated annually; last one completed in March 1998.

Unique services

Most professional services are covered in the RVP; therefore, creating a complete fee schedule. However, Colorado insurers can determine a fee when the fee schedule does not identify a maximum fee. Colorado's rules require insurers to establish fees that "reflect the complexity, time and level of training and expertise required to perform the service or procedure. The methodology for the determination of payment used by the insurer shall be made available to the provider upon request." The only alternative medicine service with an established fee in Colorado is acupuncture. All other alternative medicine services require prior authorization from the insurer; therefore, providing an opportunity to either negotiate a fee or establish the fee based upon criteria in the rule. Establishing a fee for alternative medicine services is difficult because there are no standard billing code system, such as CPT for physician's services, and the services vary greatly. Hospital fee schedules are difficult to create and implement due to the non-standardization of coding, (except for Medicare's single payer system) difficult to assess cost, and a higher political vocalization.

Implementation strategy

In Colorado, the transition period was anticipated to be approximately three to four months. The transition time period ranged from the adoption of the new fee schedule (based upon the date of service) to the actual possibility insurers may receive and process bills under the new fee schedule. In reality, it took longer for insurers to transition to the new fee schedule. It appeared the insurers were not keeping abreast of the rule changes, and once aware, it took them additional time to automate the new fee schedule. Colorado is in the process of assessing and considering using their web site to provide an ongoing tool for the public to access information, announcements and education.

Especially in the last few years, it has become more difficult for workers' compensation to keep up with AMA's CPT code updates every year. The time necessary to do the data collection, analysis, rule writing, task force commentary, and regulatory rule-making (approximately six months to one year) means the finalized update will overlap the next AMA CPT update, resulting in the completed update being already outdated.

Were the state's goals achieved?

RVP is achieving all its goals except for the ease of implementation and accessibility. RVP is simpler than the Medicare system to use, but more work needs to be done on implementation to make it more accessible.

Political issues, technical problems, and lessons learned

Overall, providers responded to the RVP with ambivalence, although providers did want the fee schedule for free. St Anthony's press does not provide subsets of the RVP for providers who only need specific sections.

One implementation problem was created by the separation of the codes and values from the rule. It was imperative that the public have both the rule and the RVP to ensure accurate application of the fee schedule regulations. Therefore, creating the fee schedule as one book, inclusive of all the rules, codes, and values would make it easier to implement. The highly restrictive regulations and rule adoption process in Colorado make the process of updating fees quite difficult. A community stakeholder task force consisting of providers, injured workers', insurance and hospital representatives, designed to obtain public and political "buy-in" for the proposed rule and fee schedule changes, may create greater consensus and prevent opposition during the rule making process. It is important each member know they represent their constituents and the desired fiscal impact the agency is trying to achieve before attending a task force meeting. In this way, the expectations are set up ahead of time, and the process may become less political. Future challenges may include dealing with new financial arrangements, such as episode of care and case rates, and, to a very limited extent with any capitation arrangements.

Florida

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Fee schedule approach

Florida's fee schedule is based on RBRVS, with the exception of anesthesia, for which the state developed its own fee schedule, and pathology, which uses the McGraw-Hill RVUs. Implementation was September 1997.

State goals

The major goal was to implement a fee schedule that contains costs and provides timely access to services for injured workers. The state wanted a system that was tied more closely to national standards for easier physician administration. In addition, the state explicitly wanted to reallocate resources between surgical and non-surgical services so that better care up-front would avoid complications.

Reason for selecting payment method

RBRVS was chosen as a fair method that would better reflect costs.

Conversion factors and adjustments

Medicine	\$33.00
Physical Medicine	\$33.00
Radiology	\$33.00
Surgery	\$44.00
Anesthesia	\$26.60 (based on state fee schedule)
Pathology	\$10.03 (based on McGraw-Hill RVUs)

The conversion factor was determined by taking paid claims data for 1996 and determining what factor would yield budget neutral payments for 1997. There is no geographic adjustment. The respondent believes Florida has the lowest workers' compensation payment rates in the country.

Updates

There has been no update since the initial implementation. By statute, a three-member panel that includes the Insurance Commissioner and governor appointees from labor and business must approve all revisions. Staff would like to implement annual RVU and CPT updates based on Medicare. For the conversion factors, the statute provides that any increase can be no greater than the national growth in the CPI. However, no updates have been implemented because the panel has not called a meeting.

Unique services

Florida has 30 unique codes for services such as independent medical exams. They also have 6 codes that vary from Medicare.

Implementation strategy

Implementation of the RBRVS fee schedule included a small overall increase, approximately 2 percent. The phase-in period was supposed to be four years, with no change greater than 20 percent in any year for any particular service; if the change was less than 20 percent, the conversion factor was applied to the Medicare RVU. However, the phase-in was not implemented because the panel has not met. The respondent would like to adopt this decision rule without having a panel meeting.

Were the state's goals achieved?

Yes, there is more fairness. And it will be a better system if the intended process is allowed to proceed.

Political issues, technical problems, and lessons learned

The state Insurance Commissioner is an elected official who is also State Treasurer. He has resisted efforts to increase workers' compensation payment rates. One member of the three-member panel died and has not been replaced.

Radiologists and surgeons are the most vocal because they have been the most affected by the new fee schedule. The primary care physicians are allies of the Bureau because they want to move the payment levels up toward Medicare rates. The Bureau established the fee for an independent medical exam at \$400. The Florida Medical Association did not look at it when proposed and is now upset that it is not high enough.

Obtaining data in a timely manner and data cleaning are always problems. Three-quarters of claims submission are electronic but they need to determine how to get the manual data into their database. Timely medical input on coding issues is also an issue. The respondent strongly recommends making the statute self-administering to the greatest extent possible, rather than getting involved in a politicized rule-making process.

Other

In 1994, Florida passed mandatory workers' compensation managed care for all employers. Currently, virtually all employers are using managed care. Insurance companies are not required to follow the fee schedule; most of them use it as a benchmark and negotiate discounts from it. There is almost no capitation in workers' compensation managed care. With the advent of managed care, insurance companies also gained more control over utilization of services; formerly, judges for compensation claims had more authority.

Hawaii

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Fee schedule approach

The state of Hawaii began using the Medicare RBRVS in June 1995 as a direct result of legislation aimed at reducing the costs of workers compensation. The fee schedule previously used by Hawaii was reimbursing providers at rates double the Medicare rates. Due to limitations in resources, Hawaii uses the Medicare fee schedule as is without any modifications, except when there is a need for revising codes that prove to be problematic or inappropriate for workers' compensation. The RVUs are directly adopted and revised annually when Medicare revisions are released.

State goals

The primary goal was to reduce costs, which were too high. At the time of adoption there was a decreasing trend in total workers' compensation payments.

Conversion factors and adjustments

The conversion factors and geographic adjustments are directly adopted from Medicare. The conversion factor is 10 percent above Medicare. The conversion factors for anesthesia and clinical lab services are also directly from Medicare.

Updates

The conversion factor and the geographic adjustments are revised annually when Medicare revisions are released

Unique services

The professional services covered in addition to Medicare are passive and active physiotherapy by chiropractors, naturopathic medicine, and acupuncture. If services provided by these providers are similar to those coded in CPTs, Medicare's fee are used. For naturopathic medications, they pay wholesale cost plus 40 percent. It is not known what percentage of workers' compensation these services represent. A few years back, a study showed the volume of chiropractic care was second to psychiatric care.

Implementation strategy

The transition was a direct crossover to the new system with the fees set at 10 percent above the Medicare fee schedule.

Were the state's goals achieved?

No direct response (although partially answered below).

Political issues, technical problems, and lessons learned

Since the adoption, there have been physician complaints about the new low reimbursement rates. The insurers have been supporting physicians in this case. The implementation and updates have been cumbersome and complicated, requiring a full understanding of how RBRVS

works and how to keep up with the numerable changes and modifications made by Medicare at any time. However, this system has shifted the burden of doing this complicated task off the state.

The Medicare RBRVS has reduced the rates of reimbursement as expected. It has also added some complications due to complexity of the system, though at the same time reduced the burden of creating a fee schedule. The change to this system was implemented by the state legislature without sufficient direction. More direction would have improved the implementation process.

Michigan

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Fee schedule approach

Michigan's system is based on RBRVS, and was implemented in 1996.

State goals

Cost containment.

Reason for selecting payment method other than RBRVS

Not applicable.

Conversion factors and adjustments

Medicine	\$42.94
Surgery	\$54.09
Radiology	\$50.51
Anesthesiology	\$45.00 (per ASA unit)

The state established its own fee schedule for pathology services. The respondent does not know how the initial conversion factors were developed, but expects that they were probably negotiated with the state medical society. The practice expense component of the RVUs is weighted based on 60 percent Detroit and 40 percent rest-of-state, as published in the Federal Register. They use statewide rates based on this weighted average.

Updates

No updates have been performed because of the lengthy public hearing process required. It is the Bureau's intention to follow Medicare annual updates for changing RVUs and adding new CPT codes. It is also their intention to use the national CPI increase as an annual inflation factor. However, this too is still being negotiated. They also intended to move to a single conversion factor over three years. They are hoping for advisory board approval of proposed updates in September 1999, with public hearings to start in December.

Unique services

The respondent could not identify any unique codes. Upon probing, she agreed that they covered more chiropractic services than were included in the 1996 MFS. Any services not included in the fee schedule are reimbursed at 85 percent of usual and customary charges or the actual billed charge, whichever is less.

The biggest problem is not unique workers' compensation services but the fact that the fee schedule has not been updated in 3 years, and Medicare has added many new codes.

Implementation strategy

There was no phase-in. The respondent does not know whether initial implementation took place on a budget neutral basis, although they are currently discussing budget neutrality in the context of moving to a single conversion factor.

Were the state's goals achieved?

The impact of the physician fee schedule cannot be isolated. Overall expenses have gone down, but the state has also seen quicker return to work and improved employer safety.

Political issues, technical problems, and lessons learned

Physicians have viewed workers' compensation payment as the last bastion to be defended, after facing decreases from Medicare, Medicaid, and managed care. They will never be satisfied with the RVUs, the conversion factor, or moving to a single factor. The state has added payment for return to work reporting required by carriers and for non-standard reports required by the employer or employee. They are also considering reimbursement for rehabilitation nurses who attend office visits with clients. On the negative side, they are changing follow-up days from 14 to 90 to follow Medicare. The most significant opposition has come from hand surgeons, who have threatened to leave the state (but have not).

The respondent strongly recommends against multiple conversion factors because moving to a single factor at a later point is perceived as taking something away. She recommends that clear, fair, consistent policies be maintained from the beginning, avoiding under-the-table agreements. She favors statutory authority to do annual updates without public hearings.

Minnesota

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Fee schedule approach

Minnesota adopted Medicare's RBRVS system of payment in 1993. However, this system is modified in a way specific to the state. The state manipulates the RVUs to create differences in compensation amounts rather than use different conversion factors. At the time of the implementation of this fee schedule, the legislature mandated a 15 percent overall reduction in the workers' compensation fees from the old fee schedule expenditures. This overall reduction was achieved by manipulating the RVUs rather than the conversion factor as is customary elsewhere. The update of RVUs is tagged into HCFA updates, but it has been completed only twice in 1995 and 1996. The new update is now in progress.

State goals

The reasons for adoption of a fee schedule were the wildly escalating costs of medical care, particularly workers' compensation medical care. An in-depth study conducted in 1990-91 suggested implementation of a fee schedule to control the inflationary manner of reimbursement. A second goal was to include over one half of services that were unregulated, because no service codes were assigned to them.

Reason for selecting payment method

Not answered directly.

Conversion factors and adjustments

There is only one conversion factor in Minnesota, originally set at \$52.06 in 1993. In October 1999, the conversion factor will be increased to \$62.27. Originally the conversion factor was created based on a database of expenditures from previous years and the distribution of services (claim experience) of the State Fund (which has over 70 percent of claims in the state).

The conversion factor was created in the following manner. First, overall expenditures were reduced by 15 percent. Next, using the existing mix of services, the total RVUs were calculated. The conversion factor was then determined by the ratio of total reduced expenditures to total RVUs. The geographic adjustment for cost differences is taken directly from HCFA for Minnesota.

Updates

The conversion factor is increased annually by the percentage increase in the state's average weekly wage. Even though there is only one conversion factor, four specialty/service categories are identified (medicine/surgery, pathology/laboratory, physical medicine, and chiropractic) as

the basis of fee differences that are reflected in RVUs. The update of the conversion factor is done through expedited procedure, so no public hearings are conducted; only approval by a judge is needed. The update of the geographic adjustment is tied to that of the RVUs.

Unique services

Additional professional services for pathology/lab and chiropractic are also reimbursed by adding new codes for those services.

Implementation strategy

The transition strategy was a direct crossover to the new system.

Were the state's goals achieved?

The fee schedule is absolutely achieving its goals. Currently, premium rates in Minnesota are 75 percent of 1984 levels.

Political issues, technical problems, and lessons learned

The biggest technical problems in implementation and updating have to do with the lag in the time the CPT codes are available and the time it takes to develop the appropriate fee schedule. A second technical problem is how to allow coding updates with rules. The political problems at the time were mostly because of provider's discomfort with a Medicare fee schedule. They argued that there is no empirical evidence that this method of payment works or its benefits are not supported by the literature. The physicians resisted and opposed implementation till the legislature mandate required it. At that point, the state was able to receive cooperation from doctors in various specialties and reach consensus. A second source of opposition came from organized labor, which argued against capitation of workers compensation under managed care. This resulted in no capitation, therefore, all care delivered under managed care is paid under the fee schedule. The provider's are still arguing with the updates because not all specialties receive the same fees for similar services. For example, chiropractic and physical therapists may get a lower fee for providing hot packs compared to a medical doctor. This is because their reimbursement rates are based on their previous charges for and the volumes of these services.

In hindsight, the state would recommend against manipulating the RVUs to achieve cost containment; it would be easier to do adjust the CF. Unconditional application of HCFA updates each year may not be a good strategy; it is preferable to evaluate each recommended change. Minnesota has to do it since it is specifically discussed in the administrative rule. On the other hand, using HCFA recommended changes is supported by the body of work done by HCFA and has the advantage of being better accepted and defensible.

Mississippi

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Fee schedule approach

Mississippi uses the Medicare RBRVS with charge-based conversion factors supplied by Medicode. Implementation was August 1, 1993.

State goals

Mississippi had no prior fee schedule; physicians were paid billed charges. Cost containment was the primary goal; the state could not find carriers willing to write workers' compensation insurance and small businesses could not afford the premiums.

Reason for selecting payment method

RBRVS was chosen as the basis for the fee schedule because the Commission anticipated that more and more private payers would adopt the federal system, and they felt that RBRVS could be defended as fair at public hearings. Medicode was chosen as a vendor because they are a reputable company that provided clean data.

Conversion factors and adjustments

Medicode develops the conversion factors. The state's goal is to set fees at the 60th percentile of usual fees for surgery and the 55th percentile of usual fees for all other services, from the Medicode charge database. The respondent did not have the actual factors at hand. Initially, they evaluated four geographic regions within the state, but decided to use statewide rates. Carriers are required to use the fee schedule.

Updates

The most recent update was in 1997. The statute provides that the state will review the fee schedule annually but will revise it only as necessary. The initial fee schedule was viewed as quite generous, therefore the first update after 1993 did not occur until 1997. No new codes are added unless the entire fee schedule is updated. At that time, they add new codes using the current Medicare RVUs.

The Commission was not required to hold public hearing regarding the 1997 update; they filed notice with the Secretary of State, waited 30 days, and implemented it as a revision to the existing schedule.

Unique services

Mississippi has its own fee schedule for work hardening, functional capacity exams, and physical therapy and occupational therapy initial evaluations and follow-up exams. They have not yet addressed dental services.

Implementation strategy

There was no phase-in. Implementation of the fee schedule was roughly budget neutral overall, although there was some shift from surgery to medicine. The Cost Containment Supervisor stated that it represented a decrease for most physicians.

The state had an advisory panel that grew to 40 physicians and also included physical therapists, chiropractors, pharmacists, and other providers. The Commission held numerous meetings with special interest groups that served a valuable education process. Public hearings were held prior to adoption of the legislation.

Were the state's goals achieved?

Yes. There has been no increase in workers' compensation premiums since the fee schedule was implemented. However, the respondent stressed that mandatory utilization review has been more important in controlling workers' compensation costs than adopting a fee schedule to cap fees.

Political issues, technical problems, and lessons learned

Physicians knew that a fee schedule was inevitable. Workers' compensation costs were so high that companies were going out of business. The state knew the fee schedule was generous and was workable; initial physician complaints settled down after two to three months. The update in 1997 occurred in response to surgeon complaints. Medicode performed an analysis showing that the surgical fees were 12 percent below the 60th percentile target.

There have been no real technical problems. Most questions relate to interpretation of the state's instructions. The biggest problem is that capping fees creates the incentive to manipulate the system in other ways, such as increasing utilization and upcoding. The respondent feels that the state has done a good job in keeping up with the providers through regulatory requirements and especially utilization review.

Montana

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Fee schedule approach

Montana has been using St. Anthony's RVP since 1993. The quarterly updates received from RVP are implemented as received. Not all changes are across the board, and some may be minor.

State goals

The RVP fee schedule was adopted because it is easy to use and was the most standardized version being used in the U.S. Cost containment was also a factor. The state also wanted to prevent provider-induced demand and therefore higher costs. The state has a legislative mandate to limit fee increases to the percent increase in the average weekly wage index, therefore imposing a ceiling on the medical costs of workers compensation. At the time of the implementation of this fee schedule there was a freeze on fees.

Reason for selecting payment method

This fee schedule was adopted after a study of all other payment systems available at the time based on the legal requirement within the state that costs should not increase more than a certain percentage each year. RVP was the most suitable system for which an appropriate conversion factor could be calculated.

Conversion factors and adjustments

Medicine	\$ 4.27
Surgery	\$91.39
Physical Medicine	\$ 6.66
Radiology	\$17.67
Anesthesia	\$32.86
Pathology	\$15.31
Acupuncture	\$ 4.27
Chiropractic	\$ 4.27
Dental	\$ 8.25

Conversion factors are based on historical costs of the 10 most frequent codes within each specialty. No geographic cost differences are applied. The state has studied this possibility, but found it hard to set up so that it operates properly.

Updates

The conversion factors are updated annually based on the percentage increase in the average weekly wage in the state. The updates then are mailed to the all users.

Unique services

A number of services such as chiropractic, dental, acupuncture, and physical and occupational therapy are not reimbursed based on the RVP but are based on codes developed by the state. This was done to prevent an upsurge in the volume of these services after RVP was put in place. The costs for these services are controlled by the conversion factors rather than volume control. These codes are updated by administrative rule. DME is covered separately at 30 percent above cost. It is not know what percentage of total volume of services DME and specialties outside of RVP represent.

Implementation strategy

The fee schedule was implemented without a transition period.

Were the state's goals achieved?

The fee schedule is achieving its goals, particularly ease of application and implementation.

Political issues, technical problems, and lessons learned

The biggest implementation problems have resulted from external forces that have significant effects on costs, such as managed care or reductions in benefits. Implementation took one and half years of discussions and negotiation using a panel comprised of representatives of all medical specialty groups, insurers, and other interested parties. This approach proved to be a good strategy.

The largest technical problem was lack of a utilization database, so the state had to use data from their state fund, which covered over 70 percent of all cases. The providers' response was and is relatively positive. Some specialists have complained about fees being too low. Also, the state is now considering a request by the chiropractic association to use RVP codes rather than those developed by the state.

The state recommends careful study of what the fee schedule will cover when implemented. For example, services in surgery centers were previously covered either by the fee schedule or the hospital payment schedule if owned by a hospital. However, surgery centers have recently been successful in avoiding regulation of payment for their services. This loophole has resulted in more patients being sent to surgery centers, where providers receive payment for full charges.

Nevada

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Fee schedule approach

The state adopted St. Anthony's RVP in 1992. The updates are based on those received from St. Anthony annually. Currently, the state is in the process of adopting new regulations.

State goals

The previous system was based on California RVUs, which had many gaps. The new fee schedule was adopted to provide a complete schedule that is universal and research based.

Reason for selecting payment method

The state was not interested in a federal system and so chose RVP.

Conversion factors and adjustments

Medicine	\$ 6.00
Surgery	\$117.57
Radiology	\$ 20.59
Laboratory	\$ 51.54
Pathology	\$ 14.30.

The conversion factors are calculated annually based on paid data from the previous year. The conversion factors are based on a survey of group health data to remain competitive with the market. No geographic cost differences are applied.

Updates

The conversion factors are updated annually but are not to exceed the CPI by law.

Unique services

Any professional services not covered by the RVP are paid on a fee-for-service basis.

Implementation strategy

The transformation from the previous system to the current one was done with the help of Milliman and Robertson, a health care consulting firm. The schedule was implemented without a transition period.

Were the state's goals achieved?

The schedule seems to have achieved its goals and no recommendations are made to do anything differently.

Political issues, technical problems, and lessons learned

No technical or political problems were reported either with the implementation or the updates.

North Carolina

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Fee schedule approach

North Carolina's fee schedule is based on the 1995 Medicare Fee Schedule, using Medicode as a vendor to develop conversion factors. Implementation was January 1, 1996.

State goals

The state had a prior fee schedule implemented in 1993 that was based on surveys of charges. The respondent believes that the medical society exerted pressure for a fairer system.

Reason for selecting payment method other than RBRVS

Not applicable.

Conversion factors and adjustments

General Medicine	1.58
Surgery	2.06
Physical Medicine	1.30
Radiology	1.96
Pathology	1.58

Anesthesia is reimbursed on a flat fee basis. Note that the conversion factors are multiplied by the MFS amounts, not by the RVUs. They initially were calculated based on prior paid claims. The Commission was trying to achieve a discount from billed charges of approximately 6 to 7 percent in order to be consistent with reimbursement by the state employees health plans. Per statute, the rates are based on the North Carolina 1995 Medicare fees.

Updates

New CPT codes are added at the then current MFS rate. No other codes have been changed and the conversion factors have not been updated. The Commission obtains the fee schedule data and Medicare guidelines from Cigna, the local Medicare fiscal intermediary. Any update will require public hearings.

The Commission does not have the staff to maintain the fee schedule internally. They are satisfied with the convenience and legitimacy provided by Medicode, which they regard as a stable vendor that will be around for a while. Medicode sells the fee schedule to providers for \$75.

Unique services

North Carolina has unique codes for documentation, chiropractic treatment, and services provided by psychologists; these are paid according to a fee schedule. Services such as functional capacity testing performed by physical therapists require a provider contract with the insurance carrier. Although these services and fees have become relatively standardized, they

are still paid “per agreement.” The new CPT codes include work hardening and work conditioning, which have been adopted by the state.

Implementation strategy

There was no phase-in. When implemented, the fee schedule was estimated to represent no overall change in reimbursement for general medicine, slightly lower fees for physical medicine, a 23-percent reduction in radiology, and an 8-percent reduction in surgery. The North Carolina Medical Society appointed a Medical Advisory Committee that participated in the development of the fee schedule and is now used for interpretation in specialty areas.

Were the state’s goals achieved?

Yes, providers and payers view the fee schedule as fair.

Political issues, technical problems, and lessons learned

The Commission is now getting pressure for a new fee schedule because they have not implemented CPT code updates. The issue of chiropractic payment is holding this up; these providers want their own codes rather than using the CPTs that fall within their scope of practice. Once this is resolved, the Commission will go ahead and publish a new fee schedule. They anticipate maintaining the approach of using a MFS base with an external conversion factor benchmark.

Most problems have been created by the hospital payment system, not professional services.

North Dakota

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Fee schedule approach

North Dakota implemented St. Anthony's RVP in January 1998. It is updated annually as the new updates are released by St. Anthony.

State goals

The fee schedule was adopted so that the medical community would find it easy to understand, and the state would find it easy to manage. Cost containment was also a goal. At the time of implementation, there was an 8.9-percent overall increase in medical workers compensation costs.

Reason for selecting payment method

This system was chosen prior to the respondent's employment but likely because the old system was too old and the new system is well accepted by the community.

Conversion factors and adjustments

Medicine	\$ 5.50
Surgery	\$80.15
Physical Medicine	\$ 3.75
E&M	\$ 5.50
Radiology	\$17.20
Anesthesia	\$35.00
Pathology	\$15.00
Chiropractic	\$13.10

Medicode developed conversion factors for these eight groups of services. The company benchmarked the conversion factors on charges for workers compensation within the state and compared them to other states that had similar patterns of charges. The state does not make geographic adjustments.

Updates

The conversion factors are updated annually based on actuarial analysis of the market.

Unique services

All professional services covered are the same as those under RVU.

Implementation strategy

The fee schedule was implemented without a transition period.

Were the state's goals achieved?

The fee schedule is achieving its goals by containing costs and improving the management of the system. The new system increased fees by 8.9 percent.

Political issues, technical problems, and lessons learned

The state has not encountered any technical or political problems during implementation. The overall provider response to the implementation of the updates has been positive; this is attributable to the ease of managing the system. In retrospect, the state would not do anything differently.

Ohio

Respondent: Kathy Cooper
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Bureau of Workers' Compensation
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Fee schedule approach

Ohio's fee schedule is based on RBRVS. Implementation was March 1, 1997.

State goals

Cost containment — by 1990, medical payments had started to exceed compensation payments. Initially, a fee schedule based on charge-based RVUs was adopted. It was inflationary, however; annual expenses increased each year despite no changes in the workers' compensation program.

Reason for selecting payment method

RBRVS was selected to avoid the inflationary nature of a charge-based fee schedule.

Conversion factors and adjustments

General Medicine	\$44.27
Surgery	\$97.10
Anesthesia	\$37.00
Physical Medicine	\$55.90
Radiology	\$56.40

Pathology services are reimbursed based on a fee schedule developed by the state. The conversion factors were determined by consensus agreement of a committee comprised of providers, employers, labor, attorneys for injured workers, and workers' compensation Bureau staff. The composition of this committee is legislatively mandated.

They use the Ohio geographic adjustments as published annually in the *Federal Register*. At implementation, they also had urban/rural adjustments by zip code. However, an evaluation showed that these had minimal dollar impact and there were few rural areas, so this adjustment was eliminated for administrative simplification. Services provided out of state are paid at the Ohio rates.

Updates

There has been no update since the initial implementation. Ohio has maintained the 1997 RVUs, and added new codes published in 1998 and 1999. They did not adopt changes related to the Balanced Budget Act of 1997. They currently are using a consultant to analyze the fee schedule because they think the surgery and radiology conversion factors may be too high. Updates to the conversion factors will require a consensus agreement of the same committee that approved the original conversion factors. They have tried to reach agreement a couple of times but have failed to do so.

Unique services

Ohio uses unique codes for rehabilitation services and independent medical exams. These are paid according to “billed history,” i.e., usual and customary charges. The respondent estimates that failure to include these services in the fee schedule may have a significant financial impact.

Implementation strategy

Implementation of the RBRVS fee schedule was budget neutral overall. There was no phase in.

Were the state’s goals achieved?

Yes. RBRVS is easier to explain and justify than a purchased fee schedule.

Political issues, technical problems, and lessons learned

Each specialty group differed in its reaction to the fee schedule. However, the consensus process and the fact that it was budget neutral overall dampened the criticisms. They are facing major disagreements now in attempting to update the conversion factors. The Bureau would like to evaluate moving to a single conversion factor but has been unable to do so. The respondent also recommends making the modifier definitions very clear so providers do not game the system.

Other

In 1997, managed care was also introduced to the workers’ compensation program. MCOs do medical management. If the MCO has a contract with a provider, it will also reprice claims before submitting them to the state. The contract typically provides for a percentage discount from the workers’ compensation fee schedule. The state pays the billed amount, the MCO repriced amount, or the fee schedule amount, whichever is less. MCOs receive a percentage of the employer premium as well as incentive payments for electronic submission within certain time frames.

Oklahoma

Respondent: Janice Wolf
Medical Fee Specialist
Medical Services Division
Workers' Compensation Court
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Fee schedule approach

Oklahoma adopted St. Anthony's RVP in 1987 (updated 4/89, 8/91, 1/96, 1/98). The RVUs are updated through a public hearing process and reviewed by the administrator. Through this process, some RVUs may be adjusted.

State goals

The fee schedule was primarily used to reduce costs, but not so much as to affect quality care or reduce access. At the time of implementation costs were considered too high by many.

Reason for selecting payment method

There are at least two reasons for the adoption of this fee schedule: Medicare's RBRVS did not contain all the necessary CPT codes, and the RVP had been published for many years and seemed to be a reliable system.

Conversion factors and adjustments

Oklahoma used to have a conversion factor based on New York State's that was adapted for Oklahoma by a survey of costs for the state's medical community. However, now they are using one based on the Conversion Factor Report published by McGraw-Hill, Inc. This report has information on percentiles and specialties; it is not used directly but is changed based on the administrator's decision. There are distinctions made based on specialty and service, but there are too many to list, and the state views the conversion factors as proprietary. No geographic adjustments are made.

Updates

The conversion factor is not necessarily updated regularly and there is no requirement to inflate it, but it is reviewed every two years. In fact, fees were frozen by the legislature prior to implementation of the RVP and even when implemented there was a directive to reduce costs by a fixed percentage. If the conversion factor is to be inflated, it is done through a public hearing process when groups of physicians may complain about the fees for selected services.

Unique services

Professional services covered are those under the RVP and no other physician services are covered. The state covers some additional services such as DME and supplies, pharmaceuticals, ambulatory surgical center services, and inpatient hospital services. The reimbursement is as follows:

- DME: cost +25 percent with MD markup limited to \$15 an item,
- Pharmaceuticals: Redbook AWP +\$6,
- ASC: DRG unit value * \$920,
- Inpatient: DRG unit value * 920 + \$450 for each 24hr period [this component is not related to professional services].

Implementation strategy

The fee schedule was implemented without a transition, but with instructions from the legislature to cut costs by a fixed percentage.

Were the state's goals achieved?

The fee schedule seems to be achieving its goals specially when the ground rules are applied (i.e., capping services or utilization). However, they have not done studies to evaluate whether costs are truly reduced.

Political issues, technical problems, and lessons learned

It appears there were no political problems because the fee schedule was adopted by a legislative action with specific language to allow for RVP. Technical problems included unit values errors in RVP, as well as problems with the current electronic version that could not be opened in a spreadsheet format. The responses from physicians are centered on some spinal surgery codes that some doctors think are valued too low. The state does not have any suggestions for doing things differently.

Oregon

Respondent: Claudia Stone
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Workers' Compensation Division
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Fee schedule approach

Oregon adopted the Medicare RBRVS in 1996. It is updated annually, but not implemented until July of each year, because legislation requires that public hearings be held to discuss the changes. Oregon uses the RBRVS in its entirety.

State goals

The fee schedule was adopted to accomplish three main goals: simplification of the payment method, compliance with other dominant payment methods, and reduction of costs. It appears that the adoption occurred at a time of increases in total costs, since the new system created a ceiling on the costs of workers compensation, where the costs were uncontrollable before.

Conversion factors and adjustments

Medicine	\$89.43
Surgery	\$91.53
Physical Medicine	\$66.42
Radiology	\$78.17
Anesthesia	\$45.42
Pathology	\$89.43

There are no geographic cost differences.

Updates

The conversion factor was updated annually about 3-4 percent based on the physician component of the CPI, but there has been a freeze on increases in the conversion factors because of the high reimbursement rates in Oregon, which are higher than all but two other states.

Unique services

Oregon does not introduce new codes for services outside the Medicare RBRVS. However, because not all the codes in Medicare are applicable to workers compensation, some are not used. Alternatively, existing codes on evaluation (and some other services) are refined to reflect the higher costs of worker compensation, and applied across specialties.

Implementation strategy

The transition strategy was revenue neutral, paying some providers higher and other lower, but controlling costs overall. Oregon implemented this fee schedule without a phase-in period.

Were the state's goals achieved?

The goals of the fee schedule were achieved by controlling costs, although there is still concern that expenditures may be too high because the conversion factors are higher than most other states. The system of payment is easier for providers and insurers.

Political issues, technical problems, and lessons learned

The implementation was a highly politicized process as providers argued for higher conversion factors and the insurers for lower conversion factors. Attempts to reduce the conversion factors recently were defeated because of the highly political nature of this issue. The largest technical problem encountered was the tremendous effort required for all involved parties to change their reporting systems (the previous fee schedule was based on California and Oregon). In retrospect, they would not change the implementation process.

Pennsylvania

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Fee schedule approach

Pennsylvania adopted the 1994 Medicare Fee Schedule (MFS), multiplied by 113 percent as a base, froze it, and applies annual percentage increases. The philosophy was to use RBRVS as a starting point only for the evolution of a workers compensation fee schedule for Pennsylvania. They do not follow other Medicare payment policies, with the exception of bundling/unbundling, which they are mandated to follow.

State goals

Goals were to cap spiraling medical costs and reduce workers compensation premiums. This was the first reform in 23 years.

Reason for selecting payment method

Pennsylvania adopted RBRVS for payment of motor vehicle claims in 1990. Workers compensation then adopted it because the motor vehicle division had, on some notion of universality. However, the auto program actually follows the current MFS plus a percentage, whereas workers compensation froze the 1994 MFS as a base.

Conversion factors and adjustments

Because Pennsylvania uses the MFS and not the underlying RVUs, there is no conversion factor. In 1994, the MFS identified four geographic regions in Pennsylvania. Medicare has since reduced these to two, but the state has maintained rates for four regions.

Updates

By statute, the fee schedule is inflated annually by the percent increase in the statewide average weekly wage. Due to the upturn in the economy, this has resulted in annual increases ranging from 2.8 percent to 4.8 percent. As a result, workers compensation rates are now at 134.5 percent of the 1994 MFS. When Medicare adds new codes, Pennsylvania adds these to the fee schedule at then current MFS rates and they become part of the base for subsequent annual increases.

Unique services

There are few unique professional services not covered in the MFS. Per statute, covered services not included in the MFS are paid at 80 percent of usual, customary, and reasonable fees. The program has special rules for chiropractic services.

Implementation strategy

The initial MFS multiplied by 113 percent represented a major decrease in payments from the previous FFS system. There was no phase-in – the law passed in June and went into effect in August. The fee schedule is not technically mandatory; the insurance carrier or employer must

choose to apply the fee schedule. A few small carriers may ignore it, but almost everyone has adopted it.

Were the state's goals achieved?

Yes.

Political issues, technical problems, and lessons learned

The major concern is that annual increases keep compounding, such that workers compensation is again the most generous payer. The respondent feels their system does need more flexibility to adjust the annual inflation factor; they are trying to do this through regulation rather than opening up the statute again. With hindsight, the respondent feels that Pennsylvania did not do a good job determining market rates and finding a middle point. However, implementation occurred just before the rapid increase in managed care in the state.

Prior to passage of the bill, physicians and labor joined together in lobbying regarding their concern that decreased rates would lead to diminished access and quality. As a result, the division is required to do an annual survey of all workers injured in the prior year. Worker satisfaction with access and quality has actually increased since implementation of the fee schedule.

Initial responses included providers threatening to leave the system and hiring personnel to file fee reviews on everything. Fee schedule reviews have decreased over time. Physicians now support the fee schedule but are resisting insurers' use of PPO networks to discount from the schedule. If a physician files a fee review complaining they are receiving less than the fee schedule, the Division will tell the provider that by law he or she is entitled to receive the full amount. This is in contrast to other states that permit carriers to negotiate discounts from the fee schedule and pay the lower of billed charges, the fee schedule, or the negotiated amount.

Initially, staff did not understand the system at all and depended on consultants to build the charge master, which has various technical problems. Most current political issues relate to hospital, not physician, payment. The respondent advises that any state give its new fee schedule a chance to work and not tinker with it every year or two the way some states do. It took Pennsylvania 4-5 years to work out the details.

South Carolina

Respondent: David Schindler
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Fee schedule approach

South Carolina implemented a fee schedule based directly on the Medicare RBRVS in 1995.

State goals

Prior to implementation of the fee schedule, the Occupational Medicine Committee of the state medical association set workers compensation fees. The Commission's goals were to take control of fees away from the doctors' committee and to move to a cost-based rather than charge-based system.

Reason for selecting payment method

RBRVS was chosen because it was becoming such a common method, and they wanted to achieve consistency with other payers.

Conversion factor and adjustments

The conversion factor is \$54.03 for all services except pathology, which is reimbursed based on the MFS amount plus 64 percent. The Commission was able to establish a single conversion factor due to internal medical association politics; their occupational medicine committee favored two conversion factors but the association overall favored one. The argument used against multiple factors is that RBRVS is designed for use with a single factor.

Updates

The most recent update was in September 1998. The state typically releases a new version of their fee schedule every 18 months, which puts them out of sync with the federal schedule. In the past update, they used the 1998 RVUs and CPT codes. Once 1999 values were published by Medicare, they added the new CPTs with their 1999 values, but left all other codes at the 1998 level.

Each year when the RVUs are published, the state collects workers' compensation utilization data and analyzes the impact of the new RVUs. This impact is incorporated into the political decision about the overall increase for the current year. For example, in 1998, an overall increase of 2 percent was given; of which 0.5 percent resulted from updates to the RVUs and 1.5 percent from an increase in the conversion factor. There are no adjustments for geographic cost differences.

Unique services

CPT changes have taken care of the need for unique codes. They use the Medicare codes for chiropractic services. They have one or two unique codes for services such as depositions.

Implementation strategy

Because this was the first fee schedule change in 5 years, the state allowed a 5-percent increase overall. There was no phase-in. The division meets regularly with the medical association

committee. There was tremendous uproar when the legislation passed, especially from the orthopaedic community. However, when the schedule came out, providers saw that reimbursement was not significantly different from prior payments, and they quickly dropped their resistance.

Were the state's goals achieved?

Overall, yes, especially since so many services were not priced in the past and were paid billed charges.

Political issues, technical problems, and lessons learned

One caution is that Medicare changes may have significant impacts in a workers compensation program. In 1996, the RBRVS physical therapy definitions changed from 30 minutes to 15 minutes, but the RVUs did not change, effectively doubling physical therapy payments. This had a big financial impact.

The respondent believes the Commission has been too eager to increase fees every year. Their benchmarking analysis shows that the 1995 rates were 158 percent of Medicare, while the 1999 rates are now 174 percent of Medicare. He would like to work with the physicians to pick a consistent benchmark by which to adjust the fee schedule.

The respondent's recommendations include using a single conversion factor, and determining in advance a benchmark for where the rates should be so that updates can be done without annual debates.

South Dakota

Respondent: James Marsh
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Fee schedule approach

South Dakota adopted the RVP by St. Anthony in 1994. The RVP is updated annually even though St. Anthony releases quarterly updates on new CPTs or refinements. Many updates are not relevant anyway, but those that are will be done annually.

State goals

The RVP was adopted to reduce the medical cost component of workers compensation, which was more than half of the workers compensation expenditure. A second goal was to level the playing field for physicians, since some providers' charges were far higher than others. At the time of the implementation of RVP, medical costs were dramatically increasing.

Reason for selecting payment method

There are two reasons for choosing RVP rather than Medicare's RBRVS: (1) the Medicare fee schedule focused too much on primary care physicians, and this was not considered appropriate for workers compensation, and (2) RVP covered all the gaps in the Medicare CPT codes.

Conversion factors and adjustments

Medicine	\$54.86
Surgery	\$98.24
Radiology	\$22.62
Anesthesia	\$39.56
Pathology	17.52

There are no geographic cost adjustments.

Updates

The conversion factors are updated annually. However, since the CPT changes are released each January and the development of new prices are not completed for some time, often July, there is a gap when prices are not available and interim prices are used.

Unique services

There are no professional services that are provided outside of RVP. However, other components of care such as supplies are paid for at a discounted fee-for-service rate.

Implementation strategy

The transition was direct from the previous method to the RVP. Conversion factors began at the 85th percentile of charges prior to RVP. Setting of percentiles was accomplished by hiring Medicode to study costs and determine 50th to 90th percentiles. In 1995, payments were reduced to the 80th percentile and in 1996 to the 70th percentile, where they have stood since without any inflation adjustments.

Were the state's goals achieved?

The RVP has achieved both goals. The first year, a significant reduction in costs was observed and the trend data show that reductions are continuing. Since 1994, there has been a 38-percent reduction in workers compensation, about half of that attributed to RVP.

Political issues, technical problems, and lessons learned

There was a tremendous provider backlash to the RVP system. The medical lobby argued that the reform was being conducted by shifting the burden to the doctors. Originally, the legislature suggested a move to the Medicare Fee Schedule at 115 percent, but that was vehemently opposed. The outcome was the political compromise and the percentile method. Once the payment method was in place there was not much noise but the changes from 80th to 70th percentile raised many objections, because it was a significant reduction. The state is satisfied with the current system and the way it was implemented. However, retrospectively, it would have been desirable to have more input from people experienced in medical billing rather than just relying on doctors' input.

Texas

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Fee schedule approach

The Texas fee schedule is based on 1995 McGraw-Hill RVPs. It was implemented in 1996 although the statute was passed in 1991. Previously, the state used the California RVS (CRVS). They are in the process of developing an update and will probably use the 1999 St. Anthony's RVP.

State goals

The previous Executive Director of the Commission was very interested in developing a unique Texas system. The goal was to update the 1992 fee schedule with new CPT codes and to choose a system that was more maintainable than the CRVS and easier to adapt to Texas needs.

Reason for selecting payment method

No direct response.

Conversion factors and adjustments

Medicine	\$ 6.44
E&M	\$ 5.29
Surgery	\$101.16
Radiology	\$ 16.79
Pathology	\$ 12.53
Anesthesia	\$ 40.00 }
CRNAs	\$ 30.00 } use ASA units

The goal in setting the initial conversion factors was for the fee schedule to be budget neutral within each group. In 1996, E&M fees were below the 30th percentile but the conversion factor was set at this level rather than trying to achieve more equitable percentiles. They tried to move surgery down a little but it is still at the high end.

Updates

There has been no update since the RVPs were implemented in 1996. The Commission intended to review and update the fee schedule every two years, but has been able to do so only twice since 1991 due to lawsuits over changes. They obtain some input from their Medical Advisory Committee as well as insurance carriers and produce a draft medical fee guideline, which is submitted to the Commissioners for approval. It is then published in the Texas Register for a 30-day public comment period and then goes back to the Commissioners for final adoption.

For the 1996 adoption of the McGraw-Hill RVPs, the Commission purchased market data (Texas charge information) from Innervation Technology Corporation and developed a conversion factor for each group. They are being sued over this methodology.

Unique services

Texas added some specific modifiers but use the McGraw-Hill RVUs for all services. They have a fee schedule for work hardening, work conditioning, required medical evaluations, functional capacity testing, and designated physician exams.

Implementation strategy

For the 1996 implementation, any given CPT code was limited to a reimbursement decrease of 25 percent. The implementation was budget neutral.

There is a Medical Advisory Committee appointed by the Commissioners. Its composition is set by statute: one physician, chiropractor, dentist, pharmacist, employer, employee, DME supplier, nurse, occupational therapist, etc.

Were the state's goals achieved?

This is not clear. Texas strives to be at the median of national benchmarks. They are concerned about a study by the National Council on Compensation Insurance that shows Texas costs to be extremely high on a per case basis. It appears that volume is a significant problem rather than fees.

Political issues, technical problems, and lessons learned

From a technical standpoint, the fee schedule seems to be working reasonably well, except that they would like to be able to update it more quickly. They sent out questionnaires to get input and received generally positive feedback.

By statute, workers compensation can pay no more than any private payer, but it is difficult to determine what the market is paying in this managed care era. They are trying to purchase market data.

The Commission is using paid claims to target new conversion guidelines. They have been challenged in court multiple times and the agency is concerned about what data can be used. They will not purchase conversion factors this time. The lawsuits filed have been by individual physicians/groups, not the Texas Medical Association. Because of the litigious atmosphere, the Commission does not have much communication with providers.

The respondent characterized many of the problems as endemic to Texas. He finds it unusual that chiropractors are permitted to direct care. He strongly recommends that the statute include a methodology for updates so that they are not continually subject to challenge.

Other

The Commission pays the lower of billed charges, the fee schedule, or the contracted amount for all services. Texas is not a managed care state, but physicians may have discounted fee agreements with carriers, e.g., Blue Shield.

Washington

Respondent: Tess Britton
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Marc Hawkins
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Fee schedule approach

Washington adopted the Medicare RBRVS in 1993. The RVUs are updated annually without making any changes to those recommended by HCFA, unless there are reasons not to accept new codes; for example, codes that do not make sense for workers compensation.

State goals

In 1990 the governor commissioned a study in response to the high health care costs. The three biggest programs in the state were workers compensation, Medicaid, and the Health Care Authority. The study recommended taking advantage of the purchasing power of these three programs by using the same fee schedule method. So the goals were to have a similar fee schedule that was administratively simpler and controlled costs. At the time of implementation fees were increasing.

Conversion factors and adjustments

The conversion factor is \$47.12. Payment for services provided by physician assistants or nurses are equal to 90 percent of this amount. The state coordinates increases with Medicaid and the Health Care Authority, which is responsible for active and retired state employees. There are no within-state geographic differences, but the ratios of the state and national averages are: work component, 0.981; practice cost, 1.010; and malpractice, 0.42. Adjustments are made annually, but the basis of the adjustment is HCFA updates obtained from the office in Seattle. The state has developed local codes for chiropractic, naturopaths, home health, brain injury, substance abuse, work hardening, and special reports. Some services are reimbursed using flat fees, some are tied to RBRVS, and others have other local codes. RBRVS codes comprise 30 percent of total costs, and flat fees 15 percent.

Updates

The conversion factor is updated annually. Each year, the changes in RVUs are taken into account and result in changes in the conversion factor in a budget neutral manner. There is a cost of living increase that is tied into the states' percentage increase in the average weekly wages. The last adjustment was a 5.42-percent increase.

Unique services

Anesthesiologists are paid on a fee for services system and not included in the RBRVS.

Implementation strategy

Washington adopted the Medicare RBRVS in a period that lasted from September 1993 to May 1995. The transition strategy was to implement the RBRVS using a combination of the old and

new method of reimbursement and slowly reducing the fees to the desired amount. However, this system proved to be too confusing and after one year physicians requested that the state go directly to the new system.

Were the state's goals achieved?

The fee schedule is considered to be achieving its goals, given that adjustments have been implemented in the meantime.

Political issues, technical problems, and lessons learned

The biggest technical problem, apart from the transition strategy, was the inaccuracies in the RVUs assigned by Medicare to some specialties such as orthopedics and psychiatry. Also, some specialties such as radiology were hit hard. When the state evaluated their payments after one year they found these problems and addressed them. There were no specific political problems, other than the specialties that are mentioned above being disgruntled with their payments. The medical association had agreed early on that a uniform system of payment would be beneficial to all and since the state did not have the resources to develop such a system internally, the Medicare RBRVS would be a suitable system.

Physician response to the updates has been to request higher conversion factors when they are considered too low. There seems to be confusion when the conversion factor goes down and a cost of living increase is implemented at the same time. The state holds public hearings every year, yet no physicians show up. In retrospect, the state recommends that the prospective fee schedule be carefully scrutinized before implementation for errors and appropriateness. Also, do not underestimate the amount of personnel or resources required for implementation of such a system. Finally, a good consultant to help with the implementation is important. The state used the accounting/consulting firm KPMG.

Other

Washington administers the State Fund, which is the only insurer except for the self-insured. The law prohibits workers compensation from being capitated, so all managed care providers are paid using the fee schedule for physician fees.

West Virginia

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Benjamin Taylor
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Fee schedule approach

West Virginia uses a version of the Medicare RBRVS that was modified specifically for the state by Health Economics Research (Waltham, MA and Washington, DC). Implementation was November 1994.

State goals

West Virginia's primary goal was to implement a consistent system for all state payers: the Public Employees Insurance Agency, the Medicaid program, and the workers compensation program. Cost containment was not an explicit goal for workers compensation; they address budget considerations through utilization review, not the fee schedule. The three programs use the same RVUs, although the conversion factors vary due to different budget constraints. However, the program rules are the same, which simplifies coding and billing for physicians.

Reason for selecting payment method

Prior to 1994, workers compensation used a fee schedule obtained from Consultek Inc., of Atlanta, GA. This fee schedule did not appear to have a scientific methodology, just some regional studies, and grew more and more outdated. The three agencies worked jointly to develop an RFP for an outside consultant and selected HER.

Conversion factors and adjustments

Medical/Surgical	\$45.66
Anesthesiology	\$44.28

The initial conversion factor was determined based on budget neutrality with prior year (i.e., 1993) paid claims.

Updates

All RVU and CPT updates are handled by HER. The conversion factors are updated annually through negotiation with the other two state payers, trying to stay as consistent as possible. Medicaid is generally about \$10 lower. The intent is to inflate the conversion factors according to the medical service inflation reported to HCFA. However, the Medicaid program actually decreased its conversion factor last year. In solidarity with their sister agency, the workers compensation conversion factor has been held constant for 1997, 1998, and 1999. There are no geographic adjusters or urban/rural adjusters in the fee schedule.

The Division has full statutory authority to create the fee schedule, including any updates. As a matter of courtesy, they post the fee schedule at the opening of state legislature, but no public review is required.

Unique services

The state created unique codes for services such as disability evaluations, work hardening, some rehabilitation services. There are approximately 150 unique codes; they are working to pare these down. Reimbursement caps have been established, e.g. \$300/hour, maximum 2 hours for disability evaluation. Providers are paid the lower of billed charges or the reimbursement cap.

For chiropractic, they use CPT codes, e.g. minimal office visit, not HCPCS. They are concerned about utilization and are working on norms for treatment plans.

Implementation strategy

There was no phase-in; the fee schedule was implemented on a budget neutral basis. West Virginia used a physician advisory committee that worked with the consultants. This provided physicians the opportunity to discuss their policy issues prior to implementation. Getting physician buy-in is crucial, even if it means making some compromises.

Were the state's goals achieved?

Yes, the system has achieved consistency and has also saved money, although this was not primary goal.

Political issues, technical problems, and lessons learned

Overall, no significant problems have been encountered. During implementation, neurosurgeons threatened to drop out of the program. In West Virginia, use of outside consultants added legitimacy to the process.

They use RBRVS as a template but are not slavishly devoted to it; they want to maintain local flexibility. For 1999, practice expense was changed from charge to cost basis, with HCFA phasing it in over 4 years; West Virginia chose to implement the change all at once. Chiropractors are particularly unhappy because RVUs were also decreased for "passive physical medicine activities." However, West Virginia paid chiropractors unbundled fees for hot and cold packs longer than other states. Their consultant's recommendation for how to handle provider complaints about specific RVUs is to refer them to the national RVS Updating Committee (RUC). The rationale is that if the RVUs were truly inappropriate, they would be helping their fellow providers throughout the country by providing justification for a modification while enabling the state to maintain the consistency and integrity of the fee schedule.

Wyoming

Respondent: Martin Mueller
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Workers' Safety and Compensation Division
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Fee schedule approach

Wyoming has adopted St. Anthony's RVP since 1991. The reimbursement rules are rewritten annually. However, each year the changes in RVP are analyzed to determine their potential fiscal impact. If the fiscal impact is significant, and it rarely is, there will be deliberation as to whether to adopt the changes. The changes without a significant fiscal impact that add new codes or improve codes will most likely be adopted.

State goals

Prior to 1991, Wyoming had its own RVS system that was outdated, with many gaps in codes. The reasons for adapting an RVS were to use a non-arbitrary, well studied, and fair system of reimbursement that was also compatible with other payment methods used by insurance companies. Reduction in medical costs were not a consideration even though they were increasing dramatically (15 percent annually) at the time.

Reason for selecting payment method

At the time of this adoption, Medicare RBRVS was not fully developed and compared to other available systems, RVP seemed to be the best and well liked by others who were using it.

Conversion factors and adjustments

Medicine	\$ 5.25
Surgery	\$96.00
Physical Medicine	\$ 4.00
Radiology	\$20.57
Anesthesia	\$30.00
Pathology	\$13.00
Orthotics/Prosthetics	\$50.00

These conversion factors were determined in 1991 based on the analysis of previous year's expenditures with a 15 percent increase. There are no geographic cost adjustments.

Updates

Each time an update is considered, the conversion factors for Wyoming are compared to those of other states who are using RVP by St. Anthony, taking into account the lower cost of practice and living in Wyoming. The update is not necessary across the board; the state may update some specialties but not others. Once rates are determined, they may be reconsidered if a specialty complains; the rates are also compared with Medicare and Medicaid before making adjustments. There have only been two significant updates since 1991.

Unique services

There are no additional services outside of RVP.

Implementation strategy

The fee schedule was implemented without a phase-in with the provision that any services provided prior to the implementation date would be paid according to the prior schedule. This was done to prevent a flood of claims that were held back to take advantage of the new generous payments.

Were the state's goals achieved?

The fee schedule is achieving its goals.

Political issues, technical problems, and lessons learned

There were no political problems partly because the prior method caused dissatisfaction and partly because the conversion factors chosen were high enough and generous. The technical problems were related to updating the computer systems to handle the new system. Provider response has been positive with a wait and see attitude. The state's overall approach has generally been to listen to concerns of physicians and accommodate them where possible particularly by adjusting the RVUs. In a few cases physicians even suggested the RVUs were too high. In retrospect, the state would not do anything differently. They attribute their success to their flexibility and adaptability from implementation onwards.