

RBRVS Public Meeting November 14, 2012

Summary of public comments

Todd St. Vaughn, Practice Management: New RFA and other WC requirements add burdens to primary and secondary treating physicians. Take that into consideration.

David Ford, CMA: The sooner we can get this done, the better. Prefer not to have the default kick in. Ground rules are as important as conversion factors. Medicare is targeted at a different population. Differing rules include consult codes, fee schedule for interpreters. In Medicare, there are 2 or 3 follow-up visits in the global surgical period, while in worker's' compensation (WC) there can be ten visits, many of them devoted to convincing the employee to go back to work.

Stephen Levine, MD, CA Neurology Society: The percentage of neurologists in CA who are willing to treat WC has been falling: 22.9%, down from over 50% in 2005. The ones who are treating WC are nearing retirement age. The key driver is the level of reimbursement for neurodiagnostic testing (EMG, NCV, etc.). CWCI has found that non-surgical diagnostic testing comprises ~3% of medical spending. CMS payments have "devastated" payments for cardiology. It is difficult to find a cardiologist to treat a patient in the WC system. Needing a pulmonologist and getting a list of supposedly WC doctors, he could not find one of them who would actually see a WC patient. Now seeing a 50% cut in MC reimbursement for neurodiagnostic testing. CA was already 13th lowest paid in the country for neurodiagnostics.

Andy Parker, MD, US Healthworks, and Maureen Larson: Dr. Parker has been on an AMA RUC committee; they encourage DWC to implement the RBRVS soon as the codes are outdated. Supports the change to RBRVS and the 4-year transition. 31 other states, including TX, have adopted RBRVS and none have gone back. Texas' experience showed no loss of access, notwithstanding a telephone survey of certain subspecialists.

Ground rules changes: Under OMFS, every patient is new, not an established patient. There are special occ med codes-- we should keep them or develop them—e.g., DFRs, AOE/COE, after-hours codes to encourage after-hours availability and keep patients out of the ER, dispensed supplies. Encourages continued examination of PT modalities and procedures.

Cascades: can result in reimbursement at less than the cost of the supplies. Physical therapy is a loss. Either keep supplies separately reimbursable or don't cascade.

Prolonged service codes -- there is no code for review of medical records. Conclude: this has been a long time coming. Everyone's platforms already run RBRVS, both providers and payors. Implementation should go easily. 90 days from adoption date to effective date.

Don Schinske, WOEMA: We've wanted and needed RBRVS for a long time now, since at least 2002. This was one of the reasons WOEMA supported SB 863, but there are ways to improve the ground rules. Codes should be developed to reimburse complex history & physicals (for Occ Med). Codes could be more sensitive to what is actually done in an encounter. But if this would delay the conversion to RBRVS, we would rather tolerate the awkward codes.

Frank Navarro, CMA: Appreciate the sense of urgency. We've been living with ground rules that are interpreted differently depending on the payor. We urge the Division to pull together, as done for standardization of e-billing. Urge an advisory panel for development of ground rules.

Dianne Przepiorski CA Orthopedic Association: We need to convene advisory groups to walk through the ground rules. This kind of work has reduced billing disputes in the past, so let's do it up front. Arthroscopic codes are taking a large fee schedule hit in first year. Do not want to incentivize more surgically invasive procedures by cutting arthroscopic codes.

CA WC definition of "physician" is very different from MediCare rules. Watch for scope of practice issues when adopting Medicare rules.

Urge new ground rules to make WC more efficient. Improve process to head off disputes, not just resolve them [referring to IBR]. Move the patient through the process more quickly, so they don't languish in an occupational medicine clinic forever, and don't jump to pain management specialist before treatment by orthopedist is complete. I understand that the bill allows the addition of non-Medicare covered service to go above the 120%?

Carlyle Brakensiek – CSIMS: Medicare fee schedule will affect access, impairment ratings, and level of disputes. Keeping access is a challenge. If current OMFS equates to 117% of Medicare, you only have a little bit of margin to

adjust when converting. Advocate for multiple conversion factors. TX had access problem at 125% of Medicare, had to step it up to over 160% of Medicare. That is why TX does not have an access problem now. Conversion factors give money to doctors. Ground rules take money away. Under AMA guides, a number of the criteria for impairment evaluation require diagnostic testing, and this won't be done if discouraged by the ground rules.

Medicare ground rules are 50,000 pages long and create more opportunity for disputes. People who say the transition will be easy are either naive or disingenuous. Implementation of the fee schedule will affect Gov. Brown's legacy. There are inadequate incentives for physicians to encourage reporting. Need to adequately reimburse for PR-2, PR-4, supplemental reports (copy of email to Director Baker is submitted).

Rev Deacon Sal Alvarez, from Catholic Archdiocese of San Jose, representing coalition led by Voters Injured at Work, including numerous Latino rights organizations: Opposed SB 923 and defeated it on Assembly. Opposed the Medicare fee schedule because when it is adopted at low conversion factor, injured workers lose access to care. The only way to preserve access is to adopt multiple conversion factors so that specialists will stay in the system. Only one or two states use a single conversion factor, and it is higher than will be used in CA. Most use multiple conversion factors. Oppose the single conversion factor. Multiple conversion factors will preserve access and avoid potential civil rights litigation.

Steven Holtz, MD, Pres of CA Neurological Society: As a teacher trying to produce more neurologists for the country and also as a doctor treating WC, he is concerned. The numbers of neurologists are diminishing. The lifeblood of neurologists is cognitive services, not doing things to patients. The procedures, like EMGs, are ancillary to the thinking, but they are critical. If you take away the diagnostics that distinguish a surgical case from a conservative care case, you will drive up costs, limit patient's care.

Tim Madden, representing CA Occ Med Physicians, a group of about 20 primary care occ clinics: Support the recommendation to convene work groups and advisory committees. Look at what other states like GA and MD have done with ground rules.

Bernyce Peplowski, DO, (background-- from self-insurer side at Lockheed, then two large medical groups and two large payor groups): Focus is to deliver appropriate care, control costs, and optimize care, working as a team. We can do this as a team.

Maria Crane, consultant, Am. Insurance Corporation: Confirming, regardless of what we do with ground rules, we need to stay at 120% of MC overall? So whatever we do to increase payment in one area must come out of another. Implementation would normally take 90-120 days' notice, but if a lot of things arrive at once, it would take longer for insurers to implement.

Lisa Anne Forsythe, Coventry: It will take more than 90 days. More like 6 months turnaround to implement new procedures. The more complicated the ground rules, the longer it will take for us (payor side) to implement.