

*Workers' Compensation
Medical Services Review Committee
Meeting Minutes
December 12, 2014*

I. Call to order

The Medical Services Review Committee was called to order at 8:59 am on Friday, December 12, 2014, in Anchorage, Alaska.

II. Roll call

Chair Mike Monagle was unable to attend due to illness. The meeting was chaired by the Director's designee, Janel Wright, Chief of Adjudications.

The following Committee members were present, constituting a quorum:

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

Members Vince Beltrami and Jane Griffith were excused. Director Monagle participated telephonically.

Acting Chair Wright introduced Carla Gee from Optum Insight. Ms. Gee will be presenting Optum's analysis of Alaska workers' compensation medical data.

III. Approval of Agenda

A motion to approve the agenda was made by member Smith and seconded by member Scott. The agenda was approved unanimously.

IV. Approval of Minutes

A motion to approve the minutes from the November 7, 2014 meeting was made by member Dr. Foland and seconded by member Scott. The minutes were approved unanimously.

V. Optum Analysis of Medical Data

- Optum analyzed medical data the Division collected from the National Council on Compensation Insurance (NCCI) and FairHealth (FH), and CY2015 relative values (RV) from the Centers for Medicare and Medicaid Services (CMS). The analysis does not include facility pricing. Optum anticipates having the facility pricing analysis completed by the end of December.
- The draft analysis from Optum leaves several questions unanswered. How does the MSRC intend on addressing gap fills where CMS does not produce relative values or has missing procedure codes, such as durable medical equipment (DME) and pathology and lab work? Does the Committee want a

single professional fee schedule or separate fee schedules for facilities and non-facilities? Will there be a single conversion factor (CF) or multiple CF's? Is the goal to produce CF's that are budget neutral? Will the Committee include the geographic pricing cost index (GPCI) for Alaska in the RV calculation? What modifiers does the State intend on adopting? How does the Committee want to address the professional/technical component for radiology, lab, and pathology?

- The spreadsheet produced by Optum includes both RV's for non-facility practice expense and facility practice expense. The RV's for facility practice are lower on the assumption that facility costs are included in facility billing. The existing workers' compensation fee schedule uses a single professional services fee schedule. It does not have separate pricing for professional services provide in facility and non-facility settings. Optum's analysis includes the assumption that the Committee will be incorporating GPCI adjustments.
- Optum walked the Committee through the various tabs of the worksheet, explaining each tab and column. Optum will be putting together a "users guide" which explains the worksheet, the methodology used, and assumptions made. The guide will be distributed to the committee members.
- Optum's analysis produced budget neutral CF's for each service category based on the NCCI and FH data:
 - Evaluation and Management - 77.1508
 - HCPCS (durable medical equipment, supplies, materials, etc) - CMS does not provide RV's for this service category
 - Laboratory and Pathology - 230.1021 (there are many RV gaps in CMS)
 - Medicine - 79.7376
 - Radiology - 313.6682
 - Surgery - 219.8798
 - Composite (combined non-facility service categories) - 126.8798
- Member Scott commented that she had contacted the Idaho Industrial Commission and discussed their fee schedule development. When Idaho first transitioned to a RV fee schedule, they had multiple CF's, but reduced that number over time. Member Scott opines Alaska should adopt as few conversion factors as possible, with the goal of transitioning to a single CF.
- The committee discussed the calculated CF's on the pivot tab of the Optum worksheet, which are based on billed data. The question is whether billed data or paid data should be used. Optum stated that paid data can be skewed by other factors, such as network pricing. It was noted that while Alaska does allow employers to negotiate pricing with providers, employers cannot steer injured workers to a specific provider. The Workers' Compensation Board (Board) has heard testimony in the past from bill review companies that very few providers in Alaska participate in network pricing for workers' compensation. Optum stated that if paid data is used, the data set would have to be adjusted to remove modifiers that can impact payments, such as modifiers 50 (reduction for bilateral procedures) and 51 (reduction for multiple procedures).

- Optum’s analysis compares NCCI’s billed data against FH’s billed data. The budget neutral fee schedule RV conversion comes in between the 75th and 80th percentile of FH data values.
- Optum pointed out that since Alaska’s existing fee schedule is based on common procedure terminology (CPT) codes from 2010, there are many new codes in the CMS RV data that will not have any utilization values. Optum could crosswalk new CPT codes to their prior coding (if applicable) should the committee so desire.

Break 9:58am-10:17am

VI. Analysis of Medical Data (continued)

- Member Hall asked Optum to clarify the data for medical spend for surgery and radiology. He stated the numbers don’t seem to match data provided earlier by NCCI. Ms. Gee said she would verify the NCCI data.
- Member Foland stated the State Medical Association Board of Trustees had asked about PMIC medical data. Dr. Foland wanted to know how this data compares to FH data. Ms. Gee responded that she has heard of PMIC, but couldn’t speak to their data source or methodology. Dr. Foland stated that the CMS reimbursement rates being provided to intervention specialists don’t cover their costs.

VII. Presentation on Air Ambulance Services, Chris Rappleye and Juliann McCable, Guardian Flight

- Guardian is the largest air ambulance service provider in Alaska, with bases in Anchorage, Deadhorse, Dutch Harbor, Fairbanks, Juneau, Ketchikan, Kotzebue, Sitka, and Dillingham. The company operates rotary and fixed wing aircraft. The company’s goal is to have bases strategically located to achieve a maximum response time of one hour. The company is a privately owned for-profit business, owned by Air Medical Resource Group.
- Guardian medical teams can provide the following types of medical services: cardiac, trauma, neurological, metabolic, obstetrics, infectious disease, pain management, neonatal, and respiratory. Each flight is staffed with a paramedic and trauma nurse, with standby telecommunication with a doctor. On-flight staff are required to have a minimum of 3 years ICU experience and 5 years of paramedic experience.
- Flights are dispatched upon receipt of a necessity of transport order, which is typically made by a health aide in consultation with a regional hospital. Several members shared their experience of seeing medivacs in non-emergency situations. Dr. Hall opined this will improve once Alaska has a statewide trauma center, which may be up and running within two years.
- Each base in Alaska costs approximately \$2.0 million/year to operate. Fixed costs are due to 24/7 operations for pilots, medical staff, mechanics, maintenance, and fuel.
- The payer mix in Alaska is 45% Indian Health Services (IHS); 30% CMS; 20% commercial; and 5% uninsured. Workers’ compensation makes up

approximately 3% of the commercial payer mix. Reimbursement from CMS and IHS is substantially lower than costs, resulting in the majority of costs being shifted to commercial payers.

- Mr. Rappleye opined that cost shifting to commercial payers is happening throughout the medical industry as CMS, IHS, and other public payers reduce reimbursement rates. He further states that if the private commercial segment starts to cut back on reimbursements, service in Alaska will be negatively impacted – not just from Guardian, but from all carriers.
- Guardian does offer a family membership plan for \$125/year, which eliminates balance billing from insurers.

VIII. Public Comment

Misty Steed, Pacblu

- Pacblu provides bill review services for employers in Alaska. Her experience with air ambulance service providers is an unwillingness to reduce or negotiate pricing for their services.
- Air ambulance fees for workers' compensation is significantly higher than for other payers; Medicare, Medicaid, general health, etc. While regulation of fees for these providers may be under exclusive federal jurisdiction, is it possible that federal fee schedules be adopted by reference by the MSRC? Ms. Gee noted that there is a federal fee schedule for CMS and also for federal employees covered under the Federal Employees Liability Act.

Kevin Barry, President, Alaska Surgery Center (ASC)

- ASC is concerned with the general assumption that injured workers should be treated under a CMS fee schedule which is generally geared toward the treatment of the elderly and retired.
- ASC would like the Committee to have a single workers' compensation fee schedule for ambulatory surgical centers and hospitals. ASC's typically are allowed approximately 50% of the fee schedule allowance provided to inpatient hospitals for performing the same procedure.
- A fee schedule needs to allow for the billing of supplies and DME separate from facility pricing. Under CMS billing rules, supplies and DME are frequently bundled into CPT allowances, with the result that practitioners are unable to recover the actual cost of these items. Facilities should be allowed to bill for implants separately at invoice plus shipping.
- A fee schedule needs to allow separate billing for pain blocks as a separate surgical procedure. CMS does not allow separate billing for these procedures, ruling that they are covered under general anesthesia.
- CMS billing rules discount payment on multiple procedures, with the primary procedure reimbursed at the full fee schedule rate, and secondary procedures reimbursed at 50% of the fee schedule allowance, or less. The workers' compensation fee schedule needs to allow higher payment of secondary procedures than what CMS allows.

- The workers' compensation dispute resolution process needs to move quicker for medical procedure and billing disputes. Currently it takes months and months for disputes to be resolved.
- Finally, fee schedule changes should be implemented the first of the year instead of mid-year. Providers develop their fees in consideration of set fee schedules. Changing fee schedules mid-year can negatively impact financial planning that has already been put in place for the current calendar year.
- Approximately 8-12% of ASC's patients are workers' compensation patients.

Lunch Break 12:04pm-1:30pm

IX. Presentation on Air Ambulance Services, Scott Kirby, LifeMed Alaska

- LifeMed is headquartered in Alaska, with bases in Anchorage, Fairbanks, Soldotna, Bethel and Palmer. The company operates rotary and fixed wing aircraft, and ground transportation in Anchorage. LifeMed does not own its own aircraft or hire its own pilots and mechanics – it contracts for those services. The company is a joint venture of Providence Health and Service, and Yukon-Kuskokwim Health System.
- LifeMed has received accreditation from the Commission on Accreditation of Medical Transport Services (CAMTS), the only air transport provider in Alaska to receive such accreditation. On flight staff average 15 years ICU and paramedic experience. The company partners with the simulation labs at the University of Alaska to provide training for pilots and medical staff.
- LifeMed's medical teams can provide the following types of medical services: cardiac, trauma, neurological, obstetrics, pediatric, infectious disease, burns, neonatal, and respiratory. Each flight is staffed with a paramedic and trauma nurse. An ongoing challenge is finding qualified trained staff in Alaska.
- Like all air transport providers, the treating physician, often in consultation with the onsite physician's assistant or health aide, makes the decision on a call out, and the facility destination location.
- Response charges include a lift fee and a "patient loaded" fee. The lift fee is a one-time fee that covers the cost of the flight crew and onboard medical equipment and supplies, and is currently \$12,127. The "patient loaded" fee is set to recover incurred costs such as aircraft operation, fuel, etc., and is currently \$82.60 per air mile for transports less than 800 miles, and \$55.13 per air mile for transports over 800 miles. For rotary craft the lift fee is \$16,631 and the load fee is \$174.70 per mile.
- Mr. Kirby believes LifeMed's charge master is significantly less than some of the company's other competitors in Alaska. He believes that this is because the operation is not viewed as a profit center by the company's principles.
- The payer mix in Alaska is 54% CMS; 10% private insurance; 2% government insurance (includes workers' compensation); 10% IHS; 10% self-pay, and 14% no-pay. As with Guardian, LifeMed relies on full payment by 20% of the payers to offset reduced payment from self-pays and no-pays. LifeMed does have

negotiated pricing with some payers, including Blue Cross, Aetna, United Healthcare, and the VA. The company also reduces for fast-pay, usually on a contractual case-by-case basis.

- Mr. Kirby stated he understands the concerns of the 20% mix that pays the lion's share of incurred costs, but the reality is that without these payers paying at the full charge master, LifeMed – like most carriers – would not be able to sustain their level of service. He also agreed with the comment made by Mr. Barry that fee schedule changes mid-year could have a detrimental impact to LifeMed because CY2015 budgets were set on established fee schedules. He also expressed concerns with tying a fee schedule to CMS because there is going to be continued pressure on the federal government and ultimately the states to reduce Medicaid and Medicare payments.

X. Fee Schedule Development Discussion

- Dr. Foland commented that the whole state is looking at what the MSRC is doing. Workers' compensation fee schedules have traditionally been set at 90% UCR. If workers' compensation significantly reduces below this amount, health providers may follow suit by seeking reductions from the standard 80% UCR to lower levels as well. If the Committee does anything other than budget neutral, others will follow suit. It will be a ripple effect that the committee members need to be aware of. Dr. Hall stated he is hearing the same comments.
- Dr. Foland observed that the frequency of injuries has continued to decline, but that medical costs continue to rise. Costs are determined by fees times utilization. So the real "bang for the buck" after setting fee schedules would be to address utilization.
- Member Smith responded that he too believes over-utilization needs to be addressed, but doesn't see the connection between what's being charged for treatment in workers' compensation and general health. Part of the reason for HB316 is because workers' compensation fee schedule reimbursement rates are significantly higher than general health. The intent is to bring workers' comp in line with general health. Why would general health react by lowering reimbursement rates based on what workers' compensation does?
- Optum's data analysis shows that RV budget neutral conversion factors are between the 75th and 80th percentile of FH data. So, even though the existing workers' compensation fee schedule was based on FH data from June 2010, it is apparent that providers are not billing at the full fee schedule allowance.
- Member Smith opined that the fee schedule should be based on the current paid rates, based on the data, and see who the winners and losers are. Member Scott concurred. The Optum analysis indicates a CF of 126.8798 would be budget neutral. She recognizes that there will be winners and losers, but the Committee has to pick a starting point and go from there.
- Member Smith pointed out that the budget neutral CF's are based on billed data, he would prefer to see them based on NCCI's paid data, which would bring the CF down. There was general discussion that Optum's data does not match what NCCI and the Division have reported as total medical spend.

Optum acknowledged that there is a \$12.7 million difference, primarily due to procedure codes that are not cross walked in CMS CY2015 RV's. Director Monagle stated that the Division's annual report reflects \$179.7 million in total medical spend in CY2013. Ms. Gee stated again that Optum's analysis excludes data that did not cross walk to CMS 2015 RV's, **excludes certain modifiers (50 and 51)**, and facility pricing. It was also pointed out that NCCI data excludes self-insured data. Mr. Monagle says the self-insured medical spend in CY2013 was reported at \$47.0 million.

- Ms. Gee asked whether the committee wishes Optum to build a fee schedule, and develop custom RV's for gap fills (missing CPT RV's, lab/pathology fees, and DME). The other option would be to use CMS fee schedules and let billers and payers do the calculations. Dr. Pfeifer opined that the preferred method should be one that is easy for billers and payers to navigate, at the lowest cost to the State to implement. Ms. Gee responded that the simplest method would be to use information that is publically available, which would be the CMS schedules.

Break 3:03pm-3:23pm

- There was a general discussion on NCCI charge and paid data in Optum's analysis in light of what has been reported by the Division in their annual report data collection. As previously noted, Optum's analysis does not include facility pricing, HCPCS codes, and certain modifiers. Ms. Gee will look at the data further and get back to the committee.
- Director Monagle opined that the goal is to utilize CF's that achieve budget neutrality based on the current worker's compensation fee schedule. Tab 'CF by service area' calculates the CF's for each service area, and a single aggregate CF for all service areas. Ms. Gee noted that even using the calculated CF for each service category, there will be some winners and losers because each CF is an average. However the swings will be less than using a single conversion factor. Dr. Hall agreed, noting that the difference in calculated CF's by service category are significant, and opined using a single CF will result in very significant gains and loses. He suggested starting off with multiple CF's and migrating toward a single CF after several years. Dr. Foland asked if other states have phased in conversion. Ms. Gee responded that Connecticut phased in CF's over a four year period. It was noted that California and Idaho also phased in CF's. Member Scott recommended using multiple CF's with the goal of moving toward a single CF in several years. Dr. Foland wondered if the committee could still identify one CF, but give service categories a percentage over or under to mitigate significant pricing swings. Dr. Pfeifer agreed that using a single CF preserves the RV methodology.
- Director Monagle recommends using CMS fee schedules plus a multiplier for HCPCS and pathology and laboratory, and developing rules for coding stop gaps. Under the current fee schedule this is done "by report". Dr. Foland expressed concern with using CMS fee schedules, as the CMS reimbursement rates don't come close to covering costs.

- There was final discussion on whether the committee would like to split professional services out for facility and non-facility pricing. Director Monagle stated that workers' compensation fee schedules have historically not split out professional services, however the final decision is up to the Committee. The Committee will also have to decide whether it wishes to allow separate billing for implants, as Idaho allows.

XI. Other Business

- The Committee discussed when to hold its next meeting. The next meeting is scheduled for December 19th. However, because Optum's facility analysis will not be available until the end of the month, and since Ms. Gee needs time to make adjustments to Optum's non-facility analysis, it was recommended to cancel the 12/19 meeting and meet next in mid-January.
- After discussion, the Committee elected to meet again on January 15th and 16th, 2015. On January 15th the Committee will review Optum's facility and non-facility analysis, then will have the rest of that day and the following day to make conversion factor recommendations.
- There was discussion whether the Committee members may share Optum's analysis with their constituent groups. Director Monagle and Ms. Gee concurred that the Committee could not share the NCCI and FH data without written approval, but they could share the analysis – such as the pivot table values and conversion factors calculated by Optum.
- Dr. Foland asked that Optum provide a user's guide to their spreadsheet as soon as possible. Dr. Pfeifer also asked that Optum add functionality to the spreadsheet that would allow users to plug in conversion factors and see what impact that would have on CPT codes so that he could share the results with his constituents.

Meeting Adjourned 4:25 pm