WOEMA Readies for Fee Schedule Debate

By Don Schinske, WOEMA Lobbyist

California’s Division of Worker’s Compensation has released its update from the Lewin Group that reports on changes in reimbursement expected from a switch from the Official Medical Fee Schedule (OMFS) to an RBRVS-based payment system. Under the Lewin Group modeling, the adoption of a single-modifier, RBRVS-based schedule with no new dollars added to the system would boost payments for Evaluation & Management (E & M) codes by 20 percent.

Payments for the surgical codes, on the other hand, would drop 25.9 percent. This dynamic set the stage for debate among the physician specialties in the coming months. WOEMA and its primary care allies will fight for the long-overdue increase in E & M payments while other specialties will aim to protect existing reimbursement levels.

Those tensions surfaced May 19 and 20, at two informational hearings on the Lewin update in Los Angeles and Oakland. The authors noted that their work, so far, has been based on a dollar-neutral assumption, and that more modeling will be forthcoming based on various levels of expanded overall expenditures. The question of new dollars is important: the easiest path politically for WOEMA and its allies is one in which E & M reimbursement can be raised with little or no effect on surgical payments. DWC Medical Director Dr. Anne Searcy explained that the Division has made no decision yet about expanding the pool of available dollars. She noted that DWC is already starting to informally calculate some possible increases, and that the Lewin Group will now crunch out several alternatives.

At the May 20 hearing in Oakland, WOEMA advocate Don Schinske pressed DWC and the Lewin authors on two points:

• That all additional modeling done by the Lewin Group incorporate the 28 percent increase in physician work and practice costs associated with the practice of occupational medicine relative to the similar code payments in Medicare. This disparity was noted in the original 2002 Lewin Group report on the fee schedule, but was not incorporated in the update. WOEMA noted that this component of the RBRVS payment calculation has likely increased under the system reforms of 2004, and continues to rise owing to such regulatory changes as the
newly proposed PR-2 form, which requires additional reporting and assembly time.

• That the discussions on RBRVS conversion include information from other states about any changes in utilization, patient satisfaction, and return-to-work measures that occurred after their own switch to an RBRVS system. That is, are there other things besides making physician pay more equitable to recommend the RBRVS switch?

For their part, representatives from the surgical specialties argued that the fee schedule should not reduce payment for the procedural codes to the point where patient access to care is affected. The Lewin authors – Al Dobson and Pete Welch, chiefly – noted that the use of multiple conversion factors is frequently used to “soften” the blow of an RBRVS conversion. However, WOEMA and its allies will continue to argue that the use of multiple conversions would serve only to lock in the existing disparities.

And so the debate, as the process begins in earnest over the next couple of months, will focus on several factors in the fee schedule:

• Whether the new schedule will come with new dollars overall, or will simply reallocate the current reimbursement pie.
• The number of conversion factors
• The so-called “ground rules,” meaning the specific payment rules for particular codes (i.e., the cascading downward of payments for multiple similar procedures).
• Effects of the changes on patient access (i.e., potential decline in participation by surgeons, versus the potential increase in participation by psychologists and psychiatrists).

Dr. Searcy did make one point clear at the meeting: DWC has no plans to adopt the Medicare modifier for the schedule, both because the Medicare modifier does not translate well to occupational health, and because of political vicissitudes of Medicare funding.

The Medical Director did urge stakeholders to submit comments on the Lewin Report, suggestions for additional modeling, their own office data, and other comments to herself and Administrative Director Carrie Nevans.

At the hearing WOEMA spoke directly with representatives from the other specialties, offering to work together toward a common recommendation. Such discussions will occur as well within the CMA’s Workers
Compensation Technical Advisory Committee, where WOEMA Legislative Chair Steve Schumann, MD, holds a seat.

Also on the regulatory front, WOEMA issued an alert to members urging them to contact DWC and oppose the Division’s proposed changes to the PR-2 form. The new form includes a “discussion” section in which the provider must explain why the particular treatment was ordered, as well as a requirement that all prior treatment orders for that injury be attached. WOEMA has no issue with the intent of the change – which is to ensure a sound basis for treatment – but is opposed to the extra work required absent any adjustment in the fee schedule. Indeed, the basic problem with the proposed change, as well as the adoption of the restrictive pharmacy fee schedule last year, is that even rational fixes to the current system are unduly burdensome unless payment for the basic Work Comp visit codes gets fixed.

Pending changes in the draft regulations by the Division, WOEMA will oppose their adoption through the formal hearing process.

On the Legislative front, WOEMA this month issued a letter to Hawaii Governor Linda Lingle, urging her to sign HB 2929. The bill provides that employers and employees agree upon an independent medical examiner, which is a switch from current arrangement of employer choice. WOEMA expects to continue to provide input to the Hawaii lawmakers in their longstanding, often contentious efforts, to reform one of the more expensive Workers’ Comp programs.