

MINUTES OF IWCC MEDICAL FEE ADVISORY BOARD  
IWCC CHICAGO OFFICE, ORAL ARGUMENT ROOM  
HELD ON FEBRUARY 22, 2007

Present at the meeting were:

Chairman Dennis Ruth  
Ms. Maddy Bowling, Employer Representative  
Ms. Elena Butkus, Medical Provider Representative  
Mr. Eric Dean, Employee Representative  
Mr. John Smolk, Employer Representative

Participating via conference call were:

Mr. Ronald Powell, Employee Representative  
Ms. Kathryn Tazic, Employer Representative

Other attending IWCC board members were:

Mark Flannery, Workers' Compensation Advisory Board (on conference call)  
David Menchetti, Workers' Compensation Advisory Board  
Kim Presbrey, Workers' Compensation Advisory Board

IWCC staff present at the meeting were:

Mr. Glen Boyle, Medical Fee Schedule Project Manager  
Kathryn Kelley, IWCC General Counsel  
Susan Piha, IWCC Research and Education Manager

~~~~~

Chairman Ruth called the meeting to order at 9:18 a.m.

Copies of the notice and agenda were distributed, along with past meeting minutes; handouts from Glen Boyle regarding the hospital outpatient fee schedule and Ambulatory Payment Classification (APC) payment rates; explanation of benefits form from the Texas Department of Insurance Division of Workers' Compensation; standard UB-92 claim form used by hospitals to bill for inpatient and outpatient services; and a memo directed to the Medical Fee Advisory Board from Charles Burnham and Jennifer Tronc with Liberty Mutual regarding provider payment.

Upon motion duly made, seconded and unanimously carried, the minutes of the Board meeting held on December 7, 2006 were approved as presented.

The Chairman first welcomed David Grant from the Division of Insurance (DOI) who was participating via conference call to obtain a better understanding of overlapping issues between the Commission and DOI, including explanation of benefits and payment policies.

Next, the Chairman spoke about the fee schedule as a whole. He noted that approximately \$1.25 billion in medical bills go through the workers' compensation system each year, and the system

continues to move forward and appears to be working well with the new fee schedule in place. He added that concerns would continue to be addressed as the fee schedule is still in its early stages. He then asked Glen Boyle, medical fee schedule project manager, to provide an overview of the development of the new medical fee schedules.

Mr. Boyle first spoke about the new outpatient nonsurgical treatment fee schedule including diagnostics, pathology and lab, and PT and indicated the schedule has been completed by Ingenix. He next spoke about the development of hospital outpatient surgery fees, which were created using data from the Illinois Department of Public Health. This data was the most comprehensive set found with 633,000 records, the most credible, largest, and cohesive dataset that could be found.

Mr. Boyle explained the key components in the IDPH data included the following:

1. identification of the procedures performed in every operative setting of those records;
2. identification of the total dollar amount associated with those operative settings; and
3. the removal of implants and other pass-through codes amounts as addressed earlier in the DRG inpatient fee schedule.

The fee schedule was calculated using ICD9 codes (Volume 3 codes), similar to diagnosis or procedural codes. Boyle indicated that codes are of a questionable value in 2007, as many hospitals do not use the CPT (HCPCS) coding system. In fact, if CPT codes were utilized, a rule would need to be implemented requiring hospitals to return to this older coding system.

Due to the importance of utilizing new codes with the medical fee schedule, Mr. Boyle recommended a different coding system. Another coding system is available similar to DRG and related to CPT codes are Ambulatory Payment Classifications (APC) codes. Mr. Boyle was able to crosswalk the codes from ICD9 to CPT to APC using a standard grouper, IRP from Ingenix. Mr. Boyle identified the ICD9 codes that only group to one APC code, then used the CMS relative weights for each APC, and calculated a conversion factor for each geozip that can be applied to all the APC codes. Similar to the anesthesia code, a single conversion factor was established for each geozip that can be used with the entire APC system. Because established and accepted rules regarding APCs already exist allowing the Commission to use these APC amounts with set guidelines, the codes can be easily adopted and utilized.

The board discussed the development of the rules by CMS. The Chairman noted that hospitals are following standard billing practices regardless of whether it is related to workers' compensation or Medicare. Mr. Boyle indicated that every hospital has the capability of attaching APC codes for billing purposes. The Chairman noted he would discuss this issue further with the Illinois Hospital Association.

Mr. Boyle provided the board with examples of how the new code would work. He explained that a conversion amount was established for each geozip, and each APC code would be assigned a weight. The calculation of the fee amount would be determined by multiplying the conversion amount by the weight. The current formula only applies to hospitals, and another formula would be created for Ambulatory Surgical Treatment Centers (ASTC), after a cost comparison analysis using data from IDPH or CMS was completed to develop an exact equation.

The board discussed posting the calculated fees on the Internet, and also the importance of educating providers about payment rates to eliminate confusion. The Chairman indicated that the Commission would actually perform the calculations so the internet would have the actual

fees listed and not require payers or providers to perform the calculations, which should avoid confusion.

The board voted unanimously to accept questions from the audience regarding the fee schedule.

After a short break, the board next discussed the issue of American Medical Association (AMA) code changes due to certain treatment codes no longer being valid. Maddy Bowling discussed three reasons for codes changes, including the following:

1. elimination of codes due to elimination of treatment
2. replacement of code numbers
3. new codes due to new procedures

Ms. Bowling noted when codes numbers are simply replaced; the new numbers automatically become 76 percent of charge, which may impact cost savings. She requested these codes be reviewed on an annual basis. Mr. Boyle noted only a small percentage of these codes are involved and offered to review the data to determine what codes could be addressed and would brief the board on his findings.

Next the board discussed the issue of balance billing forms. Eric Dean indicated that labor had reviewed the forms and he was in favor of the Commission posting information on the IWCC web site regarding injured employees' rights. Mr. Dean noted that labor would have consensus on the form at the next meeting. David Menchetti also noted he continues to discuss this form with Michael Carrigan, AFL-CIO President.

The board then discussed the subject of payment policies including explanation of benefits (EOB). The Chairman noted that Mark Flannery had outlined his concerns regarding significant costs involved with providing EOB for each and every bill, especially when the majority of workers' compensation claims are not disputed.

Some members discussed concern over the costs of requiring 1 standard EOB as it was indicated that many carriers already provide an EOB, though in several different formats. Instead, it was suggested carriers are required to include certain specific information as opposed to a specific format.

The board discussed DOI oversight of carriers with David Green. Mr. Green indicated providers can contact DOI any time regarding contractual discounts. Mr. Green noted that DOI will take action against any intermediary taking additional monies that are not contractual. He said a link is available on DOI's web site to file a complaint, and anyone may contact Mr. Grant directly with a complaint at (217) 782-6369.

In further discussion of EOBs, Ms. Butkus suggested requiring EOBs to include information regarding which contract the payment is being reimbursed against. Mr. Menchetti suggested setting requirements for EOBs. Additionally, the board discussed the process Wisconsin's Department of Workforce Development (DWD) uses to review disputes between payer and provider

The Chairman requested that each group submit a proposal at the next meeting regarding suggestions for EOB requirements.

Next a prompt payment proposal submitted by the business group was discussed. The proposal would help to clarify when interest is applied, at what rate, and related requirements.

The board also discussed data elements that providers should be required to submit to payers. Mr. Grant noted that the Equity and Provider Contracting Act set specific standards for notification and specific standards for an appeal protocol, though not specific to workers' compensation. The board discussed specific documents that providers could be required to provide, including medical record, chart notes, emergency room, and other reports.

A date for the next board meeting was set for May 17 at the same location and time.

There being no further business, the meeting adjourned at 12:00 noon.