A Report on Methodology for the Department of Labor and Industrial Relations' Workers' Compensation Medical Fee Schedule

A Report to the Governor and the Legislature of the State of Hawai‘i

Report No. 13-10
December 2013

THE AUDITOR
STATE OF HAWAI‘I

Office of the Auditor

The missions of the Office of the Auditor are assigned by the Hawai‘i State Constitution (Article VII, Section 10). The primary mission is to conduct post audits of the transactions, accounts, programs, and performance of public agencies. A supplemental mission is to conduct such other investigations and prepare such additional reports as may be directed by the Legislature.

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4. Sunrise analyses are similar to sunset evaluations, but they apply to proposed rather than existing regulatory programs. Before a new professional and occupational licensing program can be enacted, the statutes require that the measure be analyzed by the Office of the Auditor as to its probable effects.

5. Health insurance analyses examine bills that propose to mandate certain health insurance benefits. Such bills cannot be enacted unless they are referred to the Office of the Auditor for an assessment of the social and financial impact of the proposed measure.

6. Analyses of proposed special funds and existing trust and revolving funds determine if proposals to establish these funds are existing funds meet legislative criteria.

7. Procurement compliance audits and other procurement-related monitoring assist the Legislature in overseeing government procurement practices.

8. Fiscal accountability reports analyze expenditures by the state Department of Education in various areas.

9. Special studies respond to requests from both houses of the Legislature. The studies usually address specific problems for which the Legislature is seeking solutions.

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Report No. 13-10, December 2013

Increased use of data will drive a more comprehensive fee review process

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While expenses have been slowly increasing for health care providers, legislated payment updates have remained flat since 2011.

Departmental Review of Transacted Medical Codes Would Ensure a Data-Driven Fee Schedule

Act 97, Session Laws of Hawai'i 2013, requires the State Auditor to assist the director of labor in administratively adjusting the workers' compensation medical fee schedule. In this report, our first of two responding to Act 97, we recommend a formalized process for the mandatory periodic review of Hawai'i's Workers' Compensation Medical Fee Schedule. State law requires employers to compensate an employee who is injured by accident or disease while on the job. Employers are also bound to furnish medical care, services, and supplies to employees as the nature of the injuries require. Liability of an employer for medical care, services, and supplies is limited to charges up to 110 percent of the federal Medicare fee schedule applicable to Hawai'i. The director uses the Medicare fee schedule to determine the charges for medical care and services in workers' compensation cases. Hawai'i law requires the director to update the fee schedules at least once every three years.

After working closely with the Department of Labor and Industrial Relations, we determined that the use of better data could enhance the existing fee schedule review process. Specifically, we recommend collecting and analyzing transacted current procedural terminology code data. Not only will such data capture paid physician and other health care professional services and procedures, it also represents the universe of medical services actively being delivered by health care providers in workers' compensation cases. We also propose establishing a second maximum allowable fee ceiling for Evaluation and Management (E/M) medical services. E/M services are the entry point for medical treatment in workers' compensation cases. The second fee ceiling will only apply to E/M services that have been identified by stakeholders as applicable to workers' compensation cases.

Department would need additional resources to annually review and adjust the fee schedule

Our methodology requires department personnel to annually collect, correlate, and analyze transacted CPT code data from five different sources. This differs from its current process, which involves a comprehensive review of a fixed number of codes every three years. Moreover, an annual review process must continue to fulfill statutory requirements of Chapter 201M, Hawai'i Revised Statutes (HRS), to determine the impact on small business, and of Chapter 91, HRS, to adopt administrative rules. As previously noted, the fee schedule resides in administrative rules. We project the department would need additional personnel resources both to continuously review and analyze CPT code data and determine small-business impact and adopt the department's administrative rules.

The 2013 Legislature funded 14 positions for the department beginning in January 2014; however, these positions will only partially restore the division's staffing to its pre-2009 levels. Although one of the restored positions is a research statistician in the Research and Statistics Office, this position will assume duties currently performed by the existing research statistician. For the office to effectively implement an annual fee schedule review, an additional research statistician III position should be added.

Agency response

We transmitted a draft of this report to the department on December 13, 2013. The department offered technical changes to the draft, but generally concurred with the proposed methodology and recommendations.

Response

Prior Audits

For the full text of this and other reports, visit our website: http://auditor.hawaii.gov/

A Report on Methodology for the Department of Labor and Industrial Relations' Workers' Compensation Medical Fee Schedule

A Report to the Governor and the Legislature of the State of Hawai‘i

Submitted by

THE AUDITOR
STATE OF HAWAI‘I

Report No. 13-10
December 2013

Foreword

Act 97, Session Laws of Hawai‘i 2013, requires the State Auditor to assist the director of labor in administratively adjusting the workers' compensation medical fee schedule. In this, our first of two reports, we recommend to the director and the Legislature a formalized process for the mandatory periodic review by the director of the medical fee schedule or certain fees in the schedule.

We wish to express our appreciation for the cooperation and assistance extended by the officials and staff of the Department of Labor and Industrial Relations, the Department of Human Resources and Development, the Department of Education, the University of Hawai‘i, the City and County of Honolulu, the National Council on Compensation Insurance, and other organizations and individuals whom we contacted during the course of our project.

Jan K. Yamane
Acting State Auditor

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Chapter 1
Introduction

Act 97, Session Laws of Hawai‘i (SLH) 2013, requires the State Auditor to assist the director of labor in administratively adjusting the workers' compensation medical fee schedule. The act makes two requests of the Auditor. First, by January 1, 2014, the Auditor is required to recommend to the director and the Legislature a formalized process for the mandatory periodic review by the director of the medical fee schedule or certain fees in the schedule. This report delivers on the first request.

Second, by June 1, 2014, the Auditor is required to consult with the director to identify: 1) the medical or health care services or procedures for which fee adjustments are necessary to ensure that injured employees have better access to treatment; and 2) a methodology for conducting the statistically valid surveys of prevailing charges that are necessary for adjustment of the fees. The Auditor is then required to apply the methodology and recommend adjusted fees to the director. We will deliver a separate report to the director and the Legislature that responds to the second request.

Background

Workers' compensation law

Hawai‘i's workers' compensation law requires employers to compensate an employee who is injured by accident or disease while on the job. Hawai‘i employers are also bound to furnish medical care, services, and supplies to employees as the nature of the injuries require.

Liability of an employer for medical care, services, and supplies is limited to charges up to 110 percent of the federal Medicare fee schedule applicable to Hawai‘i. The director uses the Medicare fee schedule to determine the charges for medical care and services in workers' compensation cases. The director may also establish an additional fee schedule if charges under the Medicare program are considered unreasonable or if a medical treatment, service, accommodation, or product is not covered by Medicare. Hawai‘i law requires the director to adopt and update medical fee schedules via administrative rules, which the director has done. Charges in the additional fee schedule cannot be more than the prevalent charge for fees for services actually received by health care providers. Administrative rules refer to the additional schedule as the *Workers' Compensation Supplemental Medical Fee Schedule*, or *Exhibit A*.

The law also requires the director to update the fee schedules at least once every three years. Updates are based on changes made to the Medicare fee schedule by the U.S. Department of Health and Human Services, or on a statistically valid survey performed by the director of prevalent charges of fees for services received by health care providers. In lieu of a survey, the director may also base fee schedule updates on information provided by an appropriate state agency having access to prevalent charges for medical fee information. The primary guideline for establishing prevalent charges is a schedule of all maximum allowable medical fees provided to the director by a prepaid health care plan contractor. A *prepaid health care plan* is defined in statute as any agreement by which any prepaid health care plan contractor undertakes, in consideration of a stipulated premium, to furnish health care or to defray or reimburse the expenses of health care. A *prepaid health care plan contractor* is any medical group or organization, non-profit organization, or insurer that undertakes a prepaid health care plan to provide health care.

State legislative actions

Hawai‘i’s workers’ compensation law was first enacted in 1915 and has undergone extensive changes over the years. Workers’ compensation is the first form of no-fault insurance for workers in the United States. It was initially needed to protect workers against the physical and economic hazards inherent in a rapidly growing industrial society. The 1995 Legislature made changes to the law in response to rising medical costs and insurance rates. Specifically, the 1995 Legislature addressed eight areas in the workers’ compensation program to provide fair and reasonable compensation to injured workers and reduce costs: 1) safety and prevention; 2) medical costs containment; 3) indemnity; 4) compensability; 5) insurance reform; 6) abuse and fraud; 7) dispute resolution; and 8) administrative changes.

The 1995 Legislature also eliminated using the Consumer Price Index as the criterion to increase the workers’ compensation medical fees. At that time, the Department of Labor and Industrial Relations (DLIR) claimed that the automatic cost of living adjustments resulted in a workers’ compensation medical fee schedule that was 142 percent of the national average and more than 200 percent of Medicare charges. In its place, the Legislature capped workers’ compensation medical fees at 110 percent of Medicare charges. The 1995 Legislature also empowered the director to establish additional fee schedules other than the Medicare fee schedule, but those charges may not exceed the prevalent charge for fees for services received by health care providers.

Medicare Program

Title XVIII of the federal Social Security Act, designated *Health Insurance for the Aged and Disabled*, is commonly known as Medicare. Part of the Social Security Amendments of 1965, the Medicare legislation established a health insurance program for aged persons. Medicare originally consisted of two parts: *hospital insurance*, also known as Part A, and *supplementary medical insurance*, known as Part B. Part A is generally provided automatically and free of premiums to persons aged 65 or older who are eligible for Social Security or Railroad Retirement benefits and helps pay for inpatient hospital, home health agency, skilled nursing facility, and hospice care. Part B helps pay for physician, outpatient hospital, home health agency, and other services. To be covered under Part B, all services must be either medically necessary or one of several prescribed preventive benefits. Part B services are generally subject to a deductible and coinsurance. Part B generally pays 80 percent of the Medicare-approved amount for covered services after the Part B deductible has been met, with the exception of most preventative services, where Medicare pays 100 percent.

Medicare fee schedule

Physicians were originally paid for Part B services on the basis of reasonable charge; however, beginning January 1992, allowed charges have been defined as the lesser of 1) the submitted charges or 2) the amount determined by a fee schedule based on a relative value scale (RVS). A fee schedule is a comprehensive list of maximum fees used to pay providers, suppliers, physicians, or other enrolled health care providers on a fee-for-service basis. The Medicare Physician Fee Schedule is the primary method of payment for enrolled health care professionals. In practice, most allowed charges are based on the fee schedule, which is supposed to be updated each year by a sustainable growth rate (SGR) system prescribed in federal law.

Noridian Healthcare Solutions is the Medicare administrative contractor for a group of states including Hawai‘i. The revised Medicare Physician Fee Schedule (MPFS) for Hawai‘i can be accessed on Noridian’s website.

Current procedural terminology codes

The MPFS for Hawai‘i uses current procedural terminology codes (CPT). The CPT code set is the most widely accepted nomenclature for reporting physician procedures and services under government and private health insurance programs. In 2000, the CPT code set was designated by the U.S. Department of Health and Human Services as the national coding standard for physician and other health care professionals. The CPT code set is useful for administrative management purposes such as claims processing and for developing guidelines for medical care review.

Although an updated CPT code set is published annually in late summer or early fall, the effective date is January 1st to allow physicians and other providers, payers, and vendors to incorporate changes into their systems.

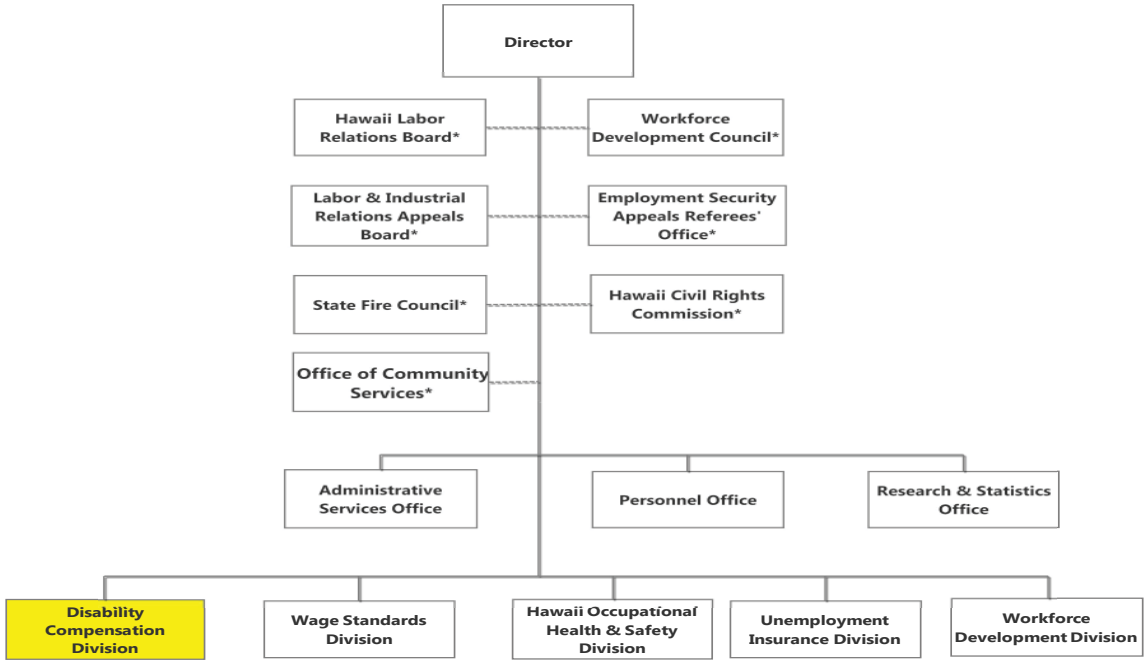
The CPT code book is arranged by medical service categories. In fact, codes under the medical service category of evaluation and management (E/M) services served as a key component in addressing one of our project objectives. The E/M services codes are placed in broad categories such as office visits, hospital visits, and consultations. Stakeholders we spoke with, including insurers and health care providers, agreed that E/M codes represent the entry point to medical treatment for workers' compensation cases.

Department of Labor and Industrial Relations operational structure

The Department of Labor and Industrial Relations is charged with administering programs designed to increase workers' economic security, and their physical and economic well-being and productivity; and to achieve good labor-management relations, including administering workers' compensation.

As of July 1, 2013, the department has five divisions and seven attached agencies, as shown in Exhibit 1.1. The most relevant to this project is the Disability Compensation Division.

Exhibit 1.1
Department of Labor and Industrial Relations Organizational Chart



*Administratively attached
Source: Department of Labor and Industrial Relations and Office of the Auditor

Disability Compensation Division

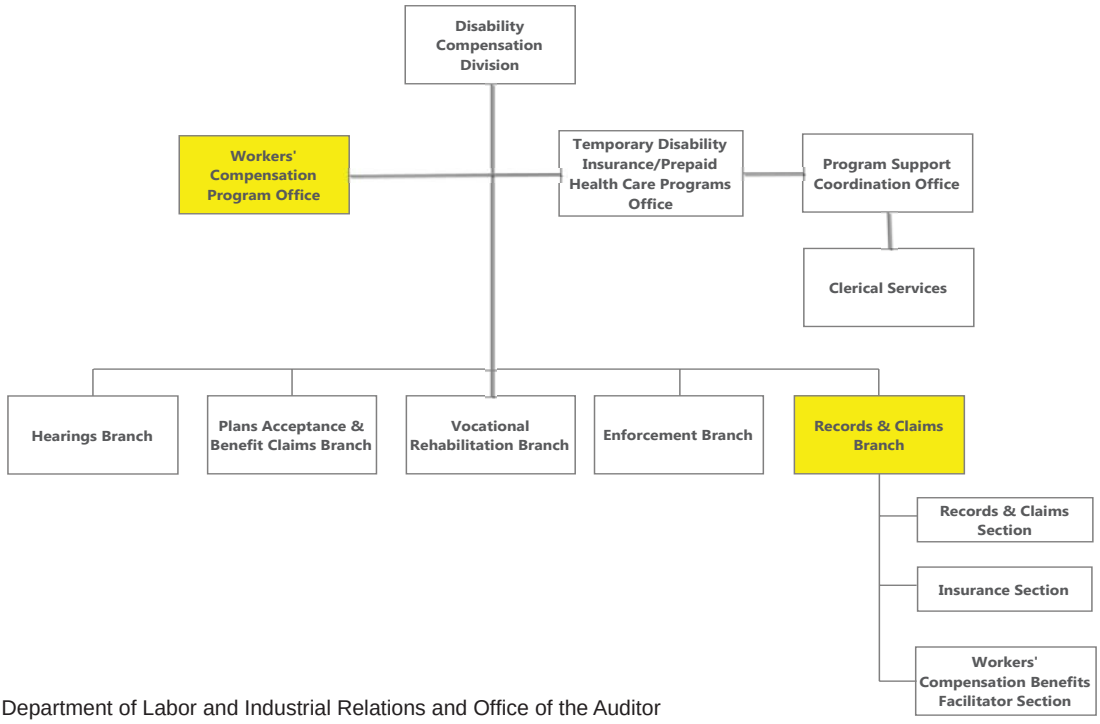
The Disability Compensation Division (DCD), which has a total of 85 positions, administers the workers' compensation, temporary disability insurance, and prepaid health care laws. The division has three program offices, one of which—the Workers' Compensation Program Office—supports the Workers' Compensation Program.

The Workers' Compensation Program Office is responsible for coordinating statewide activities relating to workers' compensation. A program chief and two program specialist positions work under the direction of the DCD administrator. The office also establishes necessary policies and guidelines for Workers' Compensation Program effectiveness and efficiency and proposes legislative and rule changes to improve, clarify, or expand the Workers' Compensation Program.

The division oversees five branches: Hearings, Plans Acceptance and Benefit Claims, Enforcement, Records and Claims, and Vocational Rehabilitation. The Records and Claims Branch processes workers' compensation claims.

Exhibit 1.2 shows the organization of the Disability Compensation Division.

Exhibit 1.2
Disability Compensation Division Organizational Chart



Source: Department of Labor and Industrial Relations and Office of the Auditor

The Records and Claims Branch has three sections:

1. ***Records and Claims Section***. This section counsels and assists employees in filing workers' compensation claims, receives and examines requests for commutation of payments, and makes recommendations for approval or disapproval. The section also receives, reviews, processes, and files reports from employers, insurers, physicians, and other sources; issues claim number memos to carriers; maintains control of records; provides copies of records to interested parties; determines record storage requirements; and coordinates storage of reports with the Department of Accounting and General Services' Archives Division. This section has a clerical supervisor and seven office assistant positions;

2. ***Insurance Section***. This section ensures all employers secure coverage through an insurance carrier or by self-insurance and maintains liaisons with the insurance commissioner on matters relating to carriers authorized and licensed to conduct the business of workers' compensation insurance in Hawai‘i; and

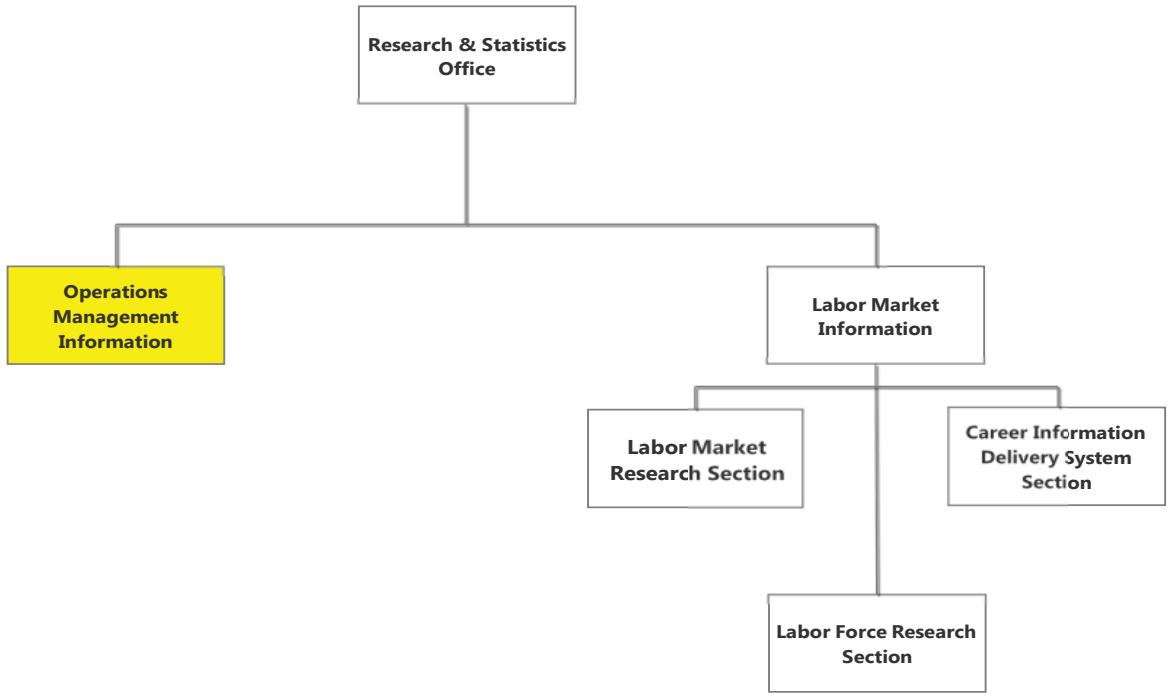
3. ***Workers' Compensation Benefits Facilitator Section***. This section facilitates the workers' compensation process to ensure claims are processed expeditiously by responding to inquiries from claimants, attorneys, representatives of insurance carriers, and employers.

Research and Statistics Office

The department's Research and Statistics Office is one of three departmental support offices. It conducts data-gathering activities and research, and maintains statistics on the labor force, the labor market, employment, occupations, and industries in Hawai‘i. The office has 35 positions, ten of which are vacant and two of which are borrowed from the Workforce Development Council. As shown in Exhibit 1.3, staff are divided into two areas, one of which—Operations Management Information—provides partial support to DCD.

Operations Management Information provides research and statistical services on matters related to core programs administered by DLIR's line divisions, the U.S. Department of Labor, and federal contracts. Other services provided include developing program and administrative data, conducting data validation, and maintaining and providing analysis from management information systems. Operations Management Information includes a position within the DCD to code workers' compensation cases characteristics for the Disability Compensation Information System (DCIS) and the DCD Lotus Notes database; maintains the annual workers' compensation data base for DCD ad hoc reports, the Hawai‘i Occupational Safety and Health Division, Wage Standards Division,

Exhibit 1.3
Research and Statistics Office Organizational Chart



Source: Department of Labor and Industrial Relations and Office of the Auditor

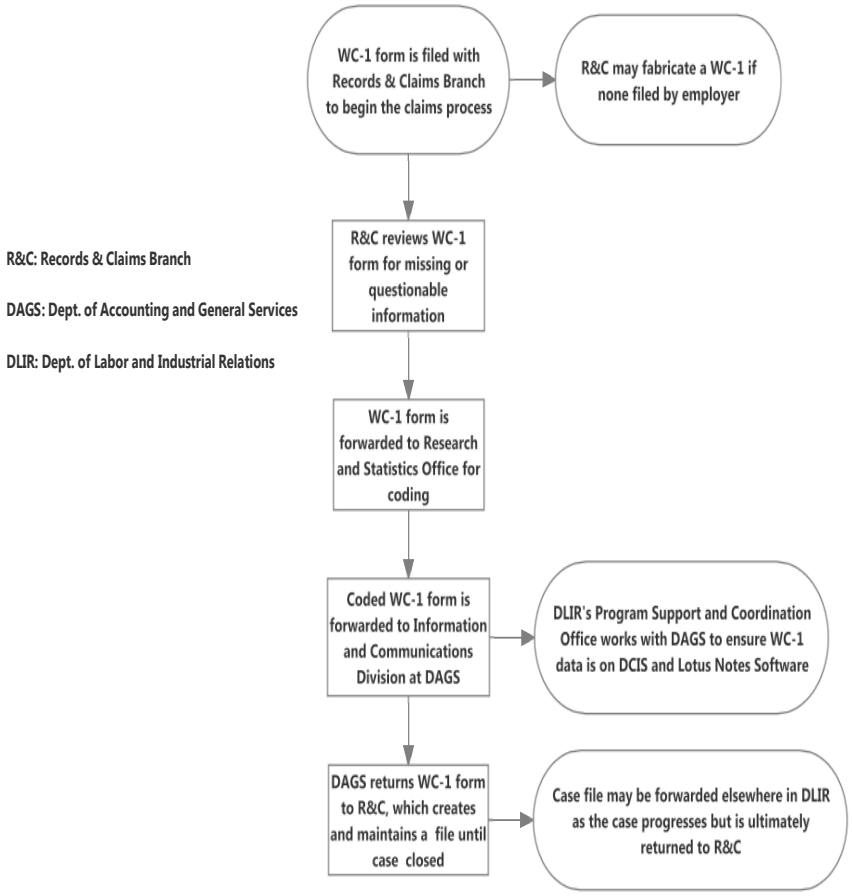
and the Director's Office. A research statistician IV is the lone position in Operations Management Information with responsibilities associated with the medical fee schedule.

Workers' compensation claims process

When an employee is injured on a job, the employer files a WC-1 form with its insurance adjuster, who reviews and forwards it to DCD. The WC-1 form is reviewed by the Records and Claims Section for irregularities or erroneous data, then sent to the Research and Statistics Office, which enters the appropriate codes for the employee's occupation, source of injury, part of the body injured, and nature of the injury. The form is returned to Records and Claims, which batches the forms for the Information and Communication Services Division (ICSD) at the Department of Accounting and General Services (DAGS). The Program Support and Coordination Office works with DAGS to ensure WC-1 information is accessible through the DAGS DCIS software and on Lotus Notes. Finally, DAGS returns the WC-1 forms to Records and Claims to create a file for each form, store, and maintain the documents until the case is resolved.

Exhibit 1.4 presents a flow chart of the general process involved in filing a workers' compensation claim.

Exhibit 1.4
Workers' Compensation Claim Process Flow Chart

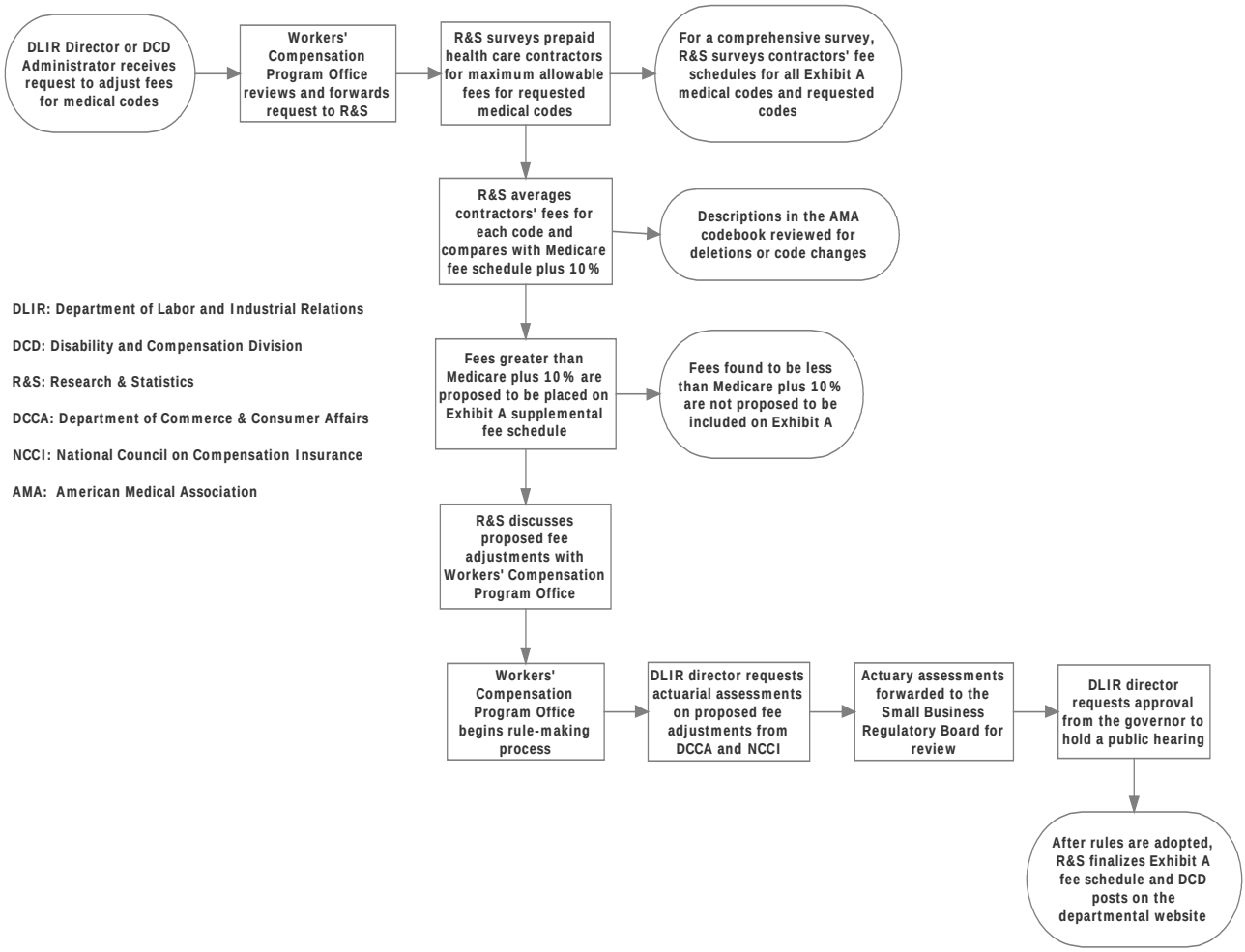


Source: Department of Labor and Industrial Relations and Office of the Auditor

Medical fee schedule review process

Review of the medical fee schedule for workers' compensation cases can be triggered in any of four ways: 1) by the workers' compensation law requirement to review fee schedules at least once every three years; 2) by a third-party request to raise fees; 3) by recent legislation that affects workers' compensation law; or 4) by issues that require changes to administrative rules. If a review is triggered by the statutory requirement, the Research and Statistics (R&S) Office initiates the process in coordination with the Workers' Compensation Program Office. When a request to increase fees is received, it is reviewed by the Workers' Compensation Program Office and approved by the DCD administrator, then forwarded to R&S as shown in Exhibit 1.5.

Exhibit 1.5
Medical Fee Schedule Review Process Flow Chart



Source: Department of Labor and Industrial Relations and Office of the Auditor

The Prepaid Healthcare Programs Office provides a list of prepaid health care contractors to R&S, which asks contractors for their medical fee schedules. The R&S calculates the survey average for each medical code on the Exhibit A Supplemental Fee Schedule and medical codes that were requested to be reviewed. For a comprehensive survey triggered by law, R&S asks for contractors' entire medical fee schedules and reviews medical codes on the current Exhibit A—including dental codes—as well as any requested codes. The survey average for each medical code is analyzed using the rate under the Medicare fee schedule plus 10 percent, as allowed by state law. If the survey average is more than allowed, R&S recommends the fee be adjusted and placed on Exhibit A. The R&S also converts each adjusted code into a unit value, which is used in Exhibit A. If the survey average for a medical code is less than the rate under the Medicare fee schedule plus 10 percent, the code will fall under the Medicare fee schedule. In addition, R&S reviews CPT code descriptions that could affect fee rates for the codes under review.

After the survey is complete, DCD obtains an actuarial assessment from the Department of Commerce and Consumer Affairs (DCCA) and the National Council on Compensation Insurance (NCCI) on the impact the proposed fee adjustments might have on workers' compensation insurance premiums. Actuarial assessments are then forwarded to the Small Business Regulatory Review Board for review and the Chapter 91, HRS, rules adoption process begins. The Workers' Compensation Program Office administers the rulemaking process, targeting an effective date of January 1st to correspond with the annually updated Medicare fee schedules' effective date.

Medical fee schedule working group

In 2013, DLIR was to conduct a comprehensive review of the fee schedule. However, instead of the usual process, the director organized and empowered a working group of doctors and injured worker organizations to identify CPT codes to review for possible fee adjustment and placement on Exhibit A. The director met with the working group in January 2013 to discuss increasing fees for frequently used procedures. The eight-member group identified 281 CPT codes for review, which was later reduced to 247. Of those 247 codes, 154 were already listed on Exhibit A. The remaining 93 codes would be new additions to Exhibit A. At the time of our report drafting, an October 30, 2013, public hearing on the proposed changes to Exhibit A had not yet taken place.

Based on interviews with the director and the working group, members reached out to colleagues and medical organizations to identify the most commonly used and under-reimbursed medical codes for workers' compensation cases. The group used a list compiled by NCCI of the most frequently used CPT codes as guidance. However, members did not provide us documentation to support which health care providers and organizations were contacted or how many responded. We also received conflicting accounts on whether group meeting minutes exist; we were unable to obtain such minutes. Also, two members told us they did not know whether all the medical codes the group identified had been transacted in the past few years.

Federal fee schedule

The working group asked R&S to base its fee calculations on the federal Office of Workers' Compensation Programs (OWCP) fee schedule instead of Medicare. However, the department was unable to adopt the request because state law requires fees to be set or adjusted based on Medicare or a survey of prevailing charges.

The U.S. Department of Labor's OWCP administers workers' compensation programs that provide benefits for work-related injuries to federal employees, postal service workers, longshoremen, harbor

workers, and employees of the U.S. Department of Energy. A workers compensation specialist with the U.S. Department of Labor told us the federal schedule typically pays 25 to 30 percent more than the Medicare schedule because it pays all medical costs, whereas Medicare uses deductibles in which employees typically pay 20 percent of the cost with the program reimbursing the remaining 80 percent to health care providers. Moreover, OWCP covers hundreds of additional medical codes not included in the Medicare schedule, such as durable medical equipment. Adoption of the federal fee schedule by DLIR would have resulted in an across-the-board fee increase and coverage for hundreds of additional medical services, goods, and treatments.

Prior Reports

We identified seven studies and audits performed by our office on Hawai‘i’s workers’ compensation system since 1984. Four of the seven reports addressed issues surrounding payment of benefits under the system but did not specifically examine the fee schedule. The remaining three reports examined the impact of the 1995 legislative decision to use the Medicare fee schedule to base reimbursements, developed recommendations to ensure health care providers are being adequately reimbursed for treating workers’ compensation cases, and examined whether a correlation exists between the fee schedule reimbursement rates and access to medical treatment for workers’ compensation cases. The following briefly summarizes these three reports, which we found to be relevant to this project.

A 1998 Legislative Reference Bureau study, Report No. 8, *The Medical Fee Schedule Under the Workers’ Compensation Law,* found that the 1995 legislative change to base the fee schedule on Medicare was cited as the most common reason why health care providers were shifting away from accepting all workers’ compensation cases. The study went on to say the fee schedule “definitely appears” to have had a negative impact on access to specialty care and to more experienced health care providers.

Our 2002 Report No. 02-07, *Management Audit of the Disability Compensation Division and A Study of the Correlation Between Medical Access and Reimbursement Rates Under the Medical Fee Schedule* reached a different conclusion. The second component of the report was a study of whether an injured employee’s access to medical care is curtailed by the practice of tying reimbursement rates to the medical fee schedule. We found that reimbursement rates at the time were not unreasonable and did not significantly impact the provision of medical services or significantly contribute to the departure of providers from the state.

In 2007, the LRB issued Report No. 5, 2007, *Workers' Compensation Fee Schedules, Maximum Allowable Fees, and Comparative Reimbursements,* which focused on procedures to ensure health care providers are adequately reimbursed for services provided in workers' compensation cases. The study did not include an assessment of whether the fee schedule had an impact on access to medical care.

Objectives of the Project

1. Assess the Department of Labor and Industrial Relations' process to review and adjust medical fee schedules in order to develop a methodology that: 1) enables the review process to include a greater number of medical codes; and 2) can be performed on an annual basis.

2. Evaluate approaches taken by other states in providing reimbursements for medical services in workers' compensation cases and analyze whether their methods are comparable to Hawai‘i's medical fee schedule.

3. Make recommendations as appropriate.

Scope and Methodology

We assessed the department's current process for reviewing and adopting medical fees for workers' compensation cases. We reviewed documents, reports, and information from the Workers Compensation Research Institute; the National Council on Compensation Insurance; the 2013 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds; the 2013 Current Procedural Terminology codebook from the American Medical Association; the 2013 CDT Dental Procedures Codebook from the American Dental Association; the U.S. Department of Health and Human Services; the Legislative Reference Bureau; and applicable sections of the Hawai‘i Revised Statutes and Hawai‘i Administrative Rules. We also interviewed department personnel and other parties our office deemed appropriate. Act 97, SLH 2013, gives our office the exclusive discretion to identify such entities and their representatives and to consult with them in private or at a public informational meeting. No person or entity, except the director of labor, has the right to be consulted by our office or be aggrieved by the lack of consultation.

We performed non-audit services for this project between July 2013 and December 2013. Although generally accepted government auditing standards (GAGAS) do not cover non-audit services, GAGAS recommends that audit organizations communicate with requestors and those charged with governance to clarify that the work does not

constitute an audit in accordance with GAGAS. Audit organizations should also assess the impact providing non-audit services on the auditor and its independence. Our office communicated these issues to lawmakers. We believe our communications adequately described our non-audit services for this project and the impact they may have on our independence in the future.

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Chapter 2
Increased Use of Data Would Drive a More Comprehensive Fee Review Process

In this report, our first of two responding to Act 97, Session Laws Hawai‘i (SLH) 2013, we recommend a formalized process for the mandatory periodic review of Hawai‘i’s *Workers’ Compensation Supplemental Medical Fee Schedule*, also referred to as *Exhibit A*. After working closely with the Department of Labor and Industrial Relations, we determined that the use of better data could enhance the department’s existing fee schedule review process. Specifically, we recommend collecting and analyzing transacted current procedural terminology (CPT) code data. Not only will such data capture paid physician and other health care professional services and procedures, it also represents the universe of medical services actively being delivered by health care providers in workers’ compensation cases.

Through a collaborative effort with the department and representatives of relevant entities—including workers’ compensation administrators, health care providers, and insurers—we identified and collected transacted CPT code data derived from more than 80 percent of Hawai‘i’s employee population. The data, encompassing a three-year period, shows services and procedures provided and paid for in workers’ compensation cases, and the frequency of those transactions. Departmental review of this data for its fee schedule will present an opportunity for annual review of most—if not every—type of medical service and procedure actively provided in Hawai‘i workers’ compensation cases.

Departmental Review of Transacted Medical Codes Would Ensure a Data-Driven Fee Schedule

At present, the department performs a comprehensive review of its *Workers’ Compensation Supplemental Medical Fee Schedule* every three years, as required by state law. The review, however, is limited to CPT codes already listed on the fee schedule and any codes requested by third parties for review. Lacking historical CPT code data, the department is unaware whether the services and procedures it reviews are actively used in workers’ compensation cases. Our recommendation for departmental collection and analysis of transacted CPT code data addresses this concern by focusing on codes that are used on a consistent basis.

NCCI and self-insured agencies can provide the data

As manager of the nation's largest database of workers' compensation information, the National Council on Compensation Insurance (NCCI) collects detailed information on up to half of all workers' compensation claims and policies filed in the United States and is licensed in Hawai‘i as a rating organization for all lines of insurance. The NCCI derives its transacted CPT code data for Hawai‘i from an estimated 20,000 private-sector policy holders. Based on 2012 employment statistics, the department calculates this represents about 70 percent of Hawai‘i's total employee population. The NCCI does not receive or collect data from self-insured employers, such as state and city governments.

Under Hawai‘i law, a workers' compensation self-insurance group must meet certain financial capability requirements to receive a certificate of approval from the state insurance commissioner. As of June 2013, 39 private companies were certified as self-insured. All state agencies and the state's four counties are also self-insured. In order to broaden the employee population, we also obtained CPT code data from select government agencies.

The state Department of Human Resources and Development (DHRD) serves as the administrator for workers' compensation claims for the executive departments except the University of Hawai‘i (UH) and the Department of Education (DOE). The DHRD also administers claims for the Offices of the Governor and the Lieutenant Governor, the Hawai‘i State Public Library System, public charter schools, and the Legislature. Based on 2012 employment figures, DHRD serves as the workers' compensation administrator for 2.98 percent of the state's employee population.

The DOE and UH use third-party administrators for their workers' compensation claims. The DOE workforce represents an estimated 6 percent of the state's employee population and the UH workforce an estimated 2.69 percent. Finally, the City and County of Honolulu's Division of Industrial Safety and Workers' Compensation adjusts all city and county workers' compensation claims but uses a third-party billing administrator. In 2012, the City and County of Honolulu workforce represented an estimated 1.78 percent of the employee population in Hawai‘i. Collectively, the workforces of the entities identified—private-sector policy holders (70 percent of the total employee population); executive departments and agencies for which DHRD serves as workers' compensation administrator (2.98 percent), the DOE (6 percent), UH (2.69 percent), and City and County of Honolulu (1.78 percent)—represent 83.45 percent of Hawai‘i's employee population.

Between September and October 2013, each of these entities provided our office with three years of transacted CPT code data (CY2010 through CY2012) and indicated similar data for subsequent years could be

made available. Research and Statistics would correlate provider data against all American Medical Association CPT code data, which can be purchased in digital media to expedite the process. Estimated delivery dates for the prior year's data range from as early as mid-January to as late as mid-September as shown in Exhibit 2.1:

Exhibit 2.1
CPT Code Data Collection Dates

Data Provider	Projected Data Delivery Date
NCCI	Mid-September
DHRD	Mid-January
DOE	Late January
UH	Mid-January
City and County of Honolulu	June

Source: Office of the Auditor

Three years of transacted code data would provide consistency and transparency

The department's fee schedule review process targets an effective date of January 1 to coincide with the annually updated Medicare fee schedule's effective date. The department's process involves collecting and analyzing CPT code data; surveying health care contractors to determine a prevailing charge for each reviewed code; and adopting rules pursuant to Chapter 91, Hawai'i Revised Statutes (HRS). For the Workers' Compensation Program Office, the rule-making process is roughly seven to eight months.

Since NCCI's CPT data is not available until mid-September, we recommend that data be lagged to provide the department ample time for rulemaking and ensure the data requested and collected from all providers is consistent. Thus, data for CY2010–CY2012 would be reviewed and analyzed for the January 2015 fee schedule. Going forward, CPT data for CY2011–CY2013 should be used for the January 2016 fee schedule and so forth. Lagging the years likely will have minimal effect on the fee schedule, since there is little variance in CPT code data from year to year.

Additionally, three years of data would enable the department to identify which CPT codes are consistently transacted year after year and which are not. To ensure consistency, we recommend the department consider only CPT codes transacted in at least two of the three years under review. Workers' compensation administrators, health care providers, and insurers we consulted approved of this methodology.

This methodology would provide needed criteria for the department. Currently, when the Workers' Compensation Program Office reviews a request to adjust a particular CPT code fee, it lacks guidance to assess the merits of the request. With the receipt of annual CPT code data, the department can assess whether a requested code is being used on a consistent basis. If the code is not used consistently, the department would be justified in asking the requester for additional information prior to undertaking a review.

Memoranda of understanding would facilitate annual data collection in future years

To implement the proposed methodology in future years, transacted CPT code data needs to be collected annually. For this report, we acknowledge the cooperation of all data providers who responded timely to our request for CPT data. However, to facilitate a working relationship between data providers and the department, we recommend the department pursue memoranda of understanding (MOUs) with DHRD, DOE, UH, and the City and County of Honolulu to ensure it receives annual data in a prescribed format and according to an agreed time schedule. A memorandum is not needed for NCCI, since it assured our office it will continue providing CPT data to the department, consistent with its practice of providing such reports and analysis pursuant to legislative activity and regulatory initiatives.

Department would need additional resources to annually review and adjust the fee schedule

Our methodology requires department personnel to annually collect, correlate, and analyze transacted CPT code data from five different sources. This differs from its current process, which involves a comprehensive review of a fixed number of codes every three years. Moreover, an annual review process must continue to fulfill statutory requirements of Chapter 201M, HRS, to determine the impact on small business, and of Chapter 91, HRS, to adopt administrative rules. As previously noted, the fee schedule resides in administrative rules. We project the department would need additional personnel resources both to continuously review and analyze CPT code data and determine small-business impact and adopt the department's administrative rules.

Budget cuts reduced the Workers' Compensation Program workforce, although some positions will be restored in 2014

In 2009, the department's Disability Compensation Division (DCD) lost 28 positions (24 percent of its workforce) due to general fund budget restrictions. From 2009 to 2012, DCD lost a total of 32 percent of its staff due to budget cuts. Losses included a research statistician, two program specialists, ten office assistants, a clerk stenographer, and the entire Cost Review Branch (although it remains on the division's organization chart, the department says it has not functioned since 2009).

Currently, a total of three staff handle all aspects of updating the fee schedule. A single research statistician in the Research and Statistics Office is responsible for tasks associated with the fee schedule; but she has other responsibilities, including administering work levies to help finance the Special Compensation Fund; determining maximum wage base and weekly benefit amounts for workers' compensation; coding workers' compensation case characteristics; developing the Workers' Compensation Data Book; and maintaining the annual workers' compensation database for ad hoc reports for Disabilities Compensation Division, the Hawai'i Occupational Safety and Health Division, the Wage Standards Division, and the Office of the Director.

The Workers' Compensation Program Office, which administers the program's rule-making process, is currently staffed with a program chief and two program specialists. After the loss of the Cost Review Branch in 2009 the two program specialists assumed some duties once performed by office assistants. The program specialists' core duties include drafting and finalizing proposed legislation and legislative testimony, rules, policy and procedure revisions; preparing policy and procedure statements, directives, and memoranda; preparing and maintaining the workers' compensation policies and procedures manual; adjusting and examining the workers' compensation Special Compensation Fund files; determining injured workers' service eligibility and entitlement; and referring claimants for other services. The program specialists voiced concerns that, without support staff, engaging in fee schedule rule-making every year in addition to their other duties would be difficult if not impossible to accomplish.

Additional staffing placed strategically in DLIR would support annual fee schedule work

The 2013 Legislature funded 14 positions for the department beginning in January 2014; however, these positions will only partially restore the division's staffing to its pre-2009 levels. Although one of the restored positions is a research statistician in the Research and Statistics Office, this position will assume duties currently performed by the existing research statistician. For the office to effectively implement an annual fee schedule review, an additional research statistician III position should be added. The statistician's primary responsibilities would be to implement the annual fee schedule review process. Based on projected increases ratified in the Hawai'i Government Employees Association's contract for bargaining unit 13, in October 2013, we estimate the position will cost the State between $43,800 and $64,900 in salary beginning in July 2013, $45,300 and $67,100 in January 2016, and $46,900 and $69,500 in January 2017.

Another of the 14 positions funded by the Legislature beginning January 2014 is a DCD clerical support position, which replaces a clerk stenographer position cut in 2009. This position, however, will be shared across the division and cannot provide support services to just the Workers' Compensation Program Office. Following discussions with department personnel, we determined another office assistant IV position is needed to provide clerical support for the Workers' Compensation Program Office. The position description should designate 20 to 25 percent of the position's responsibilities to support the annual fee schedule rule-making process. We estimate the position will cost between $28,800 and $46,100 in salary beginning July 2014.

Whether to retain dental codes on the fee schedule is debatable and subject to policy decision

At present, there are more than 100 dental codes listed on the workers' compensation fee schedule. Dental services, however, are excluded from the federal Medicare Program, except for inpatient hospital services when a dental procedure itself makes hospitalization necessary. Medicare does not cover primary dental services such as the care, treatment, removal, or replacement of teeth or secondary services unless it is an integral part of a covered primary service necessary to treat a non-dental condition (for example, tumor removal) and is performed at the same time as the covered service and by the same physician or dentist.

In the department's triennial comprehensive fee schedule review process, the Research and Statistics Office also reviews dental codes listed on the fee schedule. Because the federal Medicare fee schedule does not include dental codes, R&S surveys dental care contractors to calculate a prevailing charge for each listed dental code on the fee schedule. The NCCI data for transacted workers' compensation medical services provided from 2010 to 2012 shows 136 transacted dental codes with no more than 49 in a given year. The DHRD reported a total of 21 dental codes used over that three-year period. The DOE reported 17 and UH reported 12.

Workers' compensation insurers told us that dental services provided in workers' compensation cases are rare and at least two insurers supported the idea of removing dental codes from the fee schedule. Four of five dental care contractors we contacted also did not oppose removing dental codes from the fee schedule; one, however, argued that excluding dental codes from the fee schedule would eliminate guidance and could slow the claims and treatment process.

State law allows the director of labor to establish an additional fee schedule if a medical treatment, accommodation, product, or service is not covered under Medicare and does not exceed the prevalent charge for fees for services actually received by health care providers. Since the State's workers' compensation law includes dentistry and services

provided by dentists, it is a policy decision within the director's discretion to establish a fee schedule for workers' compensation dental services. When making this policy decision, we recommend the director consider three years of transacted CPT data (2010 through 2012), which confirms that dental services have been transacted in workers' compensation cases and that exclusion of such codes from the fee schedule could impact access. However, the director should also take into consideration the workload impact of retaining more than 100 dental codes on a fee schedule that must be annually reviewed and adjusted by the Research and Statistics Office.

Some department-created codes should be deleted, others retained

In an effort to include services that are permitted either by administrative rule or by statute, the fee schedule contains five department-created codes not listed in the Medicare fee schedule. Three of them, however, have equivalent CPT codes. These involve acupuncture and work-hardening services. Because the R&S uses the CPT code book as its primary resource when reviewing and analyzing fee schedule codes, we recommend the department delete these four codes and replace them with the corresponding CPT codes for these services.

The remaining two department-created codes refer to Section 386-79, HRS, which allows the fee schedule to set the cost of conducting department-requested medical examinations. We agree with the Workers' Compensation Program Office's reasoning for retaining these codes.

A Separate Fee Ceiling for Evaluation and Management Codes Would Address Access to Care

The 2013 Legislature could not reach agreement on an across-the-board increase of all medical fees. The Legislature did agree in Act 97, SLH 2013, however, to have our office to identify medical services for which fee adjustments are necessary to ensure injured employees have better access to treatment.

Stakeholders we spoke with agreed that evaluation and management (E/M) CPT codes represent the entry point for medical treatment in workers' compensation cases. Therefore, in order to address the objective of access to care, we recommend establishing a separate maximum allowable fee ceiling for E/M codes. Moreover, the department should continue to identify and exclude certain E/M codes from the fee schedule because they involve telephone calls or online evaluation services, non-face-to-face services that are not eligible for reimbursement under Medicare.

A higher fee ceiling for certain E/M codes may provide incentive for health care providers to accept workers' compensation cases

We surveyed insurers and health care providers to identify E/M codes applicable to workers' compensation cases. Based on their responses, we compiled a list of applicable E/M codes and cross-referenced it with Medicare fee schedule codes. The R&S used its most recent survey of health care contractors to calculate the average prevailing charge for these codes to determine whether the charge exceeded the average rate under the Medicare fee schedule. It found that for 2013 the maximum allowable fee ceiling for applicable E/M codes was 24.5 percent above Medicare.

Since health care contractors' fee schedules are updated yearly, we recommend the E/M maximum allowable fee ceiling be recalculated annually. To facilitate this process, we recommend the Legislature amend Section 386-21(c), HRS, to empower the director to establish such a fee ceiling for E/M codes based on the methodology described in this report.

Some E/M codes might exceed the new fee ceiling if consistently used

There are ten E/M codes on the current fee schedule. Based on figures provided by R&S, three of these would have exceeded the proposed E/M fee ceiling of 24.5 percent above Medicare. However, in order to remain on the fee schedule and exceed the proposed E/M ceiling, these codes must continue to be transacted on a consistent basis (at least two of the three years in the review period). If not, they are removed from the fee schedule and subject to the proposed E/M fee ceiling—which, in this example, would be 24.5 percent above Medicare.

Our survey of stakeholders, including health care providers and insurers, also identified a number of E/M codes not applicable to workers' compensation cases, which we forwarded to the Research and Statistics Office. These codes cover services under the categories of domiciliary, rest home, or home care plan oversight services; preventive medicine services for established patients; counseling risk factor reduction and behavior change intervention; inpatient neonatal intensive care services and pediatric and neonatal critical care services; and newborn care services. We recommend the department clarify that only E/M codes applicable to workers' compensation be included in the fee schedule. Mirroring current law, we also recommend performing this survey of stakeholders at least every three years to ensure their involvement in the process.

Flat Medicare fee rates since at least 2011 indicate the need for an incentive for doctors

A workers' compensation insurer told us it has agreed to pay some of its doctors more than the Medicare fee schedule rate as an incentive to continue treating workers' compensation cases. Our recommendation to establish a separate maximum allowable fee ceiling for E/M codes would provide a similar incentive to health care providers, especially since Medicare physician payment rates have been flat over the past several years.

According to the federal Centers for Medicare and Medicaid Services (CMS), updated Medicare physician fee schedule payment levels are based on a formula called the Sustainable Growth Rate (SGR) system. The SGR is intended to control the aggregate growth in Medicare expenditures for physician services. If actual Medicare expenditures exceed a specified target, the updated fee schedule payment level is reduced. If expenditures fall short of the target, the payment level is increased. Under current law, the SGR formula would have steadily reduced the physician services payment levels every year since 2002 had Congress not overridden each yearly reduction. As a result of congressional override, the projected reduction in physician payment levels is an estimated 24.7 percent in 2014. Congress is expected to continue its override of the SRG as it has every year since 2003.

Nevertheless, CMS told us total spending for Medicare physician fee-for-services has been slowly increasing for the past several years while the updated fee schedule payment levels have gone down. So while expenses have been slowly increasing for health care providers, legislated payment updates have remained flat since 2011. Currently, Medicare physician fees are about 80 percent of those paid by private health insurance. These fees are projected to drop to 40 percent within 20 years and to 25 percent in 75 years. If Congress continues to allow this payment differential, increasingly severe problems with access to physician services are expected. This growing differential supports our proposal to narrow the gap by providing an incentive to doctors to treat workers' compensation cases by establishing a higher maximum allowable fee ceiling for qualified E/M codes.

Preliminary stakeholder feedback on our methodology is positive, but data analysis is needed to determine cost impact and effect on access

We described our proposed methodology for updating the fee schedule and establishing an E/M code fee ceiling to stakeholders, including health care providers, insurers, and workers' compensation administrators. All agreed it would be "a good starting point."

After adopting our methodology, the department would need to assess its cost impact and effect on access to medical treatment for workers' compensation cases. Currently, whenever the fee schedule is changed, the department receives assessment reports from NCCI and the Department of Commerce and Consumer Affairs' Insurance Division. In addition to these reports, we recommend the department conduct its own trend analyses of access to medical treatment for workers' compensation cases. Trend analysis provides invaluable information for needs assessment, program planning, program evaluation, and policy development. For example, in public health, trend data are presented for rates arising from large populations over relatively long periods of time (for example, ten or more years). Examining data over time also permits making predictions about future frequencies and rates of occurrence. A study of time trends may focus on one or several areas: the overall pattern of change as an indicator over time, comparing one time period to another time period, comparing one geographic area to another, or comparing one population to another.

We contacted some medical billing companies in Hawai‘i that collect CPT data and could provide the basis for an analysis on access impact or indicators of possible over-treatment by health care providers. Judging by the positive responses received, we recommend the department undertake such trend analysis to gain insight into the methodology's cost impact and effect on access over time.

References

We consulted a wide array of stakeholders, who gave generously of their time and resources to support development and refinement of our fee schedule methodology. These parties include:

a. Allied Managed Care;
b. Centers for Medicare and Medicaid Services;
c. City and County of Honolulu;
d. Concentra;
e. Corvel Corporation;
f. Department of Education;
g. Department of Human Resources Development;
h. Department of Labor and Industrial Relations and its 2013 medical fee schedule working group;
i. DTRIC Insurance Company;
j. Firms Claims Services/First Insurance;
k. Hawai‘i Employers' Mutual Insurance Company;
l. Hawai‘i Government Employees Association;
m. Hawai‘i Insurance Guaranty Association;
n. Hawai‘i Medical Association;
o. Hawai‘i Medical Service Association;

p. Island Insurance;
q. Kaiser Occupational Health Services;
r. National Council on Compensation Insurance;
s. National Interstate Insurance;
t. PACBLU;
u. Solera Integrated Medical Solutions;
v. University of Hawai‘i; and
w. U.S. Department of Labor.

We also relied on documents from the American Medical Association, the American Dental Association, Noridian Healthcare Solutions, and the U.S. Department of Health and Human Services.

Conclusion

The department's medical fee schedule process can be improved by utilizing transacted CPT code data. Not only would such data provide a clearly defined pool of medical services that are actively being delivered in Hawai‘i workers' compensation cases, it would also provide opportunities for the department to determine whether codes have been transacted in at least two of a three-year period, thus ensuring reviews and fee adjustments apply to medical services that are being consistently provided. Two additional personnel are needed to implement our methodology and carry out annual rule-making.

Establishing a separate maximum fee ceiling for evaluation and management (E/M) codes will provide some incentive for health care providers to accept and continue providing treatment for workers' compensation cases. Because the impact of these changes on cost and access to medical treatment for workers' compensation cases is unknown, we recommend our review process be given a sunset date of five years after departmental implementation. We encourage the department to conduct trend analyses on the five years of data to determine these impacts. Although a longer period of time—ten years, for example—would yield more reliable data for analysis, we are mindful that the Legislature, department, and stakeholders may prefer a shorter timeframe. However, they should be mindful that a shorter period may increase the potential for error.

Recommendations

1. The Department of Labor and Industrial Relations should adopt the methodology described in this report by:

    a) Collecting transacted CPT code data for workers' compensation cases from the National Council on Compensation Insurance, the Department of Education,

the Department of Human Resources Development, the University of Hawai‘i, and the City and County of Honolulu on an annual basis;

b) Pursuing memoranda of understanding with these data providers to ensure CPT code data is provided annually in a prescribed way and according to an agreed time schedule. Inclusion of dental codes is pending the policy decision of the director of labor; and

c) Developing a written procedures manual for the fee schedule review and rule-making process that includes:

i. Incorporating scheduled CPT code data delivery dates for each data provider;

ii. Incorporating purchase order request dates for data media from the American Medical Association;

iii. Using transacted CPT code data to guide decision-making when third-party requests to adjust fees for specific codes are received;

iv. Recalculating annually the maximum allowable fee ceiling for eligible evaluation and management (E/M) codes;

v. Performing a survey of stakeholders every three years to identify which E/M codes listed in the most current CPT code book are applicable to workers' compensation cases;

vi. Stating on the Workers' Compensation Supplemental Medical Fee Schedule (Exhibit A) that certain E/M codes are not eligible after a survey of stakeholders deemed them not applicable to workers' compensation cases. List the medical service categories that cover these codes in the current American Medical Association CPT code book;

vii. Stating on the fee schedule the methodology used to identify the CPT codes under review for possible fee adjustment, including the three-year period of data collection and transaction consistency (at least two of three years);

viii. Listing maximum fee rates on the fee schedule in dollars and cents and eliminating the conversion to "unit values;" and

ix. Using the CPT code equivalents for U.S. Department of Labor codes 20560, 20561, and 97545A that are listed on the fee schedule and retaining department-created codes 99456A and 99456B;

d) Working with the Legislature to amend Section 386-21(c), HRS, as needed to adopt the fee schedule review methodology; thereafter, amending its administrative rules accordingly to implement the law;

e) Preparing position descriptions for a new research statistician III and a new office assistant IV position needed for the department to implement the methodology and perform the fee schedule review and adjustment process and rule-making process annually;

f) Ensuring resources are available for the Research and Statistics Office to purchase data media from the American Medical Association to more efficiently implement the methodology.

2. The director of labor should:

a) Approve the methodology for reviewing and updating the medical fee schedule described in this report and our recommendation to establish a separate maximum allowable fee ceiling for E/M codes; and

b) Decide whether to retain or remove dental codes from the fee schedule.

3. The Legislature should consider:

a) Amending Section 386-21(c), HRS, to:

i. Empower the director of labor to establish a maximum allowable fee ceiling annually for eligible E/M codes;

ii. Include a sunset date of at least five years hence to provide the department sufficient time to assess the methodology's impact on cost and access to medical treatment for workers' compensation cases; and

iii. Request the department assess the impact on access by performing a trend analysis that includes data prior to and after implementation of the methodology. The analysis should be submitted to the Legislature with

sufficient time prior to the sunset date to enable policymakers to review the report and engage in discussions with stakeholders on whether to continue, discontinue, or adjust the methodology;

b) Funding departmental personnel resources in order to implement the methodology described in this report; and

c) Providing sufficient resources to the department to hire one or more contractors to perform an on-going trend analysis of the impact the methodology may have on access.

Chapter 3
Hawai‘i’s Method of Setting Workers’ Compensation Medical Fees Is Unique

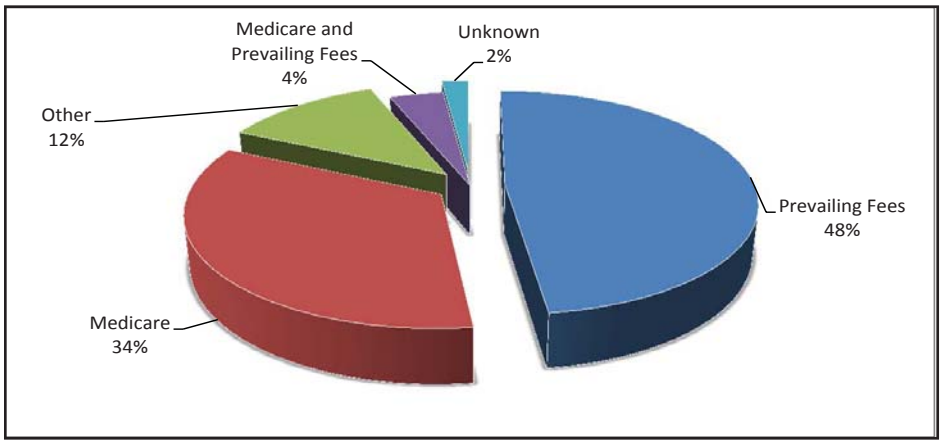
This chapter reports on the methods employed by states to set workers’ compensation medical fees. We did not analyze whether a method is more effective or more conducive to achieving an optimum reimbursement rate. Findings and conclusions of studies conducted by other organizations are incorporated into this chapter to facilitate an understanding of this subject, but the restatement of an opinion or conclusion does not imply an endorsement by our office.

States use many methods to establish reimbursement rates for medical procedures provided under workers’ compensation. Although these methods vary, they are based on one of two criteria, or a combination of the two, to set workers’ compensation medical fees.

Most States Use a Variant of Prevailing Charges or Medicare to Set and Adjust Fees

The first criterion is the Medicare Resource-Based Relative Value Scale, known as the Medicare fee schedule. The second criterion is usual, customary, and reasonable charges for procedures—simply, prevailing charges. Forty-three of the 49 states discussed below use one or more of these methods.[1] The other six states—Colorado, Kansas, Nevada, South Dakota, Utah, and Wyoming—use scales created or published by a consulting firm, OptumInsight/Ingenix. Exhibit 3.1 provides a percentage breakdown of the methods used by states in setting and adjusting their reimbursement fees.

Exhibit 3.1
States’ Methods of Setting and Adjusting Fees



Note: The vast majority of states use either prevailing fees or the Medicare fee schedule to regulate workers’ compensation medical reimbursements; however, Hawai‘i and Nebraska use both. Hawai‘i applies prevailing fees and Medicare to all codes. Nebraska uses the Medicare fee schedule for hospital services and prevailing fee for all other codes. Six other states use different methods.

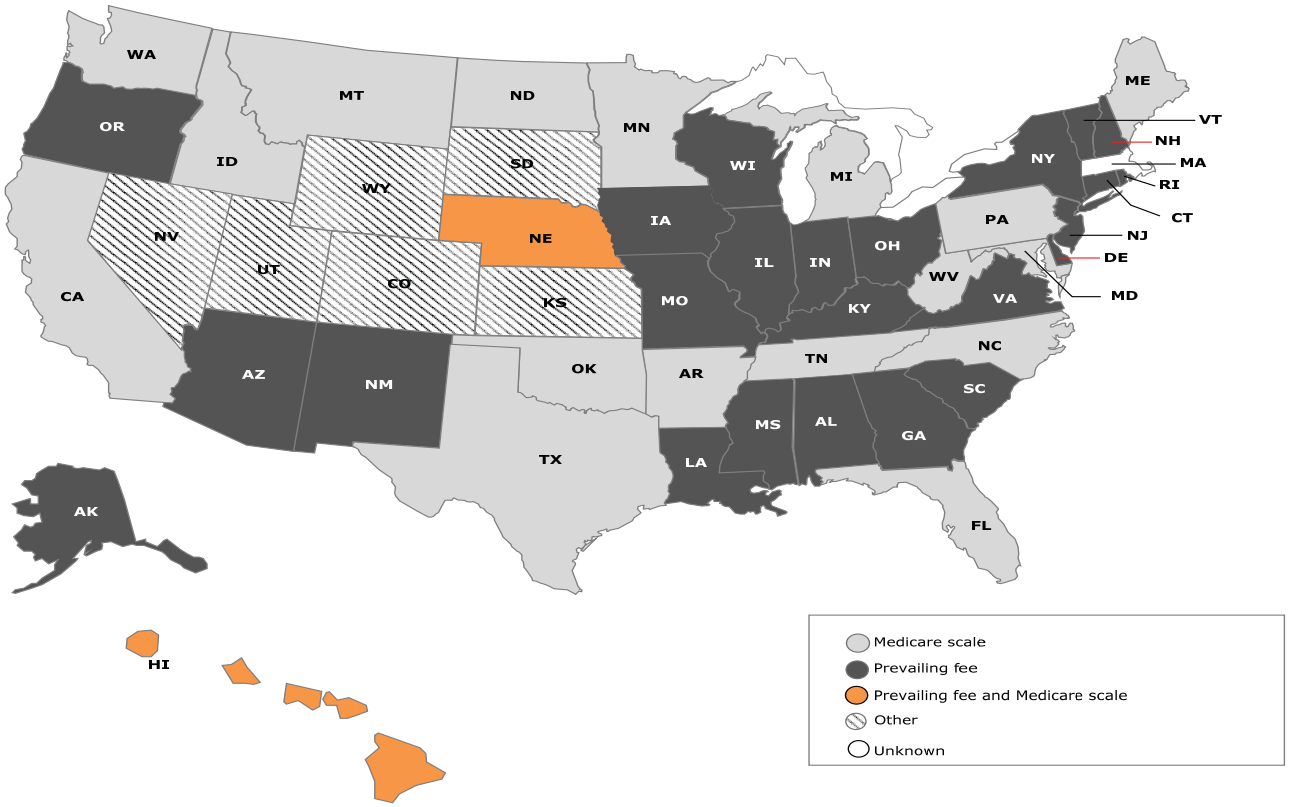
Source: Office of the Auditor

Despite overarching similarities, states vary in how they use these criteria. For example, Hawai‘i uses each criterion to create a separate fee schedule. Hawai‘i uses the Medicare scale to create a primary fee schedule, set at 110 percent of the Medicare fee schedule, and prevailing charges to create a second, supplemental fee schedule, which cannot exceed the widely accepted or practiced charge for services by health care providers. Nebraska also uses both methods to regulate fees, but does not publish separate fee schedules.[2]

To conduct our analysis, we examined publicly accessible statutes, rules, and regulations of 49 of 50 states. We could not identify the criteria Massachusetts uses to base its fee schedule,[3] so we do not include an analysis of Massachusetts.

Exhibit 3.2 illustrates the methods used by states to regulate medical reimbursements under workers’ compensation. Light gray states use the Medicare scale; dark gray states use prevailing fees; orange states, Hawai‘i and Nebraska, use both Medicare and prevailing fees; and striped states use some other method. Massachusetts—whose method is unknown—is in white.

Exhibit 3.2
Map of Workers’ Compensation Medical Fee Criteria

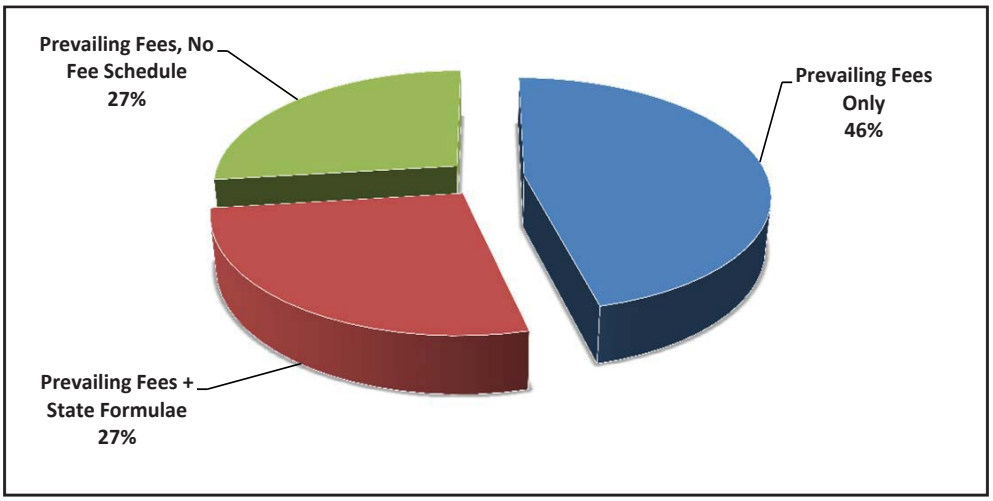


Source: Office of the Auditor

Hawai‘i is one of 26 states that use prevailing charges to set fee rates

Most states we reviewed use prevailing charges to set and adjust their fees. Altogether, 26 states—including Hawai‘i, for its supplemental fee schedule—use standards based on customary, reasonable, or prevailing charges. Aside from Hawai‘i, these states are: Alabama, Alaska, Arizona, Connecticut, Delaware, Georgia, Illinois, Indiana, Iowa, Kentucky, Louisiana, Mississippi, Missouri, Nebraska, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oregon, Rhode Island, South Carolina, Vermont, Virginia, and Wisconsin. Although most states use customary, reasonable, or prevailing charges, the methods of doing so vary.

Exhibit 3.3
Breakdown of States That Use a Prevailing Fee Method



Source: Office of the Auditor

The use of a prevailing fee method requires substantial resources

According to the Workers Compensation Research Institute (WCRI), the prevailing fee method requires substantial resources on the part of state agencies to develop the database of charges and to update the data to reflect changes in prevailing charges. The Department of Labor and Industrial Relations now has three staff members who spend substantial time revising the supplemental fee schedule, two in the Workers’ Compensation Program Office and one in the Research and Statistics Office. To update the supplemental fee schedule annually would require one more staff person in each office.

States vary in how they use prevailing fees. Hawai‘i’s law, for instance, says the supplemental fee schedule cannot exceed “the prevalent charge for fees for services actually received by providers of health care services.”[4] Alabama, by contrast, bases its schedule on reimbursements paid by the state’s largest preferred health insurer with

yearly adjustments for inflation.[5] Ohio’s statute says simply that the administrator of workers’ compensation is to develop the fee schedule “with provider and employer input.”[6]

Several states use a formula that adds nuance to prevailing fees

Seven states use a state-specific formula in addition to prevailing charges to set fees—Alaska, Arizona, Connecticut, Delaware, Illinois, New Mexico, and Rhode Island. Although the general method is similar, these states vary in the formulae they use. Delaware, for example, sets its fee schedule at 90 percent of the 75th percentile in the GEOZIP where the service is performed.[7] A GEOZIP is an area defined by reference to United States ZIP codes. Arizona sets fees at the 75th percentile of surveyed values from the states of Colorado, Nevada, New Mexico, North Carolina, Oregon, Utah, and Washington.

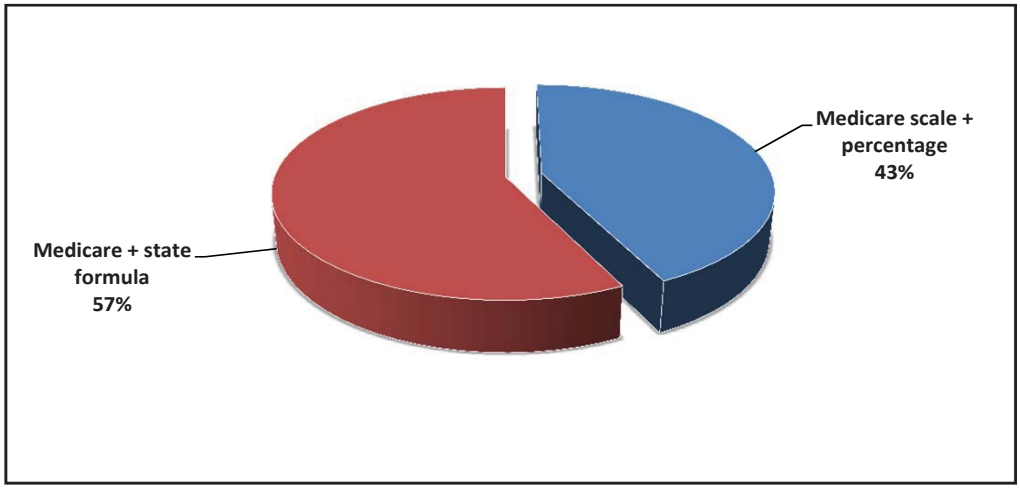
States using prevailing charges with no fee schedule have widely varying methodologies

Seven of the 49 states examined—Indiana, Iowa, Missouri, New Hampshire, New Jersey, Virginia, and Wisconsin—do not publish a fee schedule at all, but instead use customary, prevailing, or reasonable fees to set ceilings on fees. Again, methods vary. Missouri’s statute, for example, says merely that a health care provider shall not charge more for treating a workers’ compensation patient than the provider charges for treating a patient who is using private or group health insurance.[8] New Hampshire requires employers or their insurance carriers to pay the full amount of the health care provider’s bill; if a dispute arises, the state’s workers’ compensation commissioner determines if the fee is reasonable.[9] Virginia’s statute says simply that an employer’s liability for medical treatment “shall be limited to such charges as prevail in the same community for similar treatment when such treatment is paid for by the injured person.”[10] Although the use of customary, prevailing, or reasonable charges may resemble Hawai‘i, these states do not publish fee schedules.

Hawai‘i is one of 19 states that use a version of the Medicare formula to set fee rates

Altogether, 19 states use the Medicare fee schedule to regulate maximum allowable fees. This group consists of Arkansas, California, Florida, Hawai‘i, Idaho, Maine, Maryland, Michigan, Minnesota, Montana, Nebraska, North Carolina, North Dakota, Oklahoma, Pennsylvania, Tennessee, Texas, Washington, and West Virginia. These states can be categorized as either Medicare plus a percentage or Medicare plus a state formula. Their relative numbers are shown in Exhibit 3.4.

Exhibit 3.4
Breakdown of States That Use a Version of Medicare Formula



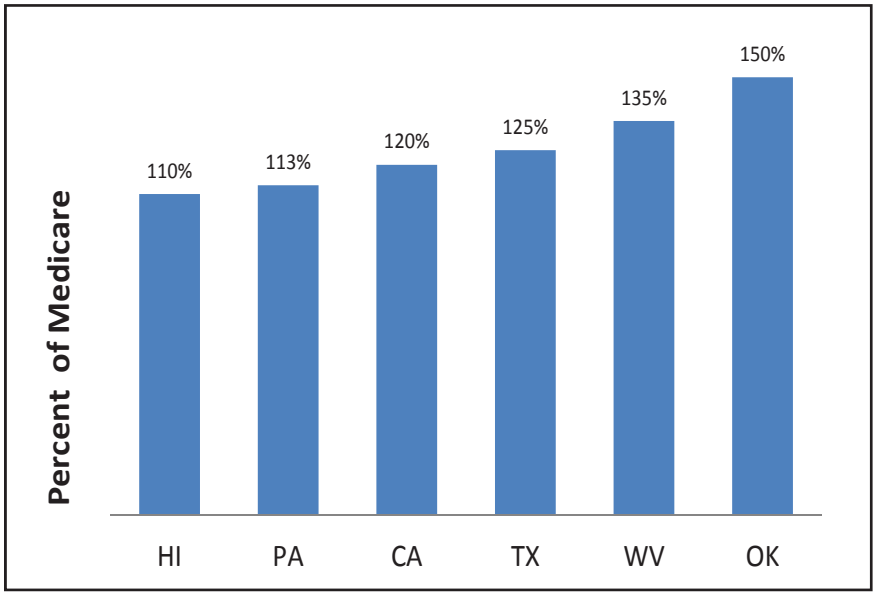
Source: Office of the Auditor

Hawai‘i offers the lowest percentage increase to the Medicare rate among comparable states

Nine states, including Hawai’i for its primary fee schedule, set their maximum allowable reimbursements on the Medicare fee schedule plus a percentage. Six of the nine use a single percentage to adjust the Medicare scale. The laws of four states prescribe a single percentage: Hawai‘i, California, Pennsylvania, and West Virginia. Oklahoma has two percentages, but one is limited to the specialty of radiological procedures.[11] Texas has three percentages, but the three are identical. Thus, in practice the six states are comparable in their use of a single adjusting percentage.

As shown in Exhibit 3.5, Hawai‘i’s percentage premium above Medicare is lowest of the six states. Hawai‘i’s primary fee schedule permits a maximum allowable charge of the Medicare fee schedule plus 10 percent. Pennsylvania sets its schedule at Medicare plus 13 percent; California at Medicare plus 20 percent, with annual adjustments for inflation; Texas at Medicare plus 25 percent; West Virginia at Medicare plus 35 percent; and Oklahoma at Medicare plus 50 percent.

Exhibit 3.5
Comparison of States With Fee Rates Based on Medicare Plus a Percentage



Source: Office of the Auditor

States using their own Medicare conversion formula have varying fee rates

In contrast to Hawai‘i, other states frequently combine the Medicare scale with formulae designed specifically for their states; in addition, the majority of these states adopt formulae for each of several practice disciplines.

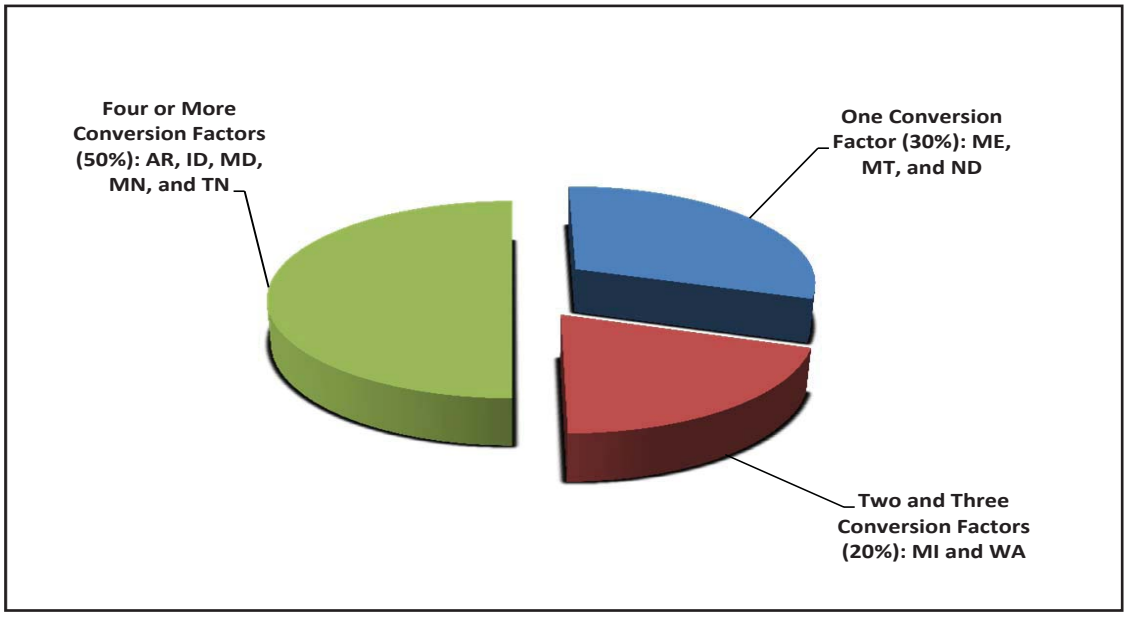
States that use specific formulae combined with the Medicare scale tend to have wide variations in fees among the various service groups within the state. Tennessee, for example, adopts formulae for a minimum of ten practice areas. As a result, as of July 2011, Tennessee’s fee schedule provided fees for major surgery that were 208 percent above the Medicare fee schedule, while fees for physical medicine procedures were 48 percent above the Medicare schedule—a 160 percentage-point difference. By contrast, for the same period in Hawai‘i, which does not use multiple, state-specific formulae to refine the Medicare scale, fees for surgery were 22 percent above Medicare. However, fees for physical medicine were 15 percent above Medicare—a seven percentage-point difference.

Some states use more complex conversion formulas than others

Not all states are as complex as Tennessee. As shown in Exhibit 3.6, Maine, Montana, and North Dakota adopt one formula for all practice

disciplines. Michigan and Washington adopt formulae for two to three practice disciplines. Arkansas, Idaho, Maryland, Minnesota, and Tennessee adopt formulae for four or more different practice disciplines. For example, Idaho uses the Medicare scale and separate formulae for medicine, surgery, physical medicine, radiology, anesthesia, and pathology.[12]

Exhibit 3.6
Breakdown by Number of Practice Disciplines Recognized in Fee Schedule



Source: Office of the Auditor

Another six states—Colorado, Kansas, Nevada, South Dakota, Utah, and Wyoming—use a fee scale combined with multiple, state-specific formulae; however, these states use scales created by the consulting firm OptumInsight/Ingenix, not the Medicare scale. That makes the use of a fee scale and state-specific formulae, which is used by 16 states, the single most popular method of setting fees.

References

The following provided documents or were contacted by our office and contributed to this chapter:

a) Workers Compensation Research Institute;

b) National Conference of State Legislatures;

c) OptumInsight;

d) National Academy of Social Insurance;

e) International Association of Industrial Accident Boards and Commissions; and

f) Hawai‘i Legislative Reference Bureau.

Endnotes

Chapter 3

[1]*Designing Workers' Compensation Medical Fee Schedules*, Workers' Compensation Research Institute, Cambridge, Mass. 2012, pp. 15-16.

[2]Nebraska Revised Statutes, 2011, Sections 48-120, 48-120.04.

[3]*Workers' Compensation Agency Profiles*, International Association of Industrial Accident Boards and Commissions, Madison, Wisc., 2013, p. 133.

[4]Section 386-21, HRS.

[5]Alabama Code, 2012, Section 25-5-313.

[6]Ohio Administrative Code, 2011, Section 4123-6-08.

[7]Delaware Code, 2013, Title 19, Section 2322B.

[8]Missouri Revised Statutes, 2012, Section 287.140.

[9]New Hampshire Statutes, 2012, Section 281-A:24.

[10]Virginia Code, 2013, Section 65.2-605.

[11]Oklahoma Statutes, 2013, Title 85 Section 327.

[12]Idaho Code, 2013, Section 72-803.

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Response of the Affected Agency

Comments on Agency Response

We transmitted a draft of this report to the Department of Labor and Industrial Relations on December 13, 2013. A copy of the transmittal letter is included as Attachment 1. We met with the department on December 18, 2013, to discuss our draft report. The department offered technical changes to the draft, but generally concurred with the proposed methodology and recommendations.

Thereafter, the department issued its response to our draft, concurring with our report's analysis and recommendations. The response, received on December 20, 2013, is included as Attachment 2. The department noted the methodology is mindful of medical care costs in workers' compensation cases as well as ensuring access to health care for injured workers. The department also expressed appreciation of the collaborative effort between the department and our office in order to produce the report.

ATTACHMENT 1

STATE OF HAWAI'I
OFFICE OF THE AUDITOR
465 S. King Street, Room 500
Honolulu, Hawai'i 96813-2917

JAN K. YAMANE
Acting State Auditor
[redacted]

(808) 587-0800
FAX: (808) 587-0830

December 13, 2013

COPY

The Honorable Dwight Takamine
Director
Department of Labor and Industrial Relations
Princess Ruth Ke'elikōlani Building
830 Punchbowl Street
Honolulu, Hawai'i 96813

Dear Director Takamine:

Enclosed for your information are six copies, numbered 6 to 11, of our confidential draft report, *A Report on Methodology for the Department of Labor and Industrial Relations' Workers' Compensation Medical Fee Schedule*.

In accordance with Act 97, our office has worked in consultation with the department and established a proposed methodology for conducting a survey of prevailing charges for the administrative adjustment of the workers' compensation medical fee schedule. Under Act 97, the director has the discretion to reject the adjustment of fees for services or procedures identified by the Auditor.

We have scheduled a meeting with your office on December 18, 2013, to discuss whether you concur with our report's methodology and recommendations. At the meeting, we request that you inform us on whether you intend to concur or comment on our methodology and recommendations. We ask that your written concurrence or comments be submitted no later than December 20th.

Copies of this confidential report have been transmitted to the Governor, the Senate President, and the Speaker of the House of Representatives.

Since this report is not in final form, access to the report should be restricted to those assisting you in preparing your comment. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Jan K. Yamane
Acting State Auditor

Enclosure

NEIL ABERCROMBIE
GOVERNOR

DWIGHT TAKAMINE
DIRECTOR

JADE T. BUTAY
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
830 PUNCHBOWL STREET, ROOM 321
HONOLULU, HAWAII 96813
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Phone: (808) 586-8844 / Fax: (808) 586-9099
Email: dlir.director@hawaii.gov

December 20, 2013

Ms. Jan K. Yamane
Acting State Auditor
465 South King Street, Room 500
Honolulu, HI 96813-2917

Dear Ms. Yamane

Thank you for the opportunity to comment on the draft ***A Report on Methodology for the Department of Labor and Industrial Relation's Workers' Compensation Medical Fee Schedule***. The DLIR essentially concurs with the analysis and recommendations contained in the draft report. The report's recommendations will help facilitate and ensure appropriate adjustments to the Workers' Compensation Medical Fee Schedule. The recommendations, including the suggested statutory changes if enacted, will provide a means to balance the costs of medical care in the Workers' Compensation system with the access to medical and health care for injured workers.

I sincerely appreciate the efforts of both our staffs in working together to make recommendations to improve the medical and health care aspects of the Workers' Compensation system.

Thank you for your work on this comprehensive and thorough Report.

Sincerely yours,

Dwight Y. Takamine
Director