State of South Carolina

1333 Main Street, Suite 500
P.O. Box 1715
Columbia, S.C. 29202-1715

TEL: (803) 737-5700
FAX: (803) 737-5768

Workers' Compensation Commission

Memorandum

To: Commissioner Andrea C. Roche, Chairman
Commissioner Susan S. Barden
Commissioner G. Bryan Lyndon
Commissioner David W. Huffstetler
Commissioner Derrick L. Williams
Commissioner Avery B. Wilkerson, Jr.
Commissioner T. Scott Beck
Gary M. Cannon, Executive Director

From: Gary R. Thibault

Date: September 18, 2009

Subject: ***2010 Medical Services Provider Manual***

The *Medical Services Provider Manual*, developed, approved and published by the Commission, sets the maximum allowable fees physicians and other medical providers may be paid for authorized services provided to a workers' compensation patient. The Commission published the first fee schedule in 1950, the last in 2003. (See Attachment 1: *2003 Medical Services Provider Manual.*) Until 1995, the fee schedule was charge based. That is, prices were based on an informal survey of physicians' charges for various procedures and discounted. Since 1995, prices have been based on the resources necessary to provide the service.

Development of the *2010 Medical Services Provider Manual* included collection and analysis of utilization data for 2008, review of new procedures, review of changes in relative values, and comparison of the *Medical Services Provider Manual* with fee schedules in other states and with Medicare.

Statutory Authority

The Workers' Compensation Commission is the regulatory agency of the State of South Carolina responsible for overseeing and administering the South Carolina Workers' Compensation Act. SC Code Ann. §§ 42-1-10 et seq. (1976). The Commission has the authority to approve or deny medical fees, as well as the statutory and regulatory discretion to set the amount of fees. (§ 42-15-90, R 67-1302)

> **§ 42-15-90. Fees of attorneys and physicians and hospital charges shall be approved by the Commission.**
>
> Fees for attorneys and physicians and charges of hospitals for services under this title shall be subject to the approval of the Commission.

> **R 67-1302. Maximum Allowable Payments to Medical Practitioners.**
>
> A. The Commission shall establish maximum allowable payments for medical services provided by medical practitioners based on a relative value scale and a conversion factor set by the Commission.
>
> (1) The maximum allowable payments and any policies governing the billing and payment of services provided by medical practitioners shall be published in a medical services provider manual.
>
> (2) The Commission may review and update the relative values and/or conversion factor as needed.

Background & Development Process

The *2003 Medical Services Provider Manual* went into effect on January 1, 2003 and was based on the Centers for Medicare & Medicaid Services (CMS), Resource Based Relative Value Scale (RBRVS). RBRVS, updated and published annually by CMS, establishes a relative value unit for most medical services. (See Attachment 2 for examples of relative values published in the Federal Register, Volume 73, Number 224, Wednesday, November 19, 2008.). Medical services are identified by current procedural terminology (CPT) codes which describe procedures and services performed by physicians and other health care providers. CPT codes are published and updated annually by the American Medical Association. The relative value for each procedure is multiplied by a conversion factor set by the Commission, currently $52, to arrive at the maximum allowable payment (MAP). MAPs represent the maximum amount that a provider can be paid for rendering services under the Workers' Compensation Act. In instances where the provider's usual charge is lower than the MAP amount, or where the provider has agreed by contract with an employer or insurance carrier to accept discounts resulting in fees lower than the Commission's MAPs, payment is made at the lower amount.

R 67-1302. Maximum Allowable Payments to Medical Practitioners.

C. An employer or insurance carrier may not pay, and a medical practitioner may not accept, more than the maximum allowable payment amounts listed in the provider manual.

RBRVS is a well recognized method for determining price based on the work involved, the expense associated with providing that service, and malpractice insurance costs. RBRVS attempts to ensure that fees are based on the resources used to provide each service. It utilizes one of the most systematic methods for setting price and is a system which has been adopted by commercial insurance carriers and workers' compensation programs in other states. It has broad base support in the business, insurance and medical communities.

In 2003 the Commission approved a 5.0% average increase in prices. Between 1998 and 2002 relative values increased 9.1% and to increase total payments 5% required a decrease in the conversion factor of $2.03, from $54.03 to $52.00. The anesthesia conversion factor was increased to $24.00, proportionally the same as the Medicare conversion factor for anesthesia and the Medicare conversion factor, 46%.

Since the adoption of RBRVS, the Commission has:

- Added a Pharmacy Section
- Added Pathology & Lab
- Added Durable Medical Equipment
- Established site of service payment differential
- Enhanced the narrative to be more user friendly
- Updated CPT codes.

Comments Received

On May 22, 2009, a notice of general public interest was published in the State Register and posted on the Commission's website announcing that the Commission was in the process of reviewing and revising the *Medical Services Provider Manual.* The notice stated that the next edition of the fee schedule would be a complete revision and include updates to payment policies, billing policies, evaluation and management services, anesthesia, surgery, radiology, pathology and lab services, medicine and injections, physical medicine, special reports and services, supplies and durable medical equipment. The notice invited comments and recommendations. The public hearing was held Friday, June 19, 2009, at the offices of the Commission. It is important to note that a public hearing was not required and was held to provide an additional avenue for comments on the fee schedule. While the Commission's regulations provide the method of determining

prices, new or revised fee schedules are established by a vote of the Full Commission at a monthly business meeting. In addition to Commissioners and staff, nine people attended. Written comments were requested by June 30, 2009, and accepted through August 25, 2009. All comments received, as well as a summary of those comments, and the transcript of the hearing, can be found in Attachment 3.

The Commission has long recognized that it must balance the interests of the employee, business, insurance and medical communities to make sure that workers' compensation patients have access to quality health care services at a reasonable price. In order to maintain this important balance, the Commission assured the medical, business and insurance communities that it was committed to monitoring the financial impact of the schedule and making changes when necessary. While historically the Commission has not committed to a course of action which automatically would recognize annual fee adjustments based on one of the inflation indices, it has committed to an ongoing review of all fee schedules.

Analysis

The Commission established a data set representing over 381,000 procedures representing $34.2 million in costs performed for workers' compensation patients in South Carolina during 2008. The data set was provided by two large insurance carriers and one self-insured fund. The data set is considered sufficiently large to be representative of workers' compensation cases in this state. Those companies represent approximately 14% of the South Carolina workers' compensation market. (See Attachment 4, "Effect of Adopting 2009 Relative Values.") Based on this data set, the entire market for all procedures covered under the *Medical Services Provider Manual* is estimated at $244.3 million for 2008.

While the American Medical Association publishes codes for over 7,000 separate procedures, approximately 1,200 are used in workers' compensation. Of the 1,200, the top 200 procedures represent 80.5% of total expenditures in workers' compensation in our state. While the initial analysis was based on all procedures in the data set, the Commission's final analysis was based on the top 200 codes, which represented, in this data set, approximately $27.5 million in payments to providers.

How South Carolina Compares to Other States

Since 1993, the Workers' Compensation Research Institute (WCRI), Cambridge, Massachusetts, has published the most comprehensive studies on workers' compensation

fee schedules. It will soon publish its 2009 report in a series titled "Benchmarks for Designing Workers Compensation Fee Schedules". Those reports, published in 1993, 1994, 1996, and 2002 contain similar findings as found in the most recent 2006 study:

- There are substantial differences in fee schedule rates from state to state. The highest state's fee schedule rates are on average 3.5 times higher than the lowest states fee schedule rates.

- Alaska and Illinois have the highest average fee schedules, while Massachusetts has the lowest average fee schedule.

- The interstate variation is not rationally related to the interstate variation in the expenses that medical providers incur in producing the services.

- Most state fee schedules create financial incentives to underuse primary care and overuse invasive and specialty care. A few states avoid this by following a reasonably fully transitioned RBRVS and setting similar conversion factor across the different services groups within their state. (Hawaii, Texas, Washington, Michigan, West Virginia, South Carolina, Maine Florida, Massachusetts and Maryland)

- Several states have fee schedules that may be higher than necessary. The most likely candidates are state fee schedules that are double or more the state's Medicare rates.

- A few states may have fee schedules that are so low as to raise concerns about access to quality care.

- Currently more than half of the 42 states base their workers' compensation fee schedule on the RBRVS system, at least in part.

- Absent information concerning the efficacy of care, and absent information regarding access to care, it is difficult to determine the optimal fee schedule price.

(*Benchmarks for Designing Workers' Compensation Medical Fee Schedules: 2006*, Workers Compensation Research Institute, Cambridge, Massachusetts, November 2006)

Establishing rates involves a delicate balance. If fee schedules set prices too high, savings will be negligible and the goal of medical cost containment will not be met. If fees are set too low, fewer providers will elect to treat workers' compensation patients and

access to quality care may be affected. It has been the public policy of most states, including South Carolina, since workers' compensation insurance is required of most employers, with the cost ultimately paid by all citizens of the state as part of the price of goods and services they purchase, that medical costs be contained as are other costs in workers' compensation, including disability and wage loss. Forty-three jurisdictions have implemented workers' compensation medical fee schedules, the tool most often used to contain medical costs.

WCRI Medical Price Index, MPI-WC

WCRI has developed a medical price index for a market basket of non-hospital, non-facility procedures common in workers' compensation. This market basket is comprised of office visits, consultations, surgery, radiology and physical medicine and includes approximately 80% to 90% of all non-hospital expenditures. The report quantifies the relative prices paid for workers' compensation medical care in 25 states as well as the trend in prices paid in those states. The study, published in June 2008, tracks price changes from 2001 to 2006 and includes South Carolina, North Carolina and Georgia among the states studied. It also tracks changes in prices paid within those states and allows for interstate comparisons.

Based on WCRI's analysis, in 2006 South Carolina had a price index of 90, that is, the prices paid in South Carolina were 10% lower than the prices paid in the median state. North Carolina also had a fee index of 90 and Georgia had a price index of 100. The three lowest states were Maryland, Texas and New York with indices of 76, 82 and 86 respectively. The highest were Wisconsin, Illinois and New Jersey with indices of 195, 161 and 144. (See Attachment 5, *Medical Price Index for Workers' Compensation: The MPI-WC, Second Edition, June 2008*, Workers Compensation Research Institute, Cambridge, Massachusetts.)

WCRI also measured the difference between prices set in each state for workers' compensation purposes and those set for Medicare. Medicare, which is a major payer of medical services in all states, adjusts prices in each state according to the differences in the cost of providing medical treatment. It is one of the few national payers what has designed a system that adjusts prices based on a geographical practice cost index. (See Attachment 6, 2009 Geographic Adjustment Factors; and 2009 Geographic Practice Cost Indices by State and Medicare Locality.) Thus the prices Medicare sets and pays for services provided in Alabama, for example, differ than the prices set for Alaska. This allows comparison between states, not only of Medicare prices but the comparison of the prices set by other payers as well. For example, by using Medicare as the baseline, the percentage difference in what each state pays in relation to Medicare provides another benchmark to compare workers' compensation fees. According to WCRI, South Carolina's *Medical Services*

Provider Manual, on average sets, as of July 2006, prices 47% higher than Medicare. North Carolina sets fees 39% higher than Medicare and Georgia 58% higher.

The three lowest states were Massachusetts, Hawaii and West Virginia. Massachusetts fees, on average, were 13% below Medicare prices and Hawaii's workers' compensation fee schedule was 10% above Medicare. West Virginia was 13% higher than Medicare's. The three highest states, Alaska, Illinois, and Rhode Island set fees 236%, 163% and 116% higher than Medicare. (See Attachment 7: "Workers' Compensation Fee Schedule Premium Over Medicare Fee Schedule, by Service Group, July 2006".)

Inflation

Since January 2003, the date of the last overall increase in medical fees, the Consumer Price Index for Medical Care, in cities with populations between 50,000 and 1,500,000 in the South, increased 26.8% (January 2003 through July 2009). Over this same period of time the price for medical care services increased 28.9% for urban areas in the South. The Consumer Price Index for all items increased 17.6% during this period. (See Attachment 8, Bureau of Labor Statistics, Consumer Price Index.)

Another measure of change in the cost of physician services is the Medicare Economic Index (MEI). The MEI measures the average annual price change for various inputs need to produce physician services. It is comprised of two categories: the physician's own time, to include wages, salaries and fringe benefits, and the physicians practice expense. The physicians practice expense includes nonphysician employee compensation, office expense, drugs and medical supplies, liability insurance costs, medical equipment and other expenses. The MEI is adjusted to reflect productivity growth.

The MEI is projected to increase 1.6% in 2009 after having increased 15.7% from 2003 to 2008 for a total increase of 17.3% during this period. (See Attachment 9, "Increase in the Medicare Economic Index Update for CY 2009", Attachment 10, "Medicare Economic Index, 2003 – 2009" and Attachment 11, "Medicare Economic Index & CPI, 2003 – 2009.")

Pharmacy

In 2003, based on recommendations from its Pharmacy Advisory Committee, the Commission included a pharmacy section as part of the fee schedule. Payment for prescription drugs, both brand name and generic, is limited to the average wholesale price plus a $5.00 dispensing fee or the pharmacist's or health care provider's usual and

customary charge, whichever is less. The *Red Book*, published by Thomson Reuters, and the *Blue Book*, published by First Databank, are the sources of average wholesale prices. All prescriptions must be filled using generic drugs, if available, unless the treating physician directs otherwise.

It is important to note that average wholesale price is not equivalent to acquisition cost. It is a price determined by manufacturers. Pharmacies receive substantial discounts and rebates to average wholesale price and there is considerable variation in the discounts and rebates received.

While the payments under this formula are higher than some health insurance plans, our payment system is not as fluid, with a substantially higher number of payers involved and slightly higher transaction costs. The fee schedule amount is the maximum allowable payment a provider can be paid under the Workers' Compensation Act. In instances where the pharmacy's charge is lower than the maximum allowable payment, or where the pharmacy has agreed by contract with an employer or insurance carrier to accept discounts or lower fees, payment is to be made at the lower amount.

While no change is being recommended in the prescription pricing formula, it is an issue that will need further consideration as a result of ongoing national litigation over the method for calculating average wholesale prices. (For example, see New England Carpenters Health Benefits Fund et. al. v. First Data Bank, Inc., and McKesson Corporation. As a result of $350 million settlement in this class action lawsuit, in two years First Databank will no longer publish the *Blue Book*. See Attachment 12, "Settlement to Reduce Brand-Name Drug Prices in Many States", Workcompcentral, September 9, 2009.) In addition, there are changes underway in Medicare's pricing of drugs, specifically, changes in how prescription drugs will be priced for inclusion in set-aside agreements.

Recommendations for 2010

Based on this analysis, the following is recommended: a 3.1% average increase in prices for 2010, adoption of CMS's 2009 relative values, to include facility and non-facility relative values where applicable, and inclusion of the most recent current procedural codes published by the American Medical Association. Between 2003 and 2009 relative values increased 3.1% (See Attachment 4, Effect of Adopting 2009 Relative Values). To increase total payments 3.1%, the conversion factor would remain $52.00. The anesthesia conversion factor would be $30.00, proportionally the same as the Medicare conversion factor for anesthesia and the Medicare conversion factor, 58%. The current anesthesia

conversion factor is $24.00. The 26% increase in the anesthesia conversion factor is a result of changes implemented by Medicare since 2002.

Independent Medical Examinations

It is recommended that the fee for an independent medical examination be increased from $600 to $750. The American Medical Association defines an independent medical examination, CPT Code 99456, as a work related or medical disability examination by other than the treating physician that includes: completion of a medical history commensurate with the patient's condition, performance of an examination commensurate with the patient's condition; formulation of a diagnosis, assessment of capabilities and stability, and calculation of impairment; development of future medical treatment plan; and completion of necessary documentation/certificates and report. It is also recommended that CPT Code 99455, impairment rating by the treating physician, be increased from $97 to $150. With this change, it is recommended that in extenuating or complex circumstances, an IME fee greater than the maximum allowable payment may be approved, either by a commissioner or through administrative review by the Commission's Medical Services Division. Appropriate supporting documentation must be submitted with the request.

The following changes in fees are also recommended:

- CPT Code 99075, Medical testimony, physician, first hour from $536 to $600;
- CPT Code 99076, Medical testimony, physician, each additional quarter hour from $134 to $150;
- CPT Code 99145, Testimony by deposition, physician first hour from $320 to $400; and
- CPT Code 99146, Testimony by deposition, physician, each additional quarter hour, from $80 to $100.

For all other fees where a relative value is not available, the price will be calculated in the same manner as the 2003 schedule or the increase will be same as the overall increase approved.

National Correct Coding Initiative

It is also recommended that the National Correct Coding Initiative be cited and used to guide the billing and payment of procedures. This coding initiative was developed by the Centers for Medicare and Medicaid Services to promote correct coding of health services and prevent payment for improperly coded services. It consists of edits to evaluate claims when a provider bills more than one service for the same patient for the same date of service. It is based on coding conventions in the American Medical Associations

Current Procedural Terminology manual, coding guidelines from national societies and analysis of Medicare medical and surgical practices. Its purpose is to ensure that the most comprehensive group of codes are billed rather than the component parts and to edit two codes that cannot reasonably be performed together based on either the definition or anatomical considerations. It is a national recognized system used by Medicare since 1996, many state Medicaid programs and many health insurance carriers. The Commission for many years has used the correct coding edits as a basis for resolving bill disputes. It provides a system to determine which procedures are part of, and thus included in the payment of, the same service. The recommendation is to include a statement in the fee schedule citing its use thus providing greater clarification and guidance for proper billing and payment. If any disputes arise concerning proper coding, the dispute can be handled in the same manner as provided by R67-1305, Medical Bill Review.

The effective date of the new schedule would be January 1, 2010, or as soon thereafter as possible.

Impact on Total Payments & Premium

The National Council on Compensation Insurance (NCCI) estimates that the adoption of Medicare's 2009 relative values and the change in the anesthesia conversion factor would result in a 3.8% increase in physician costs. The dollar impact on overall workers' compensation system costs would be $7.6 million. (See Attachment 13, "Analysis of Changes to the South Carolina Physician Fee Schedule Proposed to be Effective January 1, 2010", National Council on Compensation Insurance, September 17, 2009.)

GRT:t
Attachments

1. *2003 Medical Services Provider Manual*
2. Federal Register, Vol. 73, No 224, Wednesday, November 19, 2008
3. Summary of Comments Received, Comments Received and Public Hearing Transcript
4. Effect of Adopting 2009 Relative Values
5. *WCRI Medical Price Index For Workers' Compensation: The MPI-WC, Second Edition*
6. 2009 Geographic Adjustment Factors; 2009 Geographic Practice Cost Indices by State and Medicare Locality
7. "Workers' Compensation Premium Over Medicare by Service Group, July 2006"

8. Bureau of Labor Statistics, Consumer Price Index
9. "Increase in the Medicare Economic Index Update for CY 2009"
10. "Medicare Economic Index, 2003 – 2009"
11. "Medicare Economic Index and CPI, 2003 – 2009"
12. "Settlement to Reduce Brand-Name Drug Prices in Many States", Workcompcentral, September 1, 2009.
13. "Analysis of Changes to the South Carolina Physician Fee Schedule Proposed to be Effective January 1, 2010", National Council on Compensation Insurance, Inc., September 17, 2009.

Attachment 1

2003 Medical Services Provider Manual

(Bound in separate binder)

Attachment 2

Example of Relative Values
Selected Pages
***Federal Register*, Volume 73, Number 224**
Wednesday, November 19, 2008

Federal Register

Wednesday,
November 19, 2008

Book 2 of 2 Books
Pages 69725–70238

Part II

Department of Health and Human Services

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 409, et al.
Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2009; E-Prescribing Exemption for Computer-Generated Facsimile Transmissions; and Payment for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 405, 409, 410, 411, 413, 414, 415, 423, 424, 485, 486, and 489

[CMS–1403–FC] [CMS–1270–F2]

RINs 0938–AP18, 0938–AN14

Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2009; E-Prescribing Exemption for Computer-Generated Facsimile Transmissions; and Payment for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule with comment period.

SUMMARY: This final rule with comment period implements changes to the physician fee schedule and other Medicare Part B payment policies to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. It also finalizes the calendar year (CY) 2008 interim relative value units (RVUs) and issues interim RVUs for new and revised codes for CY 2009. In addition, as required by the statute, it announces that the physician fee schedule update is 1.1 percent for CY 2009, the preliminary estimate for the sustainable growth rate for CY 2009 is 7.4 percent, and the conversion factor (CF) for CY 2009 is $36.0666. This final rule with comment period also implements or discusses certain provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). (See the Table of Contents for a listing of the specific issues addressed in this rule.)

DATES: *Effective Date:* This final rule with comment period is effective on January 1, 2009 except for amendments to § 410.62 and § 411.351 which are effective July 1, 2009.

Comment Date: Comments will be considered if we receive them at one of the addresses provided below, no later than 5 p.m. e.s.t. on December 29, 2008.

ADDRESSES: In commenting, please refer to file code CMS–1403–FC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the instructions for "Comment or Submission" and enter the filecode to find the document accepting comments.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1403–FC, P.O. Box 8013, Baltimore, MD 21244–8013.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1403–FC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to either of the following addresses:

7500 Security Boulevard, Baltimore, MD 21244–1850; or

Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by mailing your comments to the addresses provided at the end of the "Collection of Information Requirements" section in this document.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Pam West, (410) 786–2302, for issues related to practice expense.

Rick Ensor, (410) 786–5617, for issues related to practice expense methodology.

Stephanie Monroe, (410) 786–6864, for issues related to malpractice RVUs.

Esther Markowitz, (410) 786–4595, for issues related to telehealth services.

Craig Dobyski, (410) 786–4584, for issues related to geographic practice cost indices.

Ken Marsalek, (410) 786–4502, for issues related to the multiple procedure payment reduction for diagnostic imaging.

Catherine Jansto, (410) 786–7762, or Cheryl Gilbreath, (410) 786–5919, for issues related to payment for covered outpatient drugs and biologicals.

Edmund Kasaitis, (410) 786–0477, or Bonny Dahm, (410) 786–4006, for issues related to the Competitive Acquisition Program (CAP) for Part B drugs.

Corinne Axelrod, (410) 786–5620, for issues related to Health Professional Shortage Area Bonus Payments.

Henry Richter, (410) 786–4562, for issues related to payments for end-stage renal disease facilities.

Lisa Grabert, (410) 786–6827, for issues related to hospital-acquired conditions and the Physician Resource Use Feedback Program.

August Nemec, (410) 786–0612, for issues related to independent diagnostic testing facilities; enrollment issues; and the revision to the "Appeals of CMS or CMS contractor Determinations When a Provider or Supplier Fails To Meet the Requirements for Medicare Billing Privileges" final rule.

Lisa Ohrin, (410) 786–4565, Kristin Bohl, (410) 786–8680, or Don Romano, (410) 786–1401, for issues related to anti-markup provisions and physician self-referral (incentive payment and shared savings programs).

Diane Stern, (410) 786–1133, for issues related to the quality reporting system for physician payment for CY 2009.

Andrew Morgan, (410) 786–2543, for issues related to the e-prescribing exemption for computer-generated fax transmissions.

Terri Harris, (410) 786–6830, for issues related to payment for comprehensive outpatient rehabilitation facilities (CORFs).

Lauren Oviatt, (410) 786–4683, for issues related to CORF conditions of coverage.

Trisha Brooks, (410) 786–4561, for issues related to personnel standards for portable x-ray suppliers.

David Walczak, (410) 786–4475, for issues related to beneficiary signature for nonemergency ambulance transport services.

Jean Stiller, (410) 786–0708, for issues related to the prohibition concerning providers of sleep tests

Mark Horney, (410) 786–4554, for issues related to the solicitation for comments and data pertaining to physician organ retrieval services.

Regina Walker-Wren, (410) 786–9160, for information concerning educational

requirements for nurse practitioners and clinical nurse specialists.

Randy Throndset, (410) 786–0131, for information concerning physician certification and recertification for Medicare home health services.

William Larson, (410) 786–4639, for coverage issues related to the initial preventive physical examination.

Cathleen Scally, (410) 786–5714, for payment issues related to the initial preventive physical examination.

Dorothy Shannon, (410) 786–3396, for issues related to speech language pathology.

Kendra Hedgebeth, (410) 786–4644, or Gina Longus, (410) 786–1287, for issues related to low vision aids.

Christopher Molling, (410) 786–6399, or Anita Greenberg, (410) 786–4601, for issues related to the repeal to transfer of title for oxygen equipment.

Karen Jacobs, (410) 786–2173, or Hafsa Bora, (410) 786–7899, for issues related to the therapeutic shoes fee schedule.

Diane Milstead, (410) 786–3355, or Gaysha Brooks, (410) 786–9649, for all other issues.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on the following issues:

- The Exception for Incentive Payment and Shared Savings Programs (§ 411.357(x)) in section II.N.1. of this final rule with comment period;
- Sections 131(c), 144(b), and 149 of the MIPPA as described in sections III.C., III.J., and III.M. of this final rule with comment period.
- Interim Relative Value Units (RVUs) for selected codes identified in Addendum C;
- Information on pricing for items in Tables 2 through 5;
- Issues related to the Physician Resource Use Feedback Program described in section II.S.6. of this final rule with comment period; and
- The physician self-referral designated health services (DHS) codes listed in Tables 29, 30, and 31. You can assist us by referencing the file code [CMS–1403–FC] and the section heading on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

Table of Contents

To assist readers in referencing sections contained in this preamble, we are providing a table of contents. Some of the issues discussed in this preamble affect the payment policies, but do not require changes to the regulations in the *Code of Federal Regulations* (CFR). Information on the regulation's impact appears throughout the preamble, and therefore, is not exclusively in section XVI. of this final rule with comment period.

Acronyms

In addition, because of the many organizations and terms to which we refer by acronym in this final rule with comment period, we are listing these acronyms and their corresponding terms in alphabetical order below:

ACC American College of Cardiology
ACR American College of Radiology
AFROC Association of Freestanding Radiation Oncology Centers
AHA American Heart Association
AHRQ [HHS] Agency for Healthcare Research and Quality
AIDS Acquired immune deficiency syndrome
AMA American Medical Association
AMP Average manufacturer price
AOA American Osteopathic Association
ASC Ambulatory surgical center
ASP Average sales price
ASRT American Society of Radiologic Technologists
ASTRO American Society for Therapeutic Radiology and Oncology
ATA American Telemedicine Association
AWP Average wholesale price
BBA Balanced Budget Act of 1997 (Pub. L. 105–33)
BBRA [Medicare, Medicaid and State Child Health Insurance Program] Balanced Budget Refinement Act of 1999 (Pub. L. 106–113)
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement Protection Act of 2000 (Pub. L. 106–554)
BLS Bureau of Labor Statistics
BN Budget neutrality
CABG Coronary artery bypass graft
CAD Coronary artery disease
CAH Critical access hospital
CAHEA Committee on Allied Health Education and Accreditation
CAP Competitive acquisition program
CBSA Core-Based Statistical Area
CCHIT Certification Commission for Healthcare Information Technology
CEAMA Council on Education of the American Medical Association
CF Conversion factor
CfC Conditions for Coverage
CFR Code of Federal Regulations
CKD Chronic kidney disease
CLFS Clinical laboratory fee schedule
CMA California Medical Association
CMHC Community mental health center
CMP Civil money penalty
CMS Centers for Medicare & Medicaid Services
CNS Clinical nurse specialist
CoP Condition of participation
CORF Comprehensive Outpatient Rehabilitation Facility
CPAP Continuous positive air pressure
CPEP Clinical Practice Expert Panel
CPI Consumer Price Index
CPI–U Consumer price index for urban customers
CPT [Physicians'] Current Procedural Terminology (4th Edition, 2002, copyrighted by the American Medical Association)
CRT Certified respiratory therapist
CSW Clinical social worker
CY Calendar year
DHS Designated health services
DME Durable medical equipment
DMEPOS Durable medical equipment, prosthetics, orthotics, and supplies
DNP Doctor of Nursing Practice
DRA Deficit Reduction Act of 2005 (Pub. L. 109–171)
DSMT Diabetes self-management training
E/M Evaluation and management
EDI Electronic data interchange
EEG Electroencephalogram
EHR Electronic health record
EKG Electrocardiogram
EMG Electromyogram
EMTALA Emergency Medical Treatment and Active Labor Act
EOG Electro-oculogram
EPO Erythopoeitin
ESRD End-stage renal disease
FAX Facsimile
FDA Food and Drug Administration (HHS)
FFS Fee-for-service
FMS [Department of the Treasury's] Financial Management Service
FPLP Federal Payment Levy Program
FR **Federal Register**
GAF Geographic adjustment factor
GAO General Accounting Office
GPO Group purchasing organization
GPCI Geographic practice cost index
HAC Hospital-acquired conditions
HCPAC Health Care Professional Advisory Committee
HCPCS Healthcare Common Procedure Coding System
HCRIS Healthcare Cost Report Information System

HH PPS Home Health Prospective Payment System
HHA Home health agency
HHRG Home health resource group
HHS [Department of] Health and Human Services
HIPAA Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191)
HIT Health information technology
HITSP Healthcare Information Technology Standards Panel
HIV Human immunodeficiency virus
HOPD Hospital outpatient department
HPSA Health Professional Shortage Area
HRSA Health Resources Services Administration (HHS)
ICF Intermediate care facilities
ICR Information collection requirement
IDTF Independent diagnostic testing facility
IFC Interim final rule with comment period
IPPS Inpatient prospective payment system
IRS Internal Revenue Service
IVIG Intravenous immune globulin
IWPUT Intra-service work per unit of time
JRCERT Joint Review Committee on Education in Radiologic Technology
MA Medicare Advantage
MA–PD Medicare Advantage-Prescription Drug Plans
MedCAC Medicare Evidence Development and Coverage Advisory Committee (formerly the Medicare Coverage Advisory Committee (MCAC))
MedPAC Medicare Payment Advisory Commission
MEI Medicare Economic Index
MIEA–TRHCA Medicare Improvements and Extension Act of 2006 (that is, Division B of the Tax Relief and Health Care Act of 2006 (TRHCA) (Pub. L. 109–432)
MIPPA Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275)
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173)
MMSEA Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173)
MNT Medical nutrition therapy
MP Malpractice
MPPR Multiple procedure payment reduction
MQSA Mammography Quality Standards Act of 1992 (Pub. L. 102–539)
MRA Magnetic resonance angiography
MRI Magnetic resonance imaging
MS–DRG Medicare Severity-Diagnosis related group
MSA Metropolitan statistical area
NCD National Coverage Determination
NCPDP National Council for Prescription Drug Programs
NDC National drug code
NISTA National Institute of Standards and Technology Act
NP Nurse practitioner
NPDB National Practitioner Data Bank
NPI National Provider Identifier
NPP Nonphysician practitioner
NPPES National Plan and Provider Enumeration System
NQF National Quality Forum
NRC Nuclear Regulatory Commission
NTTAA National Technology Transfer and Advancement Act of 1995 (Pub. L. 104–113)
NUBC National Uniform Billing Committee
OACT [CMS'] Office of the Actuary
OBRA Omnibus Budget Reconciliation Act
ODF Open door forum
OIG Office of Inspector General
OMB Office of Management and Budget
ONC [HHS'] Office of the National Coordinator for Health Information Technology
OPPS Outpatient prospective payment system
OSA Obstructive Sleep Apnea
OSCAR Online Survey and Certification and Reporting
P4P Pay for performance
PA Physician assistant
PC Professional component
PCF Patient compensation fund
PDP Prescription drug plan
PE Practice expense
PE/HR Practice expense per hour
PEAC Practice Expense Advisory Committee
PECOS Provider Enrollment, Chain, and Ownership System
PERC Practice Expense Review Committee
PFS Physician Fee Schedule
PHP Partial hospitalization program
PIM [Medicare] Program Integrity Manual
PLI Professional liability insurance
POA Present on admission
POC Plan of care
PPI Producer price index
PPS Prospective payment system
PPTA Plasma Protein Therapeutics Association
PQRI Physician Quality Reporting Initiative
PRA Paperwork Reduction Act
PSA Physician scarcity areas
PSG Polysomnography
PT Physical therapy
ResDAC Research Data Assistance Center
RFA Regulatory Flexibility Act
RIA Regulatory impact analysis
RN Registered nurse
RNAC Reasonable net acquisition cost
RRT Registered respiratory therapist
RUC [AMA's Specialty Society] Relative (Value) Update Committee
RVU Relative value unit
SBA Small Business Administration
SGR Sustainable growth rate
SLP Speech-language pathology
SMS [AMA's] Socioeconomic Monitoring System
SNF Skilled nursing facility
SOR System of record
SRS Stereotactic radiosurgery
TC Technical Component
TIN Tax identification number
TRHCA Tax Relief and Health Care Act of 2006 (Pub. L. 109–432)
UPMC University of Pittsburgh Medical Center
USDE United States Department of Education
VBP Value-based purchasing
WAMP Widely available market price

I. Background

Since January 1, 1992, Medicare has paid for physicians' services under section 1848 of the Social Security Act (the Act), "Payment for Physicians' Services." The Act requires that payments under the physician fee schedule (PFS) be based on national uniform relative value units (RVUs) based on the relative resources used in furnishing a service. Section 1848(c) of the Act requires that national RVUs be established for physician work, practice expense (PE), and malpractice expense. Before the establishment of the resource-based relative value system, Medicare payment for physicians' services was based on reasonable charges.

A. Development of the Relative Value System

1. Work RVUs

The concepts and methodology underlying the PFS were enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (Pub. L. 101–239), and OBRA 1990, (Pub. L. 101–508). The final rule, published on November 25, 1991 (56 FR 59502), set forth the fee schedule for payment for physicians' services beginning January 1, 1992. Initially, only the physician work RVUs were resource-based, and the PE and malpractice RVUs were based on average allowable charges.

The physician work RVUs established for the implementation of the fee schedule in January 1992 were developed with extensive input from the physician community. A research team at the Harvard School of Public Health developed the original physician work RVUs for most codes in a cooperative agreement with the Department of Health and Human Services (DHHS). In constructing the code-specific vignettes for the original physician work RVUs, Harvard worked with panels of experts, both inside and outside the Federal government, and obtained input from numerous physician specialty groups.

Section 1848(b)(2)(B) of the Act specifies that the RVUs for anesthesia services are based on RVUs from a uniform relative value guide. We established a separate conversion factor (CF) for anesthesia services, and we continue to utilize time units as a factor in determining payment for these services. As a result, there is a separate payment methodology for anesthesia services.

We establish physician work RVUs for new and revised codes based on recommendations received from the American Medical Association's (AMA) Specialty Society Relative Value Update Committee (RUC).

2. Practice Expense Relative Value Units (PE RVUs)

Section 121 of the Social Security Act Amendments of 1994 (Pub. L. 103–432),

enacted on October 31, 1994, amended section 1848(c)(2)(C)(ii) of the Act and required us to develop resource-based PE RVUs for each physician's service beginning in 1998. We were to consider general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses) comprising PEs.

Section 4505(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), amended section 1848(c)(2)(C)(ii) of the Act to delay implementation of the resource-based PE RVU system until January 1, 1999. In addition, section 4505(b) of the BBA provided for a 4-year transition period from charge-based PE RVUs to resource-based RVUs.

We established the resource-based PE RVUs for each physician's service in a final rule, published November 2, 1998 (63 FR 58814), effective for services furnished in 1999. Based on the requirement to transition to a resource-based system for PE over a 4-year period, resource-based PE RVUs did not become fully effective until 2002.

This resource-based system was based on two significant sources of actual PE data: the Clinical Practice Expert Panel (CPEP) data; and the AMA's Socioeconomic Monitoring System (SMS) data. The CPEP data were collected from panels of physicians, practice administrators, and nonphysicians (for example, registered nurses (RNs)) nominated by physician specialty societies and other groups. The CPEP panels identified the direct inputs required for each physician's service in both the office setting and out-of-office setting. We have since refined and revised these inputs based on recommendations from the RUC. The AMA's SMS data provided aggregate specialty-specific information on hours worked and PEs.

Separate PE RVUs are established for procedures that can be performed in both a nonfacility setting, such as a physician's office, and a facility setting, such as a hospital outpatient department. The difference between the facility and nonfacility RVUs reflects the fact that a facility typically receives separate payment from Medicare for its costs of providing the service, apart from payment under the PFS. The nonfacility RVUs reflect all of the direct and indirect PEs of providing a particular service.

Section 212 of the Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) directed the Secretary of Health and Human Services (the Secretary) to establish a process under which we accept and use, to the maximum extent practicable and consistent with sound data practices, data collected or developed by entities and organizations to supplement the data we normally collect in determining the PE component. On May 3, 2000, we published the interim final rule (65 FR 25664) that set forth the criteria for the submission of these supplemental PE survey data. The criteria were modified in response to comments received, and published in the **Federal Register** (65 FR 65376) as part of a November 1, 2000 final rule. The PFS final rules published in 2001 and 2003, respectively, (66 FR 55246 and 68 FR 63196) extended the period during which we would accept these supplemental data through March 1, 2005.

In CY 2007 PFS final rule with comment period (71 FR 69624), we revised the methodology for calculating PE RVUs beginning in CY 2007 and provided for a 4-year transition for the new PE RVUs under this new methodology. We will continue to evaluate this policy and proposed necessary revisions through future rulemaking.

3. Resource-Based Malpractice (MP) RVUs

Section 4505(f) of the BBA amended section 1848(c) of the Act requiring us to implement resource-based malpractice (MP) RVUs for services furnished on or after 2000. The resource-based MP RVUs were implemented in the PFS final rule published November 2, 1999 (64 FR 59380). The MP RVUs were based on malpractice insurance premium data collected from commercial and physician-owned insurers from all the States, the District of Columbia, and Puerto Rico.

4. Refinements to the RVUs

Section 1848(c)(2)(B)(i) of the Act requires that we review all RVUs no less often than every 5 years. The first 5-Year Review of the physician work RVUs was published on November 22, 1996 (61 FR 59489) and was effective in 1997. The second 5-Year Review was published in the CY 2002 PFS final rule with comment period (66 FR 55246) and was effective in 2002. The third 5-Year Review of physician work RVUs was published in the CY 2007 PFS final rule with comment period (71 FR 69624) and was effective on January 1, 2007. (**Note:** Additional codes relating to the third 5-Year Review of physician work RVUs were addressed in the CY 2008 PFS final rule with comment period (72 FR 66360).)

In 1999, the AMA's RUC established the Practice Expense Advisory Committee (PEAC) for the purpose of refining the direct PE inputs. Through March 2004, the PEAC provided recommendations to CMS for over 7,600 codes (all but a few hundred of the codes currently listed in the AMA's Current Procedural Terminology (CPT) codes). As part of the CY 2007 PFS final rule with comment period (71 FR 69624), we implemented a new methodology for determining resource-based PE RVUs and are transitioning this over a 4-year period.

In the CY 2005 PFS final rule with comment period (69 FR 66236), we implemented the first 5-Year Review of the MP RVUs (69 FR 66263).

5. Adjustments to RVUs are Budget Neutral

Section 1848(c)(2)(B)(ii)(II) of the Act provides that adjustments in RVUs for a year may not cause total PFS payments to differ by more than $20 million from what they would have been if the adjustments were not made. In accordance with section 1848(c)(2)(B)(ii)(II) of the Act, if adjustments to RVUs cause expenditures to change by more than $20 million, we make adjustments to ensure that expenditures do not increase or decrease by more than $20 million.

As explained in the CY 2007 PFS final rule with comment period (71 FR 69624), due to the increase in work RVUs resulting from the third 5-Year Review of physician work RVUs, we applied a separate budget neutrality (BN) adjustor to the work RVUs for services furnished during 2007 and 2008. This approach is consistent with the method we used to make BN adjustments to reflect the changes in the PE RVUs.

Section 133(b) of the MIPPA amends section 1848(c)(2)(B) of the Act to specify that, instead of continuing to apply the BN adjustor for the 5-Year Review to work RVUs, the BN adjustment must be applied to the CF for years beginning with CY 2009. Further discussion of this MIPPA provision as it relates to the CY 2009 PFS can be found in sections III. and IX. of this final rule with comment period.

B. Components of the Fee Schedule Payment Amounts

To calculate the payment for every physician's service, the components of the fee schedule (physician work, PE, and MP RVUs) are adjusted by a geographic practice cost index (GPCI). The GPCIs reflect the relative costs of physician work, PE, and malpractice insurance in an area compared to the national average costs for each component.

RVUs are converted to dollar amounts through the application of a CF, which

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2]	Fully Implemented Non-Facility PE RVUs[2]	Year 2009 Transitional Non-Facility PE RVUs[2]	Fully Implemented Facility PE RVUs[2]	Year 2009 Transitional Facility PE RVUs[2]	Mal-Practice RVUs[2]	Global
22226		A	Revise, extra spine segment	6.03	NA	NA	2.45	2.62	1.29	ZZZ
22305		A	Treat spine process fracture	2.08	2.15	2.20	1.82	1.85	0.39	090
22310		A	Treat spine fracture	3.69	3.05	2.99	2.57	2.52	0.50	090
22315		A	Treat spine fracture	9.91	9.79	9.79	7.49	7.47	1.86	090
22318		A	Treat odontoid fx w/o graft	22.54	NA	NA	13.45	13.47	5.30	090
22319		A	Treat odontoid fx w/graft	25.15	NA	NA	14.07	14.26	6.05	090
22325		A	Treat spine fracture	19.62	NA	NA	12.52	12.44	3.88	090
22326		A	Treat neck spine fracture	20.64	NA	NA	12.40	12.51	4.43	090
22327		A	Treat thorax spine fracture	20.52	NA	NA	12.70	12.65	3.99	090
22328		A	Treat each add spine fx	4.60	NA	NA	1.87	1.97	0.94	ZZZ
22505		A	Manipulation of spine	1.87	NA	NA	0.97	0.96	0.36	010
22520		A	Percut vertebroplasty thor	9.17	42.10	47.11	4.27	4.48	1.72	010
22521		A	Percut vertebroplasty lumb	8.60	42.89	46.27	4.04	4.28	1.60	010
22522		A	Percut vertebroplasty addÆl	4.30	NA	NA	1.66	1.67	0.82	ZZZ
22523		A	Percut kyphoplasty, thor	9.21	NA	NA	4.87	5.14	1.72	010
22524		A	Percut kyphoplasty, lumbar	8.81	NA	NA	4.71	4.97	1.60	010
22525		A	Percut kyphoplasty, add-on	4.47	NA	NA	1.80	1.92	0.82	ZZZ
22526		A	Idet, single level	6.07	41.57	41.57	1.91	1.91	1.16	010
22527		A	Idet, 1 or more levels	3.03	34.18	34.18	0.57	0.57	0.58	ZZZ
22532		A	Lat thorax spine fusion	25.81	NA	NA	14.22	14.41	4.35	090
22533		A	Lat lumbar spine fusion	24.61	NA	NA	13.99	13.92	3.16	090
22534		A	Lat thor/lumb, addÆl seg	5.99	NA	NA	2.45	2.60	1.25	ZZZ
22548		A	Neck spine fusion	26.86	NA	NA	15.10	15.31	5.61	090
22554		A	Neck spine fusion	17.54	NA	NA	10.87	11.26	4.46	090
22556		A	Thorax spine fusion	24.50	NA	NA	13.36	13.73	4.35	090
22558		A	Lumbar spine fusion	23.33	NA	NA	12.01	12.36	3.16	090
22585		A	Additional spinal fusion	5.52	NA	NA	2.19	2.35	1.25	ZZZ
22590		A	Spine & skull spinal fusion	21.56	NA	NA	13.38	13.40	4.79	090
22595		A	Neck spinal fusion	20.44	NA	NA	12.82	12.85	4.41	090
22600		A	Neck spine fusion	17.20	NA	NA	11.41	11.38	3.73	090
22610		A	Thorax spine fusion	17.08	NA	NA	11.14	11.23	3.53	090
22612		A	Lumbar spine fusion	23.38	NA	NA	12.99	13.32	4.47	090
22614		A	Spine fusion, extra segment	6.43	NA	NA	2.62	2.81	1.38	ZZZ
22630		A	Lumbar spine fusion	21.89	NA	NA	12.91	13.12	4.73	090
22632		A	Spine fusion, extra segment	5.22	NA	NA	2.11	2.26	1.16	ZZZ
22800		A	Fusion of spine	19.30	NA	NA	11.60	11.92	3.76	090
22802		A	Fusion of spine	31.91	NA	NA	16.85	17.58	6.17	090
22804		A	Fusion of spine	37.30	NA	NA	18.97	19.95	7.00	090
22808		A	Fusion of spine	27.31	NA	NA	14.53	15.01	4.93	090
22810		A	Fusion of spine	31.30	NA	NA	15.32	16.12	5.15	090
22812		A	Fusion of spine	34.00	NA	NA	17.43	18.13	5.30	090
22818		A	Kyphectomy, 1-2 segments	34.18	NA	NA	17.12	17.60	6.47	090
22819		A	Kyphectomy, 3 or more	39.18	NA	NA	20.36	20.33	7.67	090
22830		A	Exploration of spinal fusion	11.13	NA	NA	7.26	7.45	2.30	090
22840		A	Insert spine fixation device	12.52	NA	NA	5.09	5.45	2.79	ZZZ
22841		B	Insert spine fixation device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
22842		A	Insert spine fixation device	12.56	NA	NA	5.12	5.48	2.75	ZZZ
22843		A	Insert spine fixation device	13.44	NA	NA	5.53	5.81	2.86	ZZZ

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29580		A	Application of paste boot	0.55	0.70	0.69	0.33	0.34	0.07	000
29590		A	Application of foot splint	0.76	0.58	0.56	0.26	0.27	0.09	000
29700		A	Removal/revision of cast	0.57	0.94	0.93	0.26	0.27	0.08	000
29705		A	Removal/revision of cast	0.76	0.78	0.79	0.38	0.38	0.13	000
29710		A	Removal/revision of cast	1.34	1.34	1.39	0.61	0.63	0.20	000
29715		A	Removal/revision of cast	0.94	1.19	1.18	0.46	0.44	0.09	000
29720		A	Repair of body cast	0.68	1.15	1.16	0.36	0.37	0.12	000
29730		A	Windowing of cast	0.75	0.74	0.76	0.35	0.35	0.12	000
29740		A	Wedging of cast	1.12	1.00	1.04	0.48	0.48	0.18	000
29750		A	Wedging of clubfoot cast	1.26	1.10	1.09	0.57	0.57	0.21	000
29799		C	Casting/strapping procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
29800		A	Jaw arthroscopy/surgery	6.73	NA	NA	4.98	5.49	0.99	090
29804		A	Jaw arthroscopy/surgery	8.71	NA	NA	5.92	6.36	1.38	090
29805		A	Shoulder arthroscopy, dx	5.94	NA	NA	4.82	5.04	1.02	090
29806		A	Shoulder arthroscopy/surgery	14.95	NA	NA	9.70	10.09	2.50	090
29807		A	Shoulder arthroscopy/surgery	14.48	NA	NA	9.53	9.92	2.42	090
29819		A	Shoulder arthroscopy/surgery	7.68	NA	NA	5.80	6.06	1.32	090
29820		A	Shoulder arthroscopy/surgery	7.12	NA	NA	5.32	5.56	1.22	090
29821		A	Shoulder arthroscopy/surgery	7.78	NA	NA	5.80	6.07	1.33	090
29822		A	Shoulder arthroscopy/surgery	7.49	NA	NA	5.71	5.97	1.28	090
29823		A	Shoulder arthroscopy/surgery	8.24	NA	NA	6.21	6.48	1.41	090
29824		A	Shoulder arthroscopy/surgery	8.82	NA	NA	6.70	6.92	1.42	090
29825		A	Shoulder arthroscopy/surgery	7.68	NA	NA	5.78	6.04	1.32	090
29826		A	Shoulder arthroscopy/surgery	9.05	NA	NA	6.37	6.67	1.55	090
29827		A	Arthroscop rotator cuff repr	15.44	NA	NA	9.67	10.16	2.67	090
29828		A	Arthroscopy biceps tenodesis	13.00	NA	NA	8.46	8.46	2.17	090
29830		A	Elbow arthroscopy	5.80	NA	NA	4.59	4.79	0.99	090
29834		A	Elbow arthroscopy/surgery	6.33	NA	NA	4.99	5.21	1.08	090
29835		A	Elbow arthroscopy/surgery	6.53	NA	NA	5.09	5.30	1.13	090
29836		A	Elbow arthroscopy/surgery	7.61	NA	NA	5.77	6.04	1.22	090
29837		A	Elbow arthroscopy/surgery	6.92	NA	NA	5.25	5.48	1.19	090
29838		A	Elbow arthroscopy/surgery	7.77	NA	NA	5.82	6.11	1.30	090
29840		A	Wrist arthroscopy	5.59	NA	NA	4.71	4.88	0.84	090
29843		A	Wrist arthroscopy/surgery	6.06	NA	NA	5.01	5.18	0.92	090
29844		A	Wrist arthroscopy/surgery	6.42	NA	NA	4.98	5.20	1.04	090
29845		A	Wrist arthroscopy/surgery	7.58	NA	NA	5.58	5.82	0.99	090
29846		A	Wrist arthroscopy/surgery	6.80	NA	NA	5.22	5.44	1.07	090
29847		A	Wrist arthroscopy/surgery	7.13	NA	NA	5.38	5.60	1.08	090
29848		A	Wrist endoscopy/surgery	6.24	NA	NA	5.37	5.44	0.86	090
29850		A	Knee arthroscopy/surgery	8.18	NA	NA	5.30	5.24	1.25	090
29851		A	Knee arthroscopy/surgery	13.08	NA	NA	8.51	8.85	2.35	090
29855		A	Tibial arthroscopy/surgery	10.60	NA	NA	7.51	7.84	1.85	090
29856		A	Tibial arthroscopy/surgery	14.12	NA	NA	9.03	9.46	2.40	090
29860		A	Hip arthroscopy, dx	8.85	NA	NA	6.24	6.44	1.36	090
29861		A	Hip arthroscopy/surgery	9.95	NA	NA	6.81	6.96	1.59	090
29862		A	Hip arthroscopy/surgery	10.97	NA	NA	7.82	8.02	1.62	090
29863		A	Hip arthroscopy/surgery	10.97	NA	NA	7.72	7.94	1.42	090
29866		A	Autgrft implnt, knee w/scope	14.48	NA	NA	9.65	10.10	2.40	090

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99060		B	Out of office emerg med serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99070		B	Special supplies	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99071		B	Patient education materials	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99075		N	Medical testimony	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99078		B	Group health education	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99080		B	Special reports or forms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99082		C	Unusual physician travel	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99090		B	Computer data analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99091		B	Collect/review data from pt	1.10	0.37	0.37	NA	NA	0.04	XXX
99100		B	Special anesthesia service	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99116		B	Anesthesia with hypothermia	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99135		B	Special anesthesia procedure	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99140		B	Emergency anesthesia	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99143		C	Mod cs by same phys, < 5 yrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99144		C	Mod cs by same phys, 5 yrs +	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99145		C	Mod cs by same phys add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99148		C	Mod cs diff phys < 5 yrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99149		C	Mod cs diff phys 5 yrs +	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99150		C	Mod cs diff phys add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99170		A	Anogenital exam, child	1.75	2.21	2.11	0.85	0.78	0.08	000
99172		N	Ocular function screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99173		N	Visual acuity screen	0.00	0.06	0.06	NA	NA	0.01	XXX
99174		N	Ocular photoscreening	0.00	0.69	0.69	NA	NA	0.01	XXX
99175		A	Induction of vomiting	0.00	0.36	0.62	NA	NA	0.10	XXX
99183		A	Hyperbaric oxygen therapy	2.34	2.58	2.75	0.61	0.64	0.16	XXX
99185		A	Regional hypothermia	0.00	1.81	1.52	NA	NA	0.04	XXX
99186		A	Total body hypothermia	0.00	1.63	1.67	NA	NA	0.45	XXX
99190		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99191		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99192		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99195		A	Phlebotomy	0.00	2.42	1.93	NA	NA	0.02	XXX
99199		C	Special service/proc/report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99201		A	Office/outpatient visit, new	0.45	0.55	0.54	0.17	0.17	0.03	XXX
99202		A	Office/outpatient visit, new	0.88	0.85	0.83	0.32	0.32	0.05	XXX
99203		A	Office/outpatient visit, new	1.34	1.12	1.12	0.45	0.46	0.09	XXX
99204		A	Office/outpatient visit, new	2.30	1.51	1.51	0.75	0.74	0.12	XXX
99205		A	Office/outpatient visit, new	3.00	1.81	1.81	0.96	0.96	0.15	XXX
99211		A	Office/outpatient visit, est	0.17	0.32	0.34	0.06	0.06	0.01	XXX
99212		A	Office/outpatient visit, est	0.45	0.55	0.55	0.16	0.16	0.03	XXX
99213		A	Office/outpatient visit, est	0.92	0.77	0.75	0.30	0.29	0.03	XXX
99214		A	Office/outpatient visit, est	1.42	1.10	1.09	0.46	0.45	0.05	XXX
99215		A	Office/outpatient visit, est	2.00	1.40	1.38	0.65	0.65	0.08	XXX
99217		A	Observation care discharge	1.28	NA	NA	0.50	0.51	0.06	XXX
99218		A	Observation care	1.28	NA	NA	0.39	0.40	0.06	XXX
99219		A	Observation care	2.14	NA	NA	0.62	0.64	0.10	XXX
99220		A	Observation care	2.99	NA	NA	0.86	0.91	0.14	XXX
99221		A	Initial hospital care	1.88	NA	NA	0.56	0.54	0.07	XXX
99222		A	Initial hospital care	2.56	NA	NA	0.74	0.74	0.10	XXX

1 CPT codes and descriptions only are copyright 2008 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

2 If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.

Attachment 3

Summary of Comments Received

Comments Received

Transcript of Public Hearing

Summary of Comments Received
Medical Services Provider Manual

	Comments	Recommendations
South Carolina Medical Association **Todd Atwater, CEO, June 23, 2009**		
	Workers' compensation system demands more from physicians.	Recommend rate increase for physician payment.
	Outdated codes and in some cases no codes since 2003.	Establish task force, including physician members of SCMA, for the purpose of updating the manual.
	Fees have not changed since 2003.	Set fees that includes cost of living increases to account for the cost of doing business relative to 2003.
	Static reimbursement yet increasing costs of running a business.	Have an annual cost of living assessment.
	Georgia and NC have updated their provider manual on an annual basis and both states make the manual available online.	Make the manual available online.
South Carolina Medical Association **Will Floyd, MD, MPH, Chair, Occupational Medicine Committee, August 19, 2009**		
	Supports using codes maintained by the American Medical Association.	Use a national average payment system of Medicare based on a multiple of 170%.
	The current fee for medical testimony is not adequate because of administrative burdens and lost compensation due to the amount of time the physician spends away from schedule patients.	Have automatic annual payment updates that adjust for inflation.
		Be able to access the manual online
		Increase fees for CPT codes 99455 and 99456 to adjust for inflation.
		Increase the fee for CPT code 99456 to $800.
		Suggests a tiered system of fees for IME to allow for extenuating circumstances.
		Increase fees for medical testimony. Do not have sufficient data to recommend an appropriate fee.
		Suggests that there be no differentiation between payment for testimony at a hearing or at a deposition.

Summary of Comments Received
Medical Services Provider Manual

	Comments	Recommendations
South Carolina Orthopaedic Association **J. Scott Broderick, MD, President** **June 24, 2009**		
	Timely access to specialty care is critical and delays lead to higher costs.	Establish task force, including members of SCOA and SCMA, for the purpose of updating the manual.
	Orthopaedic surgeons understand their role to expedite scheduling, therapy, diagnostic studies and treatment which comes at a cost.	Increase fees to account for cost of living increases since 2003.
	Additional work demands that fees paid are adequate and revised frequently	Implement an annual cost of living increase for each code.
	Physician offices are small business not immune to pressures of escalating overhead.	Make the manual available online.
	Static or decreased revenue and increased expenses are not sustainable.	
South Carolina Orthopaedic Association **Fraser Cobbe, Executive Director** **August 21, 2009**		
		Codes 99455 and 99456 be adjusted for inflation to $114.17 and $433.14. CPI has increased 17.7% since 2003.
		CPT Code 99456 would still be undervalued.
		Additional compensation should be provided for exceptional situations.
		American Academy of Orthopaedic Surgeons advisory statement on the appropriate considerations when determining compensation for medical testimony when the rate is not established by a third party or government program "Compensation for an orthopaedic expert will shall be reasonable and commensurate with expertise and the time and effort necessary to evaluate and testify on the facts of the case." Fee should equal amount earned if surgeon saw patients in the office or performed surgery. SCOA feels that $1,000 would be adequate.

Summary of Comments Received
Medical Services Provider Manual

	Comments	Recommendations
South Carolina Orthopaedic Association **Steven C. Poletti, MD, President** **August 20, 2009**	For those situations where an IME is significantly extended, a charge beyond $800 would be justifiable.	In those cases, it should be up to the physician to justify such a charge and for the commissioner to approve the additional amount. Manual be made available on line. If the fees are to be based on Medicare, it should be 1.7 times the Medicare rate. Recommends annual cost of living increases. Recommends fees be either the "floor" for reimbursement, or the actual amounts reimbursed, not the "maximum allowable".
Pee Dee Orthopaedic Associates **Geoff McLeod, Practice Administrator** **June 22, 2009**	There has been no fee increase since 2003. Physician expenses have risen considerably. Administrative aspect of treating workers' compensation patients is vastly more complex, requiring practices to develop separate methods for dealing with workers' compensation patients. PDOA's cost for three workers' compensation specialists to handle claims is $150,000 annually. PDOA is a 10 physician practice which uses an electronic medical record system that costs more than $400,000. Studies have shown that an early referral to surgical specialists has numerous benefits.	Update CPT codes. Post the manual, free of charge, on the internet Increase the conversion factor.
Lowcountry Orthopaedics & Sports Medicine, Carl H. Butler, Jr., CEO **June 29, 2009**	Workers' compensation is 27% of practice.	Establish task force, including members of SCOA and SCMA, for the purpose of updating the manual.

Summary of Comments Received
Medical Services Provider Manual

	Comments	Recommendations
	Employs 3 full time employees to meet the needs of the wc system.	Increase fees to account for cost of living increases since 2003. Implement an annual cost of living increase for each code. Make the manual available online.
South Carolina Hospital Association Thomas D. Cockrell, Senior Vice President and COO, June 30, 2009		
	Workers' compensation cases are more complex than other cases and administrative simplification should be a major consideration	Reimbursement level should be set at a multiple of Medicare in the range of 160% to 180%. If the reimbursement base is to be Medicare, there needs to be assurance that variation to the Medicare fee schedule is minimal. If the Medicare fee schedule is to be the basis, processes neeed to be in place to provide for changes to the overall methodology structure as Medicare makes changes. Processes need to be in place that would trigger automatic fee schedule adjustments for inflation.
South Carolina Small Business Chamber of Commerce, Frank Knapp, Jr., President & CEO, August 20, 2009		
	Controlling costs is vital to the system however medical provders are also vital to the system and part of the small business community. These providers should be compensated fairly. Matter of what is fair compensation through a medical fee schedule we will trust to the Commission's judgment. With regard to IME, there apppears to be some concern that the Commission's guidelines are not being applied equally and might need to be changed.	

Summary of Comments Received
Medical Services Provider Manual

	Comments	Recommendations
	Asks if the IME fee schedule being observed and monitored by the Commission for both the insurance carrier and the plaintiff.	
	Questions the purpose of the IME fee schedule for the plaintiff if those medical fees are paid by the plaintiff, are not a component of the insurance carrier costs and thus cannot increase the cost of workers' compensation premiums.	
	Asks if the IME fees for the plaintiff increasing the system's cost to the business community. If not, why are these small business medical providers having their fees restricted?	
South Carolina Society of Anesthesiologists, June 8, 2009		
	Lack of parity. Payment for anesthesia services are lowest of all physicians.	Increase the unit rate to $50.
	Medicare should not be used as a benchmark.	Split MD/nurse payment to 60/40.
	Medicare in South Carolina is particularly out of parity and the workers' compensation methodology exacerbates the problem.	Comply with HIPAA regulations.
	The workers' compensation rate for anesthesiologists is lower than the State Health Plan.	Address late and slow payments.
	The workers compensation system is slow to pay.	
	South Carolina workers' compensation payments are the lowest in the Southeast.	
	South Carolina is out of compliance with HIPAA regulations.	
	Since 2003 every payer has increased the anesthesia unit rate except workers' compensation.	

Summary of Comments Received
Medical Services Provider Manual

	Comments	Recommendations
Greenville Anesthesiology, PA Robert R. Morgan, Jr., MD, Past President, SCSOA, June 10, 2009		
	$24/unit undervalues anesthesiologists services.	
	Rate is significantly less than every other Southeastern state.	
	Medicare rates arbitrarily devalue their services relative to other physicians.	
	Workers' compensation rates are less than half of the State Health Plan.	
	Reimbursement rates have languished for many years.	

John G. Black, MD
President

Gregory Tarasidis, MD
President-Elect

Marshall L. Meadors, III, MD
Secretary

Dale R. Gordineer, MD
Treasurer

Gary A. Delaney, MD
Chairman of the Board

Todd K. Atwater, JD
Chief Executive Officer

South Carolina Medical Association

Voice of One. Power of Many.

P.O. Box 11188 • Columbia, SC 29211-1188
(803) 798-6207 • 1-800-327-1021
Fax: (803) 772-6783
www.scmanet.org

June 23, 2009

Medical Services Division
South Carolina Workers' Compensation Commission
Post Office Box 1715
Columbia, South Carolina 29202-1715

RE: Public Comment on Physician Rates

To Whom It May Concern:

In light of the SC Workers Compensation Commission's (SCWCC) request for public comment on physician rate updates, please accept this communication as the South Carolina Medical Association's (SCMA) formal comments in response to this request. The SCMA applauds the SCWCC for its review and revision of these rates and the Provider Manual at this time and greatly appreciates the opportunity to participate in the process.

The SCMA represents over 6500 physicians in South Carolina. Our association is diverse in geographic location, age, gender, ethnicity and specialty. Many of our members treat workers compensation claimants in their practices and have done so in recent years at a cost to themselves. While the medical community recognizes the economic downturn in which we currently find ourselves, it is the SCMA's position that the SCWCC incorporate in its forthcoming recommendation *a rate increase* for physician payment.

In addition to making the best medical decisions and giving quality medical treatment, which is the extent of what is needed to treat patients with Medicare or private insurance, the workers' compensation system demands so much more from participating physicians. For example, dealing with attorneys, insurance carrier's agents, return to work issues including appropriate modified duty, providing fitness for duty evaluations, completing short and long term disability paperwork, determining impairment ratings, sitting for legal depositions, trying to meet employer's expectations, in addition to providing quality care for the patient, is what makes providing workers' compensation care so much more difficult and expensive.

At the same time, physicians have been functioning in our system with outdated codes and in some cases no codes since 2003, as well as a fee schedule which has not been

upgraded in nearly seven years. The same fee paid to repair a tibia fracture in 2003 is the same a surgeon can expect to receive in 2009. We have significant concerns with this trend of static reimbursement when faced with the increased costs of running a business. Seven years with no adjustments for the rising cost of doing business as a physician, which includes cost of living increases that we must provide for our nurses and staff, increased cost of supplies, higher malpractice rates and other overhead required to simply operate a medical practice is too long.

Our two closest neighbors - Georgia and North Carolina - have updated their provider manuals on an annual basis. Also, in both of these states, the manual is available online which makes it is easily accessible to the physician user and allows for updates to the various codes to conform to changes that are made in coding nationwide.

The recommendation of the SCMA is that the *South Carolina Workers' Compensation Providers' Manual* be updated from its current 2003 form. Specifically, we recommend:

1) A task force of stakeholders be assembled, including physician members of the SCMA, for the sole purpose of updating this manual;
2) Have a fee schedule for physicians that includes cost of living increases for each of the various codes to account for such growth, and the cost of doing business, relative to the 2003 values;
3) Have a built in annual cost of living assessment;
4) Make the manual available online such that it is easily accessible for the physician user. This will also allow for fees and codes to be easily updated as needed and allow for corrections to be easily made to the manual, if necessary.

While the Commission's responsibility to its constituents is to serve employers and workers in the most fair, responsive, and timely manner possible, it cannot be accomplished without dedicated physicians working hard to aggressively treat injured workers in an attempt to minimize permanent impairment and disability, which are the real cost drivers in the workers' compensation system.

We commonly share the goal of achieving a system that is efficient, effective and returns injured employees to work as soon as possible; therefore, we must subsequently have adequate resources to ensure a patient's access to care. If injured workers cannot receive treatment in a timely manner, the entire system collapses.

On behalf of the South Carolina Medical Association, I thank you for your time, attention and consideration of these important recommendations. If any additional information is needed or you would like to discuss this matter further, please do not hesitate to contact me at 803-798-6207.

Sincerely,

Todd K. Atwater
CEO

John G. Black, MD
President

Gregory Tarasidis, MD
President-Elect

Marshall L. Meadors, III, MD
Secretary

Dale R. Gordineer, MD
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Chief Executive Officer

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(803) 798-6207 • 1-800-327-1021
Fax: (803) 772-6783
www.scmanet.org

CCC
AUG 24 '09
MEDICAL SERVICES

August 19, 2009

Medical Services Division
South Carolina Workers' Compensation Commission
Post Office Box 1715
Columbia, South Carolina 29202-1715

RE: Response to CPT Code Inquiry – Medical Services Provider Manual Update

Dear Mr. Cannon:

Thank you for the opportunity to offer insight as the Workers Compensation Commission (WCC) continues its discussions regarding the revision of the Medical Services Provider Manual. The South Carolina Medical Association (SCMA) and its members greatly appreciate the chance to provide any helpful input during this process.

In your letter to SCMA CEO, Todd Atwater, dated July 30, 2009, you specifically request comment on CPT codes 99455 and 99456 – medical disability evaluation performed by a treating physician and a non-treating physician, respectively. As well as insight on 99075 and 99076 - medical testimony in a case hearing, and medical testimony in a deposition.

As chair of the SCMA's Occupational Medicine Committee, the above requests have been vetted by the Committee members and we respectfully make the following recommendations to the WCC on behalf of the SCMA:

1. In regards to updating the Provider Manual, our general comments are:
    a. Full support of all relevant codes adopted and maintained by the American Medical Association (AMA);
    b. Use of the national average payment system of Medicare based on a multiple of 170 percent;
    c. Automated annual payment updates that adjust for inflation, and;
    d. The ability to access the manual online to make it more accessible to the physician user as well as allowing for periodic updates to conform to changes that are made in coding nationwide.
2. In regards to codes 99455 and 99456, we propose:
    a. Increasing the fees to adjust for inflation;
    b. Due to the complexity and time-consuming nature of 99456 (medical disability evaluation performed by other than the treating physician), we feel increasing the current fee to $800 would be reasonable;

c. Additionally, we also suggest establishing a tiered system of payment based on extenuating circumstances encountered during such evaluations where the physician is required to perform exceptional duties that would merit additional compensation. We would fully expect and encourage justification and stringent guidelines for these circumstances to be substantiated prior to agreement of payment.

3. Likewise, your request concerning the fees pertaining to medical testimony in both a hearing and a deposition were discussed and we respectfully suggest the following:
   a. An increase to the current fee payments rendered for these codes as set by the Commission; however, at this time the Occupational Medicine Committee given the deadline does not feel we have sufficient data to recommend an appropriate fee for these codes. We would welcome the opportunity to look into appropriate compensation in further detail before recommending a set fee amount.

      We do, however, feel strongly that reimbursement for these services is *not* currently adequate for the following reasons:

      i. Administrative burdens placed on physician and staff in order to properly prepare for testimony, including case review for both trial *and* deposition, as well as additional responsibilities upon office staff due to the absence of the physician.
      ii. Lost compensation due to the amount of time the physician spends away from scheduled patients in his/her practice providing testimony.

   The overriding justification in requesting additional compensation for these duties is clearly based on the recognition that a physician providing medical testimony in either a trial or deposition removes them from being able to treat their patients, directly impacting income, as well as the cost for continuing to maintain a viable practice, such as the cost for staff and overhead expenses while providing testimony. As a result, we suggest there be no differentiation between compensation for testimony at a trial or in a deposition as they both require similar preparation and they both remove the ability of the physician to continue to render services while providing testimony.

On behalf of the SCMA's Occupational Medicine Committee, I again thank you for your time and consideration of these important recommendations, especially given the complexity of these particular cases. If any additional information is needed or you would like to discuss this matter further, please do not hesitate to contact me at (803) 296-3304.

Sincerely,

Will Floyd MD

Will Floyd MD, MPH
Chair, Occupational Medicine Committee

South Carolina Orthopædic Association

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H. Del Schutte, Jr., MD
AAOS Board of Councilors

❖

Fraser Cobbe
Executive Director

June 24, 2009

Medical Services Division
South Carolina Workers' Compensation Commission
P.O. Box 1715
Columbia, SC 29202-1715

Dear Commissioners,

Thank you very much for this opportunity to comment on the revision of the Medical Services Provider Manual. Orthopaedic Surgeons play a vital role in the Workers Compensation system. Whether it is by covering the local emergency room to scheduling outpatient treatment in their offices, orthopaedic surgeons are on the front lines in keeping our work force on the job. We appreciate the work of the Commission in administering an effective and efficient Compensation system.

The Workers Compensation system needs to be as self-executing as possible for it to meet its goals. Timely access to specialty care is critical for returning injured employees to work as soon as possible. Delays in treatment aggravate injuries and lead to higher costs to the system. We have attached a study that was referenced in our testimony in the Open Hearing that illustrates the benefits that timely access to specialty care can have on medical systems.

As orthopaedic surgeons we understand our role in the Workers Compensation system. We need to be prepared to expedite scheduling, therapy, diagnostic studies, and treatment for injured workers focusing on a rapid return to work. This involves working closely with patients and their representatives and case managers and adjusters representing the employer if we are going to navigate the system as efficiently as possible. Performance of this role comes at a cost to our practices as we allocate sufficient resources to handle the additional work required by the system.

This additional work demands that the fees paid to physicians are adequate and revised frequently. Our fee schedule in South Carolina has not changed since 2003. Physician offices are small businesses and are not immune to the pressures of escalating overhead. The model of static or decreased revenue and increased expenses simply is not sustainable over time. We recognize static reimbursement is not just a workers compensation issue but for the system to be efficient in

17503 Mallard Court
Lutz, FL 33559

❖

866-949-3121
Fax: 813-949-8994

❖

E-Mail: scoa@cobbemanagement.com
Internet: www.scoanet.org

returning injured employees to work we must have adequate resources to ensure timely access to care.

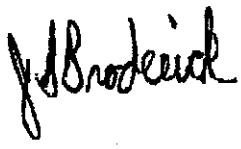
As the Commission deliberates over the Medical Services Provider Manual, we stand with the South Carolina Medical Association (SCMA) and respectively request that you consider the following revisions:

1) A task force of stakeholders be assembled, including members of the South Carolina Orthopaedic Association and the SCMA, for the sole purpose of updating this manual;
2) Increase the fee schedule for physicians that amounts to a cost of living increase for each of the various codes relative to the 2003 values;
3) Implement an annual cost of living increase for each code;
4) Have the manual be made available online and easily accessible for the physician user. This will also allow for fees and codes to be easily updated as needed and allow for corrections to be easily made to the manual if necessary.

Thank you again for this opportunity to share our recommendations on revisions to the Medical Services Provider Manual. We stand ready to serve as a resource as the Commission deliberates.

We look forward to working with the Commission to ensure our Workers Compensation system operates in an efficient manner with the singular focus of returning injured workers to productivity as soon as possible.

Sincerely,



J. Scott Broderick, M.D.
President

Costs Analysis of Successful Rotator Cuff Repair Surgery: An Outcome Study. Comparison of Gatekeeper System in Surgical Patients

F. H. Savoie III, M.D., Larry D. Field, M.D., and R. Nan Jenkins, R.N.F.A.

Summary: In an effort to determine the cost effectiveness of rotator cuff repair surgery in workers' compensation patients, a financial analysis of 50 consecutive patients with a "successful" result was performed. Treatment costs were analyzed from the date of initial injury through all evaluations, diagnostic studies, surgical reconstruction, physical therapy and work hardening. Additionally, all workers' compensation payments and the cost of settlement was analyzed. The average cost of medical care was $50,302.25 per patient. The average time to return to unrestricted duty from the date of injury was 11 months. However, patients referred to a specialist immediately following the diagnosis of a rotator cuff tear had total costs that averaged $25,870.64 and returned to work an average of 7 months postoperatively. Patients managed via a "gatekeeper" system averaged $100,280.10 in total costs and the average return to work was 18 months. These differences in cost and return to work were both statistically significant, $P < .05$. In conclusion, immediate referral of rotator cuff tears for specialized care results in decreased cost and earlier return to work. **Key Words:** Rotator cuff—Workers' Compensation—Gatekeeper.

The Workers' Compensation system was designed to provide medical coverage for job-related injuries.[1] Ideally, this system provides quality medical care and support for the worker during convalescence, allowing a rapid return to work at a reasonable cost.[1] Unfortunately, in many cases the system fails, resulting in exorbitant costs and patients unable or unwilling to work.[2-5] We have postulated that even a successful result may be more costly in a Workers' Compensation case.

The purpose of this study is to determine the actual cost of successfully returning an injured patient to work. A secondary factor we analyzed was the effect of a company physician "gatekeeper" in the management of these patients. To evaluate this hypothesis, we reviewed the financial records of 50 consecutive patients with full-thickness tears of the rotator cuff who returned to work in their previous occupation.

MATERIALS AND METHODS

Fifty consecutive patients with full-thickness tears of the rotator cuff who returned to normal work activities were evaluated for total medical costs, Workers' Compensation support pay while off work, and settlement costs. Ancillary costs (e.g., legal costs, replacement worker) were not included.

As we evaluated the cost to the Workers' Compensation system, it became apparent there were two separate groups of patients based on the type of medical care they received following the diagnosis of rotator cuff tear. Therefore, we analyzed these two groups

From the Mississippi Sports Medicine and Orthopaedic Center, Jackson, Mississippi, U.S.A.

Address correspondence and reprint to F. H. Savoie III, M.D., 1325 E. Fortification St, Jackson, MS 39202. U.S.A.

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separately in addition to the overall patient cohort. Group I patients (n = 34) were managed by early referral to an orthopaedic specialist via the company physician. Group II patients (n = 16) were managed by a "gatekeeper" type system in which the company physician was encouraged to keep medical care and decision making in house and refer to a specialist only as a last resort and only after he personally ordered and interpreted the various tests.

In 43 of the 50 patients, we were able to obtain all medical and Workers' Compensation costs. Seven patients (5 in group I, 2 in group II) refused to allow one or more parts of their financial data to be included in the study and were eliminated from the results.

RESULTS

The average total cost per patient was $50,302.25 (range, $11,699 to $462,964) in actual expenses (Table 1). The average medical cost was $20,683.50 (range, $9,526 to $75,283). The average support pay and settlement cost was $29,618.75 (range, $1,384 to $426,880).

Group I patients (Table 2) averaged $25,870.64 in actual total expenditures whereas group II patients (Table 3) averaged $100,910.60 in actual total expenditures.

In evaluating the time to return to full duty, the overall patient group returned an average of 10 months after injury (Table 1). Group I patients (Table 2) returned to work an average of 6.6 months after the injury; group II patients (Table 3) required 18 months to return to full duty.

Groups I and II were compared statistically for medical costs, Workers' Compensation cost, total cost, time from injury to surgery, and time off work. In each case, there was a statistically significant difference shown between the two groups using the *t*-test method in each comparison.

The mean cost of medical care among group I patients was $13,513 with a standard deviation of $3,817. The mean cost in group II was $35,537 with a standard deviation of $17,947. These differences in medical costs were statistically significant ($P < .001$).

The two groups were also compared in terms of the amount of Workers' Compensation payment (off work support pay plus settlement cost). In group I, the mean payment by the Workers' Compensation system was $12,358 with a standard deviation of $8,595. In group II, the mean cost was $65,373 with a standard deviation of $104,974. These differences were statistically significant ($P < .01$).

The two groups were then compared for the total cost combining medical and workers' compensation costs to the system. Group I patients had a mean total cost of $25,871 with a standard deviation of $10,007. Group II patients had a mean cost of $100,911 with a standard deviation of $107,811. These differences in total cost were statistically significant ($P < .001$).

The time variable from the injury to the surgery was also compared in the two groups. Group I patients underwent surgical reconstruction of their shoulders at a mean time of 3.9 months after injury with a standard deviation of 3.2 months. Group II patients underwent surgical reconstruction of their shoulder at a mean time of 10.1 months after injury with a standard deviation of 4.4 months. These differences are also statistically significant ($P < .001$). The amount of time required for the patient to return to work was also compared between the two groups. Group I patients returned to work after a mean of 6.6 months with a standard deviation of 4.4 months. Group II patients remained off work for a mean of 17.1 months with a standard deviation of 9.2 months. This return to work difference was statistically significant ($P < .001$).

In each category compared, the group I patients managed by early referral had statistically significant lower costs, less time off work, and more rapid return to function than patients in group II.

DISCUSSION

The Workers' Compensation system was originally designed to care for workers' with injuries directly related to their occupation. Unfortunately, the system has deteriorated to cover all types of problems that may or may not be related directly to the occupation of the worker.[1] This study is not designed to evaluate this area of the system. However, once a claim is made and verified, it is often difficult to return the patient to work.[4,5] The reasons for this are multifactorial including the physical limitations of the injury, the ergonometric requirements of the job, psychological factors related to job satisfaction and environment, and social factors (i.e., receiving pay for not working).

It has been well established that the longer a patient remains off work and the more surgery the patient has received, the less likely the patient will return to work.[3-5] This would seem to indicate that the more quickly the injured patient receives definitive care the less the cost to the patient and the system. However,

TABLE 1. *Groups I and II*

Patient	Cost	Pay-Sett	Tot-Cost	Group	Inj-Surg	Off-Work
CB	$11.626.96	$9,200.00	$20,826.96	1	2	5
EB	9,789.89	3,657.21	13,447.10	1	1	7
CHB	11,220.00	10,467.00	21,687.00	1	1	4
RC	15,715.94	7,966.30	23,682.24	1	3	8
DC	10,195.14	6,708.00	16,903.14	1	2	2
GF	12,801.84	11,240.39	24,042.23	1	6	4
EG	11,553.03	5,551.72	17,104.75	1	3	1
YZH	15,727.26	18,171.97	33,899.23	1	11	22
DH	14,781.47	11,449.46	26,230.93	1	6	13
BH	17,040.50	12,832.00	29,872.50	1	10	11
JH	14,029.28	17,006.40	31,035.68	1	4	7
LJ	19,207.80	19,370.75	38,578.55	1	1	13
BRJ	11,946.67	6,310.40	18,257.07	1	3	6
CL	9,674.94	10,178.60	19,853.54	1	6	2
ML	27,451.40	18,740.00	46,191.40	1	1	7
BM	9,526.94	8,674.00	18,200.94	1	1	3
WN	15,288.00	10,522.30	25,810.30	1	3	7
EP	11,285.00	384.76	11,669.76	1	1	1
JSC	12,037.00	47,935.00	59,972.00	1	2	9
RSM	12,897.00	18,333.00	31,230.00	1	3	5
JESM	75,283.70	74,656.00	149,939.70	2	19	23
LT	11,495.00	11,500.00	22,995.58	1	2	4
DTL	13,047.26	10,025.80	23,073.06	1	1	6
DTR	11,784.50	10,634.74	22,419.24	1	3	7
JT	10,977.50	10,832.00	21,809.50	1	1	6
GT	10,232.50	20,480.00	30,712.50	1	2	10
DT	20,413.26	5,695.33	26,108.59	1	11	4
DW	14,621.67	19,946.66	34,568.33	1	9	10
VW	12,079.86	7,040.00	19,119.86	1	9	3
PB	24,661.85	50,428.00	75,089.85	2	4	19
CC	33,460.52	18,337.04	51,797.56	2	7	16
EC	20,017.20	31,418.19	51,435.39	2	14	1
GH	13,418.28	7,528.39	20,946.67	1	4	5
TH	36,084.97	426,880.00	462,964.97	2	7	19
RL	32,256.73	27,620.59	59,877.32	2	14	28
JWM	14,768.86	27,054.00	41,822.86	2	13	19
JCP	51,254.00	28,802.76	80,056.76	2	14	37
CP	27,431.14	31,088.40	58,519.54	2	4	10
WR	30,023.71	48,000.00	78,023.71	2	11	19
JST	21,606.00	42,178.00	63,784.00	2	9	19
RSP	32,344.57	41,628.12	73,972.69	2	8	4
CASM	28,157.00	28,200.00	56,357.00	2	12	10
WW	70,174.30	38,932.78	109,107.08	2	6	16
TOTA	20,683.50	29,618.75	50,302.26	0	5	10

NOTE. Cost is Medical Cost. Pay-sett is the sum of off work support pay and settlement cost. Tot-cost is the sum of medical costs, off work pay and settlement costs. Inj-Surg is the time from the reported injury until surgical reconstruction expressed in months. Off-work is the total time until the patient returned to unrestricted work.

there has recently been a movement to limit access to specialized care in an attempt to decrease medical costs. While in some instances limiting such access may be effective, the present study seems to show that limiting access actually results in increased costs.

The more quickly a rotator cuff injury is diagnosed and repaired the more quickly the patient should be able to return to useful employment.[3,4] This study strongly supports such a philosophy. In the present study, the sooner the patient underwent rotator cuff repair the sooner the patient was able to return to work.

The degree of difference in costs between the two groups was dramatic. Although it is difficult to extrapolate these data to other work related injuries, it is apparent that early referral of surgical rotator cuff injuries to a shoulder surgeon actually decreased costs significantly.

Care should be taken not to generalize the data presented in the present study as an indictment of the gatekeeper or company physician concept.

The gatekeeper may in fact have resulted in decreased costs if all patients presenting with shoulder complaints of any kind were included in this study.

TABLE 2. *Group I: Primary Referral Patients*

Patients	Cost	Pay-Sett	Tot-Cost	Group	Inj-Surg	Off-Work
CB	$11.626.96	$9.200.00	$20.826.96	1	2	5
EB	9,789.89	3,657.21	13,447.10	1	1	7
CHB	11,220.00	10,467.00	21,687.00	1	1	4
RC	15,715.94	7,966.30	23,682.24	1	3	8
DC	10,195.14	6,708.00	16,903.14	1	2	2
GF	12,801.84	11,240.39	24,042.23	1	6	4
EG	11,553.03	5,551.72	17,104.75	1	3	1
YZH	15,727.26	18,171.97	33,899.23	1	11	22
DH	14,781.47	11,449.46	26,230.93	1	6	13
BH	17,040.50	12,832.00	29,872.50	1	10	11
JH	14,029.28	17,006.40	31,035.68	1	4	7
LJ	19,207.80	19,370.75	38,578.55	1	1	13
BRJ	11,946.67	6,310.40	18,257.07	1	3	6
CL	9,674.94	10,178.60	19,853.54	1	6	2
ML	27,451.40	18,740.00	46,191.40	1	1	7
BM	9,526.94	8,674.00	18,200.94	1	1	3
WN	15,288.00	10,522.30	25,810.30	1	3	7
EP	11,285.00	384.76	11,669.76	1	1	1
JSC	12,037.00	47,935.00	59,972.00	1	2	9
RSM	12,897.00	18,333.00	31,230.00	1	3	5
LT	11,495.00	11,500.00	22,995.58	1	2	4
DTL	13,047.26	10,025.80	23,073.06	1	1	6
DTR	11,784.50	10,634.74	22,419.24	1	3	7
JT	10,977.50	10,832.00	21,809.50	1	1	6
GT	10,232.50	20,480.00	30,712.50	1	2	10
DT	20,413.26	5,695.33	26,108.59	1	11	4
DW	14,621.67	19,946.66	34,568.33	1	9	10
VW	12,079.86	7,040.00	19,119.86	1	9	3
GH	13,418.28	7,528.39	20,946.67	1	4	5
TOTA	13,512.62	12,358.02	25,870.64	0	4	6

However, we were unable to find verifiable data supporting such a concept.

These patients had a specific surgical problem that required correction. This report does detail the benefits of early referral for specialty care when surgical intervention is warranted. In these patients who require a high level of function from their shoulders, the delay in referral to a specialist, although well intentioned and often managed by excellent physicians, resulted in increased costs, as well as delays in return to work and functional activities.

Two conclusions can be drawn from this patient cohort: (1) A successful repair of the rotator cuff places

TABLE 3. *Group II: "Gatekeeper" System Patients*

Patient	Cost	Pay-Sett	Tot-Cost	Group	Inj-Surg	Off-Work
PB	$24.661.85	$50,428.00	$75,089.85	2	4	19
CC	33,460.52	18,337.04	51,797.56	2	7	16
EC	20,017.20	31,418.19	51,435.39	2	14	1
TH	36,084.97	426,880.00	462,964.97	2	7	19
RL	32,256.73	27,620.59	59,877.32	2	14	28
JWM	14,768.86	27,054.00	41,822.86	2	13	19
JCP	51,254.00	28,802.76	80,056.76	2	14	37
CP	27,431.14	31,088.40	58,519.54	2	4	21
WR	30,023.71	48,000.00	78,023.71	2	11	19
JST	21,606.00	42,178.00	63,784.00	2	9	19
RSP	32,344.57	41,628.12	73,972.69	2	8	5
JASM	28,157.00	28,200.00	56,357.00	2	12	10
WW	70,174.30	38,932.78	109,107.08	2	6	16
JESM	75,283.70	74,656.00	149,939.70	2	19	23
TOTA	35,537.47	65,373.13	100,910.60	0	10	18

enormous costs on the Workers' Compensation system (average: $50,302.25), and (2) delayed referral of rotator cuff tears to a specialist appears to result in increased costs ($100,910.60 *v* $25,870.64) and delays in return to work (18 months *v* 6 months).

Acknowledgment: The authors acknowledge the contribution of Dr. Ray Phelps (Millsaps College) for the statistical analysis.

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EHSToday

Access to Specialists May Reduce Workers' Compensation Costs

Aug 10, 2001 12:00 AM, By OH EDITORIAL STAFF

In contrast to managed care approaches, a program offering direct access to specialist doctors and increased physicians' fees may reduce workers' compensation costs, according to a study.

In contrast to managed care approaches, a program offering direct access to specialist doctors and increased physicians" fees may reduce workers" compensation costs, according to a study in the August Journal of Occupational and Environmental Medicine.

Dr. Stephen Atcheson of Reno, Nev., and colleagues evaluated a "specialist-direct" approach to workers" compensation cases from two large hotel-casinos.

In the new approach, workers with on-the-job injuries had direct access to physicians specializing in the care of musculoskeletal injuries.

Over two years, the program reduced overall workers" compensation costs by 63 percent.

Indemnity cost -- including compensation for missed work time and disability payments -- decreased by 85 percent.

Rapid access to specialists was a major factor in reducing indemnity costs, according to the study.

For minor injuries, the specialists were likely to recommend that the worker stay on the job with modified duties.

For more serious injuries, seeing a specialist early shortened the time until the patient received definitive care.

The specialist-direct approach also increased the fees paid to the primary care doctors treating the injured patients, but did not allow them to profit from "self-referral" for tests or treatments from which they might profit financially.

Under the new system, medical costs decreased by 45 percent -- even though the doctors received higher fees, the amount of services provided decreased.

Occupational injuries are an enormously expensive problem. In recent years, employers have considered managed care approaches, limiting limited access to specialists and discounted fees paid to physicians. However, these approaches have often failed to achieve expected cost reductions.

"Although more study of the specialist-direct approach is need, the preliminary results suggest it has the potential to achieve real cost reductions, rather than cost shifting, in the management of workers" compensation cases," said Atcheson.

by Virginia Foran

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August 21, 2009

Gary M. Cannon
Executive Director
State of South Carolina
Workers Compensation Commission
1333 Main Street, Ste 500
Columbia, SC 29202-1715

Dear Mr. Cannon,

Thank you very much for the opportunity to provide input as the Workers Compensation Commission revises the Medical Service Provider Manual. Our organization sincerely appreciates the opportunity to submit comments.

Your letter dated July 30, 2009, specifically requested input on four codes or reimbursement policies currently under review. We have attempted to collect data and feedback from our members on these items while at the same time meeting your requested comment deadline of August 21st. This letter will provide our initial thoughts on these issues but we would be more than happy to work with the Commission and other interested medical associations and specialty societies to review each of these specific codes in a more in-depth fashion in the future.

You have requested our thoughts on the appropriate reimbursement for codes 99455 (medical disability evaluation performed by the treating physician) and 99456 (medical disability evaluation performed by other than the treating physician). Our recommendation is that at a minimum both codes should be adjusted for inflation as they have remained static since 2003. According to our research the Consumer Price Index (CPI) for the South East Urban Areas of the United States has increased some 17.7% since 2003. We are happy to provide that documentation if requested. If we applied that inflation adjustment to the two codes in question the updated reimbursement would be $114.17 for 99455 and $433.14 for 99456.

There was additional discussion among the membership that 99456 would still be undervalued at the current rate plus the requested CPI increase. The Commission may want to consider further elevating 99456 to recognize the significant work required in performing a disability evaluation by a non-treating physician.

17503 Mallard Court
Lutz, FL 33559

866-949-3121
Fax: 813-949-8994

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In addition to the two codes referenced above, you had requested some feedback on exceptional instances where the physician is required to perform exceptional evaluations that would warrant additional compensation. We strongly believe that in some situations Workers Compensation cases can be extremely complex and do require exceptional evaluations and review. In those exceptional situations additional compensation should certainly be available.

Finally, you had requested our thoughts on fees for providing medical testimony at a hearing and medical testimony during a deposition. As noted in your letter those fees are currently established by the Commission and the rates are as follows:

Medical Testimony at a Hearing - 99075 = $536 1st hour 99076= $134 each additional ¼ hr

Medical Testimony in a Deposition - 99145 = $320 1st hour 99145 = $80 each additional ¼ hr

The American Academy of Orthopaedic Surgeons has established an Advisory Statement to guide Orthopaedic Surgeons on the appropriate considerations when determining compensation for Medical Testimony when the rate is not established by a third party or governmental program. This Advisory Statement has been incorporated into the AAOS Code of Medical Ethics and Professionalism for Orthopaedic Surgeons. The Code specifically states the following:

"Compensation for an orthopaedic expert witness shall be reasonable and commensurate with expertise and the time and effort necessary to evaluate and testify on the facts of the case."

Furthermore the AAOS has published guidance on how surgeons can comply with this Code of Ethics when determining their fees for Medical Testimony. That guidance includes the following measurable methods:

- Fee equal to the amount earned if the orthopaedic surgeon saw patients in the office that day

- Fee equal to the amount earned if the orthopaedic surgeon performed surgery that day

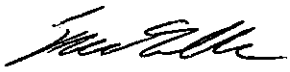
- Fee equal to the amount earned through a combination of office and surgery work

The underlying premise of these standards for determining compensation is the recognition that providing medical testimony, both during a trial or for a deposition, removes the physician from the practice and eliminates their ability to treat patients and receive reimbursement for services rendered. It also recognizes the obligations for continuing to maintain a practice including staff and overhead expenses while providing testimony.

Our organization strongly believes the current reimbursement established by the Commission is not sufficient to adequately compensate physicians for providing Medical Testimony at a hearing or during a deposition. We feel adequate compensation would be $1,000 for the first hour and $250 for every additional quarter hour. Furthermore we do not believe there should be a differentiation between compensation for testimony at a trial or in a deposition as 1) they both require the physician similar preparation, case review, and evaluation and 2) they both remove the ability of the physician to continue to render services while providing testimony.

Again, thank you very much for the opportunity to comment on these specific items. We look forward to working with the Commission during this review of the Medical Services Provider Manual and achieving our mutual goal of ensuring the efficiency of the system and quality care for injured workers.

Sincerely,



Fraser Cobbe
Executive Director

Cc: SCOA Executive Committee

Databases, Tables & Calculators by Subject

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Data extracted on: June 16, 2009 (1:09:09 PM)

Consumer Price Index - All Urban Consumers

Series Id: CUUR0300SA0,CUUS0300SA0
Not Seasonally Adjusted
Area: South urban
Item: All items
Base Period: 1982-84=100

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Annual	HALF1	HALF2
2003	175.1	176.4	177.5	177.4	176.8	177.2	177.3	177.9	178.3	178.1	177.5	177.5	177.3	176.7	177.8
2004	178.2	179.1	180.1	180.9	182.0	182.9	182.6	182.6	182.8	183.7	183.7	183.3	181.8	180.5	183.1
2005	183.6	184.7	185.9	187.3	187.3	187.8	188.5	189.4	192.0	192.5	190.7	190.1	188.3	186.1	190.5
2006	191.5	191.8	192.8	194.7	195.5	196.3	197.0	197.1	195.8	194.7	194.3	194.8	194.7	193.8	195.6
2007	195.021	195.950	197.904	199.618	200.804	201.675	201.571	201.041	201.697	202.155	203.437	203.457	200.361	198.495	202.226
2008	204.510	205.060	206.676	208.085	210.006	212.324	213.304	212.387	212.650	210.108	205.559	203.501	208.681	207.777	209.585
2009	204.288	205.343	206.001	206.657											

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(843) 763-2720

August 20, 2009

Mr. Gary Cannon
Executive Director
State of South Carolina
Workers' Compensation Commission
1333 Main Street, Suite 500
Columbia, SC 29202-1715

Dear Mr. Cannon:

This is an addendum to my letter to you dated 8/18/09.

After further review and discussion with members of the South Carolina Orthopaedic Association, and also discussion with others in the medical community, our recommendation for the fee for an independent medical examination is that it be $800. There could be situations where such evaluations are significantly extended such that a charge beyond $800 would be justifiable. However, in those cases it should then be up to the physician who performed the independent medical examination to justify such a charge to the commissioner who is hearing that particular case. The commissioner would then rule as to whether this additional amount was deserved or not.

With regard to the provider manual, our recommendation is that it be made available on line and updated as the AMA codes are updated. Further, it should include all available codes.

As for the fees for office visits and procedures, if it is to be based on Medicare, our recommendation is that the fee be 1.7 times the current Medicare rate. We also recommend a cost of living increase annually.

We are also recommending that the fees be either the "floor" for reimbursement, or the actual amounts reimbursed, and not "maximum allowable".

Thank you for your consideration.

Sincerely,

Steven C. Poletti, MD
President
South Carolina Orthopaedic Association

June 22, 2009

Medical Services Division
South Carolina Workers' Compensation Commission
Post Office Box 1715
Columbia, SC 29202-1715

Dear Sirs:

I write to you on behalf of Pee Dee Orthopaedic Associates, P.A. (PDOA) to indicate our concern regarding the current review of the Medical Services Provider Manual.

I would like to thank you for the opportunity to verbally present our position regarding the current review at the public hearing on June 19, 2009. I was very impressed with the manner in which the hearing was conducted, and the professionalism shown by commissioners that presided over the hearing.

The current South Carolina Medical Services Provider Manual has been in effect since 2003. Since 2003, the reimbursement for the services provided by physicians has seen no increase. During the same period, the expense to physicians for providing medical services has risen considerably. The administrative aspect of treating workers' compensation patients is vastly more complex than treating non workers' compensation patients. In order to deal with this complexity, medical practices are essentially required to develop a separate internal method for dealing with workers' compensation patients, each of which has its own unique issues.

In order to ensure that PDOA complies with all of the reporting requirements associated with workers' compensation patients, PDOA has three (3) employees, whose sole responsibility is dedicated workers' compensation patients. Two of the three employees are Workers' Compensation Specialists. The Workers' Compensation Specialists are responsible for triaging initial incoming phone calls, communicating information to patients, case managers, and employers. They also schedule Independent Medical Evaluations. PDOA also has an employee whose sole responsibility is to ensure that all workers' compensation claims are submitted properly to employers or insurance carriers. In total, salary and benefits for the three employees that deal solely with workers' compensation patients exceeds $150,000 per year.

The administrative issues associated with workers' compensation patients are substantially more involved than with non workers' compensation patients. From the first interaction between

Pee Dee Orthopaedic Associates, P.A.
901 E. Cheves St., Suite 100 • Florence, SC 29506
1580 Freedom Blvd., Suite 100 • Florence, SC 29505
(843) 662-5233 • Fax (843) 678-9003
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PDOA and the employer/case manager until patient discharge, every step of the treatment process is more detailed and involved than non workers' compensation patients. The amount of information needed in order to schedule a workers' compensation patient is far greater than of a non workers' compensation patient. This involves obtaining permission to see and treat the patient, the information needed for input into our computer system, work restrictions, obtaining authorization for testing or surgical procedures, maximum improvement, and impairment ratings add to the difficulty of treating workers' compensation patients.

PDOA utilizes an electronic medical record (EMR) called ChartLogic. ChartLogic electronically stores patient demographic information and treatment records. While this eases record management, EMRs are extremely expensive. PDOA expenses for ChartLogic, including software, IT support, equipment, and training have exceeded $400,000. PDOA is comprised of ten (10) physicians. For smaller practices, an EMR is simply not feasible, and therefore, the process of providing care to workers' compensation patients is made much more difficult.

We also urge the Commission to update the CPT codes in the manual and post the manual on the internet. Many of the CPT codes listed in the manual are outdated, and thus, denied by carriers. An updated manual would eliminate outdated codes, denials from carriers, and allow for instant access to coding updates. Posting the manual on the internet would also allow for instant access to updates, and give greater access to the manual for smaller providers.

Studies have shown that an early referral to surgical specialists has numerous benefits. In a retrospective study of complete rotator cuff tears by Dr. Savoie, et al, patients given a prompt referral to an orthopaedic surgeon returned to work in an average of 6.6 months, as opposed to 17.1 months for those that did not receive a prompt referral. Mean medical costs for those receiving an early referral to specialists was $13,513, opposed to $35,537 that did not. Mean workers' compensation payments (off work support pay plus settlement costs) were $12, 358 for those receiving an early referral, as opposed to $65,373 that did not. Mean total cost combining medical and workers' compensation costs were $25,871 for those receiving an early referral to an orthopaedic surgeon, compared to $100,007 that did not. Clearly, surgical specialist involvement saves the employer a considerable amount in wages, support payments, and an employees' time away from work. A copy of the article is enclosed for review.

In summary, we ask that the Commission increase the conversion factor for workers' compensation patients, update the CPT codes in the manual, and post the manual, free of charge, on the internet.

Geoff McLeod

Geoff McLeod
Practice Administrator
Pee Dee Orthopaedic Associates

Pee Dee Orthopaedic Associates, P.A.
901 E. Cheves St., Suite 100 • Florence, SC 29506
1580 Freedom Blvd., Suite 100 • Florence, SC 29505
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Costs Analysis of Successful Rotator Cuff Repair Surgery: An Outcome Study. Comparison of Gatekeeper System in Surgical Patients

F. H. Savoie III, M.D., Larry D. Field, M.D., and R. Nan Jenkins, R.N.F.A.

Summary: In an effort to determine the cost effectiveness of rotator cuff repair surgery in workers' compensation patients, a financial analysis of 50 consecutive patients with a "successful" result was performed. Treatment costs were analyzed from the date of initial injury through all evaluations, diagnostic studies, surgical reconstruction, physical therapy and work hardening. Additionally, all workers' compensation payments and the cost of settlement was analyzed. The average cost of medical care was $50,302.25 per patient. The average time to return to unrestricted duty from the date of injury was 11 months. However, patients referred to a specialist immediately following the diagnosis of a rotator cuff tear had total costs that averaged $25,870.64 and returned to work an average of 7 months postoperatively. Patients managed via a "gatekeeper" system averaged $100,280.10 in total costs and the average return to work was 18 months. These differences in cost and return to work were both statistically significant, $P < .05$. In conclusion, immediate referral of rotator cuff tears for specialized care results in decreased cost and earlier return to work. **Key Words:** Rotator cuff—Workers' Compensation—Gatekeeper.

The Workers' Compensation system was designed to provide medical coverage for job-related injuries.[1] Ideally, this system provides quality medical care and support for the worker during convalescence, allowing a rapid return to work at a reasonable cost.[1] Unfortunately, in many cases the system fails, resulting in exorbitant costs and patients unable or unwilling to work.[2-5] We have postulated that even a successful result may be more costly in a Workers' Compensation case.

The purpose of this study is to determine the actual cost of successfully returning an injured patient to work. A secondary factor we analyzed was the effect of a company physician "gatekeeper" in the management of these patients. To evaluate this hypothesis, we reviewed the financial records of 50 consecutive patients with full-thickness tears of the rotator cuff who returned to work in their previous occupation.

MATERIALS AND METHODS

Fifty consecutive patients with full-thickness tears of the rotator cuff who returned to normal work activities were evaluated for total medical costs, Workers' Compensation support pay while off work, and settlement costs. Ancillary costs (e.g., legal costs, replacement worker) were not included.

As we evaluated the cost to the Workers' Compensation system, it became apparent there were two separate groups of patients based on the type of medical care they received following the diagnosis of rotator cuff tear. Therefore, we analyzed these two groups

From the Mississippi Sports Medicine and Orthopaedic Center, Jackson, Mississippi, U.S.A.

Address correspondence and reprint to F. H. Savoie III, M.D., 1325 E. Fortification St, Jackson, MS 39202, U.S.A.

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separately in addition to the overall patient cohort. Group I patients (n = 34) were managed by early referral to an orthopaedic specialist via the company physician. Group II patients (n = 16) were managed by a "gatekeeper" type system in which the company physician was encouraged to keep medical care and decision making in house and refer to a specialist only as a last resort and only after he personally ordered and interpreted the various tests.

In 43 of the 50 patients, we were able to obtain all medical and Workers' Compensation costs. Seven patients (5 in group I, 2 in group II) refused to allow one or more parts of their financial data to be included in the study and were eliminated from the results.

RESULTS

The average total cost per patient was $50,302.25 (range, $11,699 to $462,964) in actual expenses (Table 1). The average medical cost was $20,683.50 (range, $9,526 to $75,283). The average support pay and settlement cost was $29,618.75 (range, $1,384 to $426,880).

Group I patients (Table 2) averaged $25,870.64 in actual total expenditures whereas group II patients (Table 3) averaged $100,910.60 in actual total expenditures.

In evaluating the time to return to full duty, the overall patient group returned an average of 10 months after injury (Table 1). Group I patients (Table 2) returned to work an average of 6.6 months after the injury; group II patients (Table 3) required 18 months to return to full duty.

Groups I and II were compared statistically for medical costs, Workers' Compensation cost, total cost, time from injury to surgery, and time off work. In each case, there was a statistically significant difference shown between the two groups using the *t*-test method in each comparison.

The mean cost of medical care among group I patients was $13,513 with a standard deviation of $3,817. The mean cost in group II was $35,537 with a standard deviation of $17,947. These differences in medical costs were statistically significant ($P < .001$).

The two groups were also compared in terms of the amount of Workers' Compensation payment (off work support pay plus settlement cost). In group I, the mean payment by the Workers' Compensation system was $12,358 with a standard deviation of $8,595. In group II, the mean cost was $65,373 with a standard deviation of $104,974. These differences were statistically significant ($P < .01$).

The two groups were then compared for the total cost combining medical and workers' compensation costs to the system. Group I patients had a mean total cost of $25,871 with a standard deviation of $10,007. Group II patients had a mean cost of $100,911 with a standard deviation of $107,811. These differences in total cost were statistically significant ($P < .001$).

The time variable from the injury to the surgery was also compared in the two groups. Group I patients underwent surgical reconstruction of their shoulders at a mean time of 3.9 months after injury with a standard deviation of 3.2 months. Group II patients underwent surgical reconstruction of their shoulder at a mean time of 10.1 months after injury with a standard deviation of 4.4 months. These differences are also statistically significant ($P < .001$). The amount of time required for the patient to return to work was also compared between the two groups. Group I patients returned to work after a mean of 6.6 months with a standard deviation of 4.4 months. Group II patients remained off work for a mean of 17.1 months with a standard deviation of 9.2 months. This return to work difference was statistically significant ($P < .001$).

In each category compared, the group I patients managed by early referral had statistically significant lower costs, less time off work, and more rapid return to function than patients in group II.

DISCUSSION

The Workers' Compensation system was originally designed to care for workers' with injuries directly related to their occupation. Unfortunately, the system has deteriorated to cover all types of problems that may or may not be related directly to the occupation of the worker.[1] This study is not designed to evaluate this area of the system. However, once a claim is made and verified, it is often difficult to return the patient to work.[4,5] The reasons for this are multifactorial including the physical limitations of the injury, the ergonometric requirements of the job, psychological factors related to job satisfaction and environment, and social factors (i.e., receiving pay for not working).

It has been well established that the longer a patient remains off work and the more surgery the patient has received, the less likely the patient will return to work.[3-5] This would seem to indicate that the more quickly the injured patient receives definitive care the less the cost to the patient and the system. However,

TABLE 1. *Groups I and II*

Patient	Cost	Pay-Sett	Tot-Cost	Group	Inj-Surg	Off-Work
CB	$11,626.96	$9,200.00	$20,826.96	1	2	5
EB	9,789.89	3,657.21	13,447.10	1	1	7
CHB	11,220.00	10,467.00	21,687.00	1	1	4
RC	15,715.94	7,966.30	23,682.24	1	3	8
DC	10,195.14	6,708.00	16,903.14	1	2	2
GF	12,801.84	11,240.39	24,042.23	1	6	4
EG	11,553.03	5,551.72	17,104.75	1	3	1
YZH	15,727.26	18,171.97	33,899.23	1	11	22
DH	14,781.47	11,449.46	26,230.93	1	6	13
BH	17,040.50	12,832.00	29,872.50	1	10	11
JH	14,029.28	17,006.40	31,035.68	1	4	7
LJ	19,207.80	19,370.75	38,578.55	1	1	13
BRJ	11,946.67	6,310.40	18,257.07	1	3	6
CL	9,674.94	10,178.60	19,853.54	1	6	2
ML	27,451.40	18,740.00	46,191.40	1	1	7
BM	9,526.94	8,674.00	18,200.94	1	1	3
WN	15,288.00	10,522.30	25,810.30	1	3	7
EP	11,285.00	384.76	11,669.76	1	1	1
JSC	12,037.00	47,935.00	59,972.00	1	2	9
RSM	12,897.00	18,333.00	31,230.00	1	3	5
JESM	75,283.70	74,656.00	149,939.70	2	19	23
LT	11,495.00	11,500.00	22,995.58	1	2	4
DTL	13,047.26	10,025.80	23,073.06	1	1	6
DTR	11,784.50	10,634.74	22.419.24	1	3	7
JT	10,977.50	10,832.00	21,809.50	1	1	6
GT	10,232.50	20,480.00	30,712.50	1	2	10
DT	20,413.26	5,695.33	26,108.59	1	11	4
DW	14,621.67	19,946.66	34,568.33	1	9	10
VW	12,079.86	7,040.00	19,119.86	1	9	3
PB	24,661.85	50,428.00	75,089.85	2	4	19
CC	33,460.52	18,337.04	51,797.56	2	7	16
EC	20,017.20	31,418.19	51,435.39	2	14	1
GH	13,418.28	7,528.39	20,946.67	1	4	5
TH	36,084.97	426,880.00	462,964.97	2	7	19
RL	32,256.73	27,620.59	59,877.32	2	14	28
JWM	14,768.86	27,054.00	41,822.86	2	13	19
JCP	51,254.00	28,802.76	80,056.76	2	14	37
CP	27,431.14	31,088.40	58,519.54	2	4	10
WR	30,023.71	48,000.00	78,023.71	2	11	19
JST	21,606.00	42,178.00	63,784.00	2	9	19
RSP	32,344.57	41,628.12	73,972.69	2	8	4
CASM	28,157.00	28,200.00	56,357.00	2	12	10
WW	70,174.30	38,932.78	109,107.08	2	6	16
TOTA	20,683.50	29,618.75	50,302.26	0	5	10

NOTE. Cost is Medical Cost. Pay-sett is the sum of off work support pay and settlement cost. Tot-cost is the sum of medical costs, off work pay and settlement costs. Inj-Surg is the time from the reported injury until surgical reconstruction expressed in months. Off-work is the total time until the patient returned to unrestricted work.

there has recently been a movement to limit access to specialized care in an attempt to decrease medical costs. While in some instances limiting such access may be effective, the present study seems to show that limiting access actually results in increased costs.

The more quickly a rotator cuff injury is diagnosed and repaired the more quickly the patient should be able to return to useful employment.[3,4] This study strongly supports such a philosophy. In the present study, the sooner the patient underwent rotator cuff repair the sooner the patient was able to return to work.

The degree of difference in costs between the two groups was dramatic. Although it is difficult to extrapolate these data to other work related injuries, it is apparent that early referral of surgical rotator cuff injuries to a shoulder surgeon actually decreased costs significantly.

Care should be taken not to generalize the data presented in the present study as an indictment of the gatekeeper or company physician concept.

The gatekeeper may in fact have resulted in decreased costs if all patients presenting with shoulder complaints of any kind were included in this study.

TABLE 2. *Group I: Primary Referral Patients*

Patients	Cost	Pay-Sett	Tot-Cost	Group	Inj-Surg	Off-Work
CB	$11,626.96	$9,200.00	$20,826.96	1	2	5
EB	9,789.89	3,657.21	13,447.10	1	1	7
CHB	11,220.00	10,467.00	21,687.00	1	1	4
RC	15,715.94	7,966.30	23,682.24	1	3	8
DC	10,195.14	6,708.00	16,903.14	1	2	2
GF	12,801.84	11,240.39	24,042.23	1	6	4
EG	11,553.03	5,551.72	17,104.75	1	3	1
YZH	15,727.26	18,171.97	33,899.23	1	11	22
DH	14,781.47	11,449.46	26,230.93	1	6	13
BH	17,040.50	12,832.00	29,872.50	1	10	11
JH	14,029.28	17,006.40	31,035.68	1	4	7
LJ	19,207.80	19,370.75	38,578.55	1	1	13
BRJ	11,946.67	6,310.40	18,257.07	1	3	6
CL	9,674.94	10,178.60	19,853.54	1	6	2
ML	27,451.40	18,740.00	46,191.40	1	1	7
BM	9,526.94	8,674.00	18,200.94	1	1	3
WN	15,288.00	10,522.30	25,810.30	1	3	7
EP	11,285.00	384.76	11,669.76	1	1	1
JSC	12,037.00	47,935.00	59,972.00	1	2	9
RSM	12,897.00	18,333.00	31,230.00	1	3	5
LT	11,495.00	11,500.00	22,995.58	1	2	4
DTL	13,047.26	10,025.80	23,073.06	1	1	6
DTR	11,784.50	10,634.74	22,419.24	1	3	7
JT	10,977.50	10,832.00	21,809.50	1	1	6
GT	10,232.50	20,480.00	30,712.50	1	2	10
DT	20,413.26	5,695.33	26,108.59	1	11	4
DW	14,621.67	19,946.66	34,568.33	1	9	10
VW	12,079.86	7,040.00	19,119.86	1	9	3
GH	13,418.28	7,528.39	20,946.67	1	4	5
TOTA	13,512.62	12,358.02	25,870.64	0	4	6

However, we were unable to find verifiable data supporting such a concept.

These patients had a specific surgical problem that required correction. This report does detail the benefits of early referral for specialty care when surgical intervention is warranted. In these patients who require a high level of function from their shoulders, the delay in referral to a specialist, although well intentioned and often managed by excellent physicians, resulted in increased costs, as well as delays in return to work and functional activities.

Two conclusions can be drawn from this patient cohort: (1) A successful repair of the rotator cuff places

TABLE 3. *Group II: "Gatekeeper" System Patients*

Patient	Cost	Pay-Sett	Tot-Cost	Group	Inj-Surg	Off-Work
PB	$24,661.85	$50,428.00	$75,089.85	2	4	19
CC	33,460.52	18,337.04	51,797.56	2	7	16
EC	20,017.20	31,418.19	51,435.39	2	14	1
TH	36,084.97	426,880.00	462,964.97	2	7	19
RL	32,256.73	27,620.59	59,877.32	2	14	28
JWM	14,768.86	27,054.00	41,822.86	2	13	19
JCP	51,254.00	28,802.76	80,056.76	2	14	37
CP	27,431.14	31,088.40	58,519.54	2	4	21
WR	30,023.71	48,000.00	78,023.71	2	11	19
JST	21,606.00	42,178.00	63,784.00	2	9	19
RSP	32,344.57	41,628.12	73,972.69	2	8	5
JASM	28,157.00	28,200.00	56,357.00	2	12	10
WW	70,174.30	38,932.78	109,107.08	2	6	16
JESM	75,283.70	74,656.00	149,939.70	2	19	23
TOTA	35,537.47	65,373.13	100,910.60	0	10	18

enormous costs on the Workers' Compensation system (average: $50,302.25), and (2) delayed referral of rotator cuff tears to a specialist appears to result in increased costs ($100,910.60 *v* $25,870.64) and delays in return to work (18 months *v* 6 months).

Acknowledgment: The authors acknowledge the contribution of Dr. Ray Phelps (Millsaps College) for the statistical analysis.

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Lowcountry Orthopaedics & Sports Medicine

JOEL R. COX, JR., MD
JAMES J. MCCOY, JR., MD
JAMES D. SPEARMAN, MD
DON O. STOVALL, JR., MD
RICHARD H. ZIMLICH, MD
DAVID H. JASKWHICH, MD
SHAILESH M. PATEL, MD
CHAD R. BURGOYNE, MD
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- Charleston Surgery Center

June 29, 2009

Medical Services Division
South Carolina Workers' Compensation Commission
P.O. Box 1715
Columbia, SC 29202-1715

Dear Commissioners,

Thank you very much for this opportunity to comment on the revision of the Medical Services Provider Manual. Lowcountry Orthopaedics & Sports Medicine physicians and staff are heavily involved in caring for the Workers Compensation population. On average, about 27% of the patients we treat in our practice are Workers Compensation.

Our goal when treating Workers Compensation patients is to efficiently provide treatment for injured workers in an effort to allow them to return to work as soon as possible. This involves working closely with patients, their representatives, and/or case managers and adjusters. As mentioned in our testimony in the Open Hearing, we employ 3 full time employees whose sole job is to meet the needs of the Workers Compensation system and its paperwork, authorization, and communication demands. No other payor requires this level of resource.

As you know, the South Carolina fee schedule has not changed since 2003. It has maintained outdated codes and allowed fees to fall below what some private payors allow. As small businesses, we are subject to the pressures of escalating overhead and are forced to make business decisions on the types of payors we will accept, based on the fee schedule of the particular payor and the cost to treat patients. We are grateful to the Commission for its willingness to update the Medical Services Provider Manual, and would encourage the Commission to adopt strategies similar to Georgia and North Carolina to keep the fee schedule and codes updated on an annual basis. We stand with the South Carolina Medical Association (SCMA) and respectively request that you consider the following revisions:

JUL 01 '09

(843) 797-5050
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Internet address: www.lowcountryortho.com Fax 843-797-3633

1) A task force of stakeholders be assembled, including members of the South Carolina Orthopaedic Association and the SCMA, for the sole purpose of updating this manual;
2) Increase the fee schedule for physicians that amounts to a cost of living increase for each of the various codes relative to the 2003 values;
3) Implement an annual cost of living increase for each code;
4) Have the manual be made available online and easily accessible for the physician user. This will also allow for fees and codes to be easily updated as needed and allow for corrections to be easily made to the manual if necessary.

Thank you again for this opportunity to share our recommendations on revisions to the Medical Services Provider Manual.

Sincerely,

Carl H. Butler, Jr.

Carl H. Butler, Jr.
CEO

Joel R. Cox, Jr. MD
James D. Spearman, MD
Richard H. Zimlich, MD
Shailesh M. Patel, MD
Eric S. Stem, MD
Amy M. Stanton, PA-C
Cynthia H. Zeigler CFNP

James J. McCoy, Jr., MD
Don O. Stovall, Jr., MD
David H. Jaskwhich, MD
Chad R. Burgoyne, MD
Jason K. Trigiani, PA-C
Ashley L. Burleson, NP-C

SCHA South Carolina Hospital Association
1000 Center Point Road | Columbia, SC 29210-5802 | Ph. 803.796.3080 | www.scha.org

June 30, 2009

Medical Services Division
South Carolina Workers' Compensation Commission
Post Office Box 1715
Columbia, SC 29202-1715

On behalf of the more than 85 institutional and 600 personal members of the South Carolina Hospital Association, we are pleased to submit comments to the Commission regarding the *Medical Services Provider Manual.* At this point, without specific recommendations in which to respond, our general comments are as follows:

1. **Administrative:** Generally speaking, workers compensation cases are more complex than other cases and the administrative burden is much more significant. Administrative simplification for workers compensation cases should be a major consideration.

2. **Reimbursement Base:** Due to the complexity of the cases, and the aforementioned administrative burden, the basic reimbursement level (fee schedule) should be set at a multiple of Medicare in the range of 160% - 180%.

3. **Variations:** If the reimbursement base is to be Medicare, there needs to be assurance that variations to the Medicare fee schedule is minimal – if at all. Variations to the fee schedule add to the already complex administrative burdens for providers, payors and the Commission.

4. **Methodology Updates:** Again, if the Medicare fee schedule is to be the base, processes need to be in place to provide for changes to the overall methodology structure as Medicare makes changes.

5. **Payment Updates:** Processes need to be in place that would trigger automatic fee schedule adjustments for inflation.

The hospital and medical community appreciates the opportunity to serve South Carolina workers compensation patients but feel strongly about adequate reimbursement and the minimization of the administrative burdens.

Again, thank you for the opportunity to provide comments and please feel free to contact me should there be any questions.

Sincerely,

Tommy Cockrell

Thomas D. Cockrell, FHFMA
Senior Vice President and COO

The SC Small Business Chamber of Commerce
1717 Gervais Street, Columbia, SC 29201
(803) 252-5733 fax (803) 799-0678
www. scsbc.org

August 20, 2009

Gary M. Cannon
Executive Director
Workers' Compensation Commission
P.O. Box 1715
Columbia, SC 29202-1715

Dear Gary,

Thanks for your letter requesting our input into your revisions of the Medical Services Provider Manual. As you know, The S.C. Small Business Chamber of Commerce represents a wide variety of small businesses in the state. Many of our members carry workers' compensation insurance. We have worked very hard with our Legislature and Administrative Law Court to improve the workers' compensation laws, increase the resources of the Commission to more effectively carry out their mission and protect the business community from excessive rate increases.

The Medical Service Provider Manual, which establishes allowable medical fees, is of great interest to the Small Business Chamber to the degree that medical provider fees increase costs to the small business community through premiums. Controlling costs is vital to the system, however, medical providers are also vital to the system and part of the small business community. These providers should be compensated fairly for their services.

The matter of what is fair compensation through medical fee schedule we will trust to the Commission's judgment. However, in regard to the independent medical examination fee schedule, my understanding is that it is to apply equally to all parties in a workers' compensation case. In talking with others about our response to your letter, there appears to be some concern that the Commission's guidelines in this area are not being applied equally and might actually need to be changed.

First, is the independent medical examination fee schedule being observed and monitored by the Commission for both the insurance carrier and the plaintiff? The Commission should be able to guarantee that all parties are abiding by the current fee structure and requirements. This is especially true for the insurance carriers involved because it is their independent medical fee expenses that contribute directly to the cost of workers' compensation premiums. Allowing the insurance carriers to disregard the fee schedule has a direct negative impact on small businesses. Can you shed some light on this issue?

Second, what is the purpose of the independent medical examination fee schedule for the plaintiff if those medical fees are paid by the plaintiff, are not a component of the insurance carrier costs and thus cannot increase the cost of workers' compensation premiums? Are the

independent medical examination fees for the plaintiff increasing the system's cost to the business community? If not, why are these small business medical providers having their fees restricted for the plaintiff's independent medical examinations? Your opinion on this would be appreciated.

Thank you for the opportunity to have input into this process.

Sincerely,

Frank Knapp, Jr.
President & CEO

Anesthesia Services Rates in the Workers' Compensation Program

Presented by: South Carolina Society of Anesthesiologists
June 8, 2009

June 8, 2009

Anesthesiology and the S.C. Worker's Compensation Program

Issues

1. **Lack of Parity.** Anesthesia services are reimbursed by the Worker's Comp Program at the lowest rate of all physician providers (as compared to % of charges and % of commercial rates).
2. **Medicare Should Not be the Benchmark for Worker's Comp.** The 1992 Medicare Fee Schedule arbitrarily reduced the anesthesiology conversion factor by 29% and again in 1998 the entire Medicare formula conversion was flawed with a resulting 54% reduction. Medicare rates are usually 71-80% of commercial rates across all specialties, except for anesthesiology, where it is only 30% of the commercial rate.
3. **Medicare in South Carolina is particularly out of parity.** The Medicare conversion factor for South Carolina is in the bottom 2% of the nearly 250 Medicare Conversion Factors for Anesthesia.
4. **WC's Methodology Exacerbates the Problem.** In 1998, the S.C.'s Worker's Comp Program changed its reimbursement methodology by instituting a 50/50 fee split between the anesthesiologist and the anesthesia nurse. Before 1998, the MD rate was twice that of the nurse rate. Not only does this devalue the role of the physician, but the actual reimbursement rate to the physician is $12/unit and not the published $24/unit, when the MD is supervising an anesthesia nurse.
5. **WC is Lower than the State Health Plan.** The S.C. State Health Plan reimburses at a rate of $50/unit for anesthesia services (effective 01/01/09). This is more than twice that of the Worker's Comp rate. ***Note: The only physician services in the WC Program that are reimbursed at a rate less than the State Health Plan are Anesthesia Services.***
6. **Problems with Processing Claims.** The WC system is slow to pay with the average A/R over 100 days. Claims that are not WC and subsequently filed with another carrier are denied for lack of timely payment because it took so long for WC to process and notify the provider that the claim was in fact not a WC claim. Too many claims are being filed hard copy, on the instructions of WC staff.
7. **S.C. WC is the Lowest in the Southeast for Anesthesia Services.** *(see below)

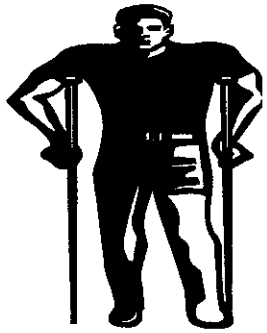
- **North Carolina rate:** **$58.20/unit** (MD gets 2/3 in MD/Nurse cases)
- **Georgia rate:** **$35.63/unit** (MD gets 100% in MD/Nurse cases)
- **Alabama rate:** **$47.20/unit** (MD/Nurse is 50/50)
- **Florida rate:** **$44.24/unit** (MD gets 100% in MD/Nurse cases)
- **Median Managed Care rate:** **$62.48/unit**

8. **S.C. WC is out of compliance with HIPAA regulations.** S.C. WC is not using the 2009 CPT codes for processing claims. HIPAA mandated that all insurance companies, payers and providers must use the current codes.
9. **Since 2003**, every payer has increased the anesthesia unit rate, except the S.C. Workers' Compensation Program. Even Medicare and Medicaid have had an increase.
10. **The S.C. State Health Plan is perhaps the most comparable plan.** The rate from S.C. Workers' Comp is only 48% of what the State Health Plan reimburses. (WC $24/unit vs. State Health Plan $50/unit).

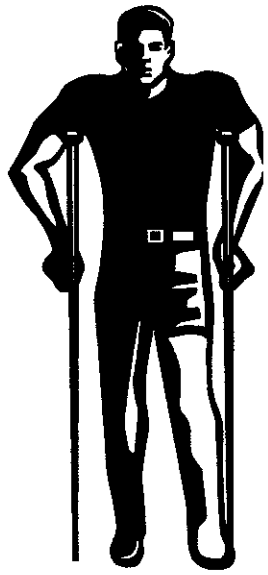
Solutions

1. **Increase the unit rate to $50/unit.**
2. **Split the MD/Nurse payment 60/40 for medically directed cases with an anesthesiologist and a nurse anesthetist.**
3. **Comply with HIPAA regulations.**
4. **Address late and slow payments.**

Worker's Comp vs. State Health Plan



$24/unit



$50/unit

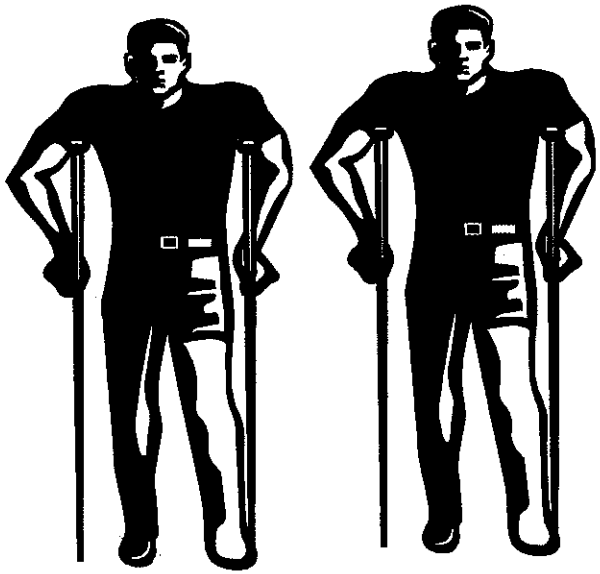
Worker's Comp rates are 48% of the SC State Health Plan rates

Non-Parity in Reimbursement for Anesthesia Services
Medicare vs. Commercial

Commercial Insurance Rates

All Physicians Except Anesthesiologists

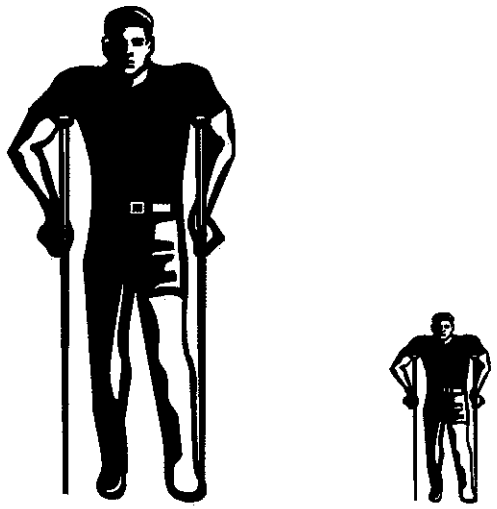
Anesthesiologists



Medicare Rates

All Physicians Except Anesthesiologists

Anesthesiologists



WORKERS' COMP AND ANESTHESIA REIMBURSEMENT

Presented by the SCSA

August 29, 2005 (2009 updates in red)

CURRENT RATE: $24.00/UNIT

HOW IS THE REIMBURSEMENT FOR ANESTHESIA CALCULATED? Base units plus time units multiplied by a conversion factor. Each anesthesia procedure is allotted a certain # of base units (as determined by the American Society of Anesthesiologists) plus the time involved in the operation or procedure, and then multiplied by the conversion factor.

WHAT IS A UNIT? A unit is x number of base units plus the measure of time involved in an anesthetic. Anesthesia time begins when the anesthesiologist begins to prepare the injured employee for the induction of anesthesia and ends when the anesthesiologist is no longer in personal attendance (e.g., when the injured employee may be safely discharged from the recovery area.)

HOW MANY MINUTES IN A TIME UNIT? In South Carolina, a unit is defined by the WC Commission as 15 minutes.

IS THIS THE SAME IN OTHER STATES? NO. Georgia uses a 10 minute unit; N.C. uses a 1 minute unit; Florida uses a 10 minute unit. Only a few other states, such as Alabama use a 15 minute unit.

WHAT DIFFERENCE DOES THE TIME MATTER? In a 60 minute period, there are more 10 minute units than 15 minute units. Thus, in one hour, six 10 minute units are equal to $144.00, while four 15 minute units are equal to $96.00.

HOW DID S.C. WORKERS' COMP DECIDE ON $24.00/UNIT? The commission sets its rates on a percent of Medicare.

HOW DOES MEDICARE DETERMINE ITS RATES? Medicare uses several formulas to determine the reimbursement for physician providers.

ISN'T MEDICARE THE SAME FOR ALL PHYSICIANS? Absolutely not! In 1992, the Medicare Fee Schedule arbitrarily reduced the anesthesiology factor by 29% and again in 1998 the entire Medicare formula conversion was flawed with a resulting 54% reduction for anesthesiology.

HOW DOES MEDICARE COMPARE TO COMMERCIAL RATES? For all physicians, except anesthesiologists, the Medicare rate is between 71%-80% of commercial products. For Anesthesiologists (see previous answer) the percent of commercial is only ~~24%~~. 30%

HOW IS MEDICARE AS A PAYOR IN SOUTH CAROLINA? For anesthesiology, the Medicare conversion factor is in the bottom 2% of the nearly 250 Medicare Conversion Factors.

SO USING MEDICARE AS A BENCHMARK, BY DEFINITION CREATES A LACK OF PARITY BETWEEN ANESTHESIOLOGISTS AND ALL OTHER PHYSICIAN PROVIDERS? That's correct.

HOW DOES S.C. WORKERS' COMP COMPARE TO OTHER PAYORS IN THE MARKET? Only Medicare and Medicaid pay worse than S.C. Workers' Comp.

$50.00

WHAT DOES THE STATE HEALTH PLAN PAY? ~~$45.00~~/unit, plus the state splits the payment 60/40 (MD/Nurse).

DOES S.C. WC PAY MOST PHYSICIANS COMPARABLY TO THE STATE HEALTH PLAN? Yes, except for anesthesiologists.

HOW DOES THE S.C. WORKERS' COMP REIMBURSEMENT COMPARE TO MANAGED CARE? The national average is ~~$50.00~~/unit and the state average is ~~$56.80~~/unit.
$55.00 $62.48

DIDN'T THE S.C. WC COMMISSION GIVE ANESTHESIOLOGISTS A 7% INCREASE IN 2002. WHILE GIVING ALL OTHER PHYSICIAN PROVIDERS A 5% INCREASE? Yes, and 7% of a much smaller number is far less than 5% of a larger number. Thus the 7% increase in 2002 was 4 times less than the 5% increase given to other physicians.

DON'T ANESTHESIA NURSES ALSO GET PAID BY THE COMMISSION? Yes.

DO THEY GET PAID A SMALLER PERCENT OF THE PHYSICIAN RATE? NO. In fact, before 1998, the nurses were paid 50% of the physician rate. In 1998, the S.C. WC Commission changed its methodology (without comment or input from the anesthesiologists or the SCMA) to a 50/50 split between the physician and the supervised nurse.

WHAT DID THIS DO TO THE AMOUNT REIMBURSED TO THE PHYSICIAN? The $24.00/unit became $12.00/unit.

WHAT DOES THAT MATTER SINCE THE PHYSICIAN EMPLOYS THE NURSE AND THE MONEY ALL COMES TO THE PRACTICE? Physician groups are employing fewer and fewer nurse anesthetists. Hospitals in South Carolina now employ more than ~~75%~~ 80% of the nurses.

DO OTHER PAYORS SPLIT THE FEE 50/50? Medicare does, but Medicaid does not and most commercial and managed care carriers do not. For example, S.C. BCBS splits the fee 65/35.

 NC

Medical Fee Schedule: Section 4

In Accordance with the N.C. Industrial Commission's Medical Fee Schedule & Subsequent Updates, 1996-2009

Bernadine Singh
Chief Medical Fee Examiner
N.C. Industrial Commission
E-mail: Bernadine.Singh@ic.nc.gov

NOTE 1: To purchase a complete copy of the American Medical Association's ***Current Procedural Technology Codes***, telephone Ingenix, Inc. at **(800) INGENIX (464-3649), option 1**, or go to http://www.shopingenix.com/modules/catalog/catalog_category.asp to order a CPT® code book online.

NOTE 2: Please report any problems or errors directly to *Bernadine.Singh@ic.nc.gov*.

NOTE 3: This page was last revised on **February 20, 2009.**

TABLE OF CONTENTS

Anesthesia Section 4

The following anesthesia codes are to be approved based on fee per minute. (Effective April 1, 2000.)

AL

ANESTHESIA REIMBURSEMENT FACTOR

The Anesthesia conversion factor is equal to $47.20 per unit. Department of Industrial Relations, Administrative Code Rule 480-5-5-.15(9) provides the guidelines for determination of units.

Effective: June 15, 2008

NCIC Code	Description	Allowance
ANT01	major, general or spinal, by anesthesiologist (first hour)	$3.88 per minute up to and including 60 minutes
ANT01	major, general or spinal, by anesthesiologist (second hour and subsequent hours)	$2.05 per minute beyond 60 minutes
ANT02	major, general or spinal, by Certified Registered Nurse Anesthetists (first hour)	$2.55 per minute up to and including 60 minutes
ANT02	major, general or spinal, by Certified Registered Nurse Anesthetists (second hour and subsequent hours)	$1.05 per minute beyond 60 minutes

Major, general or spinal anesthesia services should be distinguished by the the use of "Type of Service" code "7" on the CMS (HCFA) 1500 Form, and by the documentation of time (actual minutes) on the bill.

Note to Processors

- Unusual monitoring services are not considered part of the basic anesthesia package. Codes 36620-36625 and 93503 are such codes, and may be billed in addition to the "ANT" codes.
- When billing for injections or other pain management procedures that are not considered part of a general anesthesia service, the appropriate CPT code should be used and reimbursed accordingly.
- Use of CPT code 01996 for daily management of epidural or subarachnoid drug administration is allowed. Reimbursement is $130.00 per day.
- There are some items that have no CPT codes, such as any type of supply or minor anesthesia. These items must be entered as CPT code 99070.

N.C. Industrial Commission ▪ Medical Fees Section
4337 Mail Service Center ▪ Raleigh, NC 27699-4337
Telephone: (919) 807-2503 ▪ Fax: (919) 715-0282
NCIC Home Page: http://www.ic.nc.gov/

GA

georgia.gov

State Board of Workers' Compensation

Medical

The April 1, 2009, Georgia Workers' Compensation Medical Fee Schedule is available for purchase. Click on the link(s) below which will direct you to the website where you can place your order.

Be sure to check this website for any updates to each year's fee schedule as they will be posted here.

Some notable changes to the 2009 fee schedule are as follows:

1. Maximum allowable reimbursements (MAR) have all been recalculated.
2. CPT codes were updated with code additions, deletions and revisions in accordance with the AMA.
3. IME rates have increased to $600.00 for the first hour and $150.00 for each additional 15 minutes. Use state-specific code IME01 when billing for IME.
4. Physician Testimony/Deposition rates have increased to $600.00 for the first hour and $150.00 for each additional 15 minutes.
5. Translation/Interpretation for physician and PE use during face-to-face Evaluation and Management visits use state-specific modifier TR. See detailed information in Section IV, pages 11 and 12 of April 1, 2009 fee schedule.
6. Transportation - Ambulance and Air Services has been added to the fee schedule.
7. Non-Emergency Transportation reimbursements have increased by 1.7%.
8. Anesthesia base rate has been increased to $35.63.
9. Home Health Services hourly rates have increased by 1.7%.
10. State-specific modifier -TR has been added in circumstances where an interpreter/translator is required during a face-to-face E/M services provided by a physician or PE.
11. Medical Record copy reimbursement remains unchanged from 2008.
12. Pharmacy reimbursement remains unchanged from 2008.

April 1, 2009 Medical Fee Schedule - Binder

April 1, 2009 Medical Fee Schedule - CD

April 1, 2009 Medical Fee Schedule Updates

FL

Anesthesia

CPT Code	BV + TM
00100	4 + TM
00102	6 + TM
00103	5 + TM
00104	4 + TM
00120	5 + TM
00124	4 + TM
00126	4 + TM
00140	5 + TM
00142	6 + TM
00144	4 + TM
00145	6 + TM
00147	6 + TM
00148	4 + TM
00160	6 + TM
00162	7 + TM
00164	4 + TM
00170	5 + TM
00172	6 + TM
00174	6 + TM
00176	7 + TM
00190	5 + TM
00192	7 + TM
00210	11 + TM
00212	5 + TM
00214	9 + TM
00215	9 + TM
00216	15 + TM
00218	13 + TM
00220	11 + TM
00222	6 + TM
00300	5 + TM
00320	6 + TM
00322	8 + TM
00340	10 + TM
00352	5 + TM
00400	3 + TM
00402	6 + TM
00404	5 + TM
00406	13 + TM
00410	4 + TM
00450	6 + TM
00452	6 + TM
00454	3 + TM
00470	6 + TM
00472	10 + TM
00474	3 + TM
00500	15 + TM
00520	6 + TM
00522	4 + TM
00524	8 + TM

Anesthesia

CPT Code	BV + TM
00528	8 + TM
00529	12 + TM
00530	4 + TM
00532	4 + TM
00534	7 + TM
00537	8 + TM
00539	17 + TM
00540	13 + TM
00541	5 + TM
00542	15 + TM
00546	15 + TM
00548	15 + TM
00550	10 + TM
00560	15 + TM
00562	20 + TM
00563	25 + TM
00566	25 + TM
00580	20 + TM
00600	10 + TM
00604	13 + TM
00620	10 + TM
00622	15 + TM
00630	8 + TM
00632	7 + TM
00634	10 + TM
00635	4 + TM
00640	3 + TM
00670	13 + TM
00700	5 + TM
00702	7 + TM
00730	5 + TM
00740	5 + TM
00748	4 + TM
00752	6 + TM
00754	7 + TM
00756	7 + TM
00770	15 + TM
00790	17 + TM
00792	13 + TM
00794	8 + TM
00796	30 + TM
00797	10 + TM
00800	3 + TM
00802	5 + TM
00810	6 + TM
00820	3 + TM
00830	4 + TM
00832	6 + TM
00840	8 + TM
00842	10 + TM

Anesthesia

CPT Code	BV + TM
00844	8 + TM
00846	8 + TM
00848	8 + TM
00851	6 + TM
00860	6 + TM
00862	7 + TM
00864	8 + TM
00865	8 + TM
00866	10 + TM
00868	10 + TM
00870	5 + TM
00872	7 + TM
00873	5 + TM
00880	10 + TM
00882	10 + TM
00902	5 + TM
00904	4 + TM
00906	4 + TM
00908	6 + TM
00910	3 + TM
00912	5 + TM
00914	5 + TM
00916	5 + TM
00918	5 + TM
00920	5 + TM
00921	5 + TM
00922	6 + TM
00924	4 + TM
00926	5 + TM
00928	5 + TM
00930	4 + TM
00932	4 + TM
00934	5 + TM
00936	5 + TM
00938	4 + TM
00940	3 + TM
00942	6 + TM
00944	6 + TM
00948	4 + TM
00950	5 + TM
00952	4 + TM
00953	5 + TM
01120	6 + TM
01130	3 + TM
01140	5 + TM
01150	5 + TM
01160	4 + TM
01170	8 + TM
01173	7 + TM
01180	3 + TM

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Anesthesia

CPT Code	BV + TM
01190	4 + TM
01200	4 + TM
01202	4 + TM
01210	6 + TM
01212	10 + TM
01214	10 + TM
01215	10 + TM
01220	4 + TM
01230	10 + TM
01232	10 + TM
01234	8 + TM
01250	4 + TM
01260	5 + TM
01270	5 + TM
01272	4 + TM
01274	6 + TM
01320	4 + TM
01340	4 + TM
01360	5 + TM
01380	3 + TM
01382	4 + TM
01390	3 + TM
01392	4 + TM
01400	4 + TM
01402	5 + TM
01404	5 + TM
01420	3 + TM
01430	3 + TM
01432	5 + TM
01440	5 + TM
01442	8 + TM
01444	8 + TM
01462	5 + TM
01464	5 + TM
01470	3 + TM
01472	5 + TM
01474	5 + TM
01480	5 + TM
01482	4 + TM
01484	4 + TM
01486	5 + TM
01490	5 + TM
01500	8 + TM
01502	6 + TM
01520	4 + TM
01522	5 + TM
01610	5 + TM
01620	4 + TM
01622	4 + TM
01630	10 + TM

Anesthesia

CPT Code	BV + TM
01632	6 + TM
01634	8 + TM
01636	15 + TM
01638	10 + TM
01650	6 + TM
01652	10 + TM
01654	8 + TM
01656	10 + TM
01670	4 + TM
01680	10 + TM
01682	4 + TM
01710	3 + TM
01712	5 + TM
01714	5 + TM
01716	5 + TM
01730	3 + TM
01732	5 + TM
01740	5 + TM
01742	5 + TM
01744	5 + TM
01750	10 + TM
01760	3 + TM
01760	7 + TM
01770	6 + TM
01772	6 + TM
01780	3 + TM
01782	4 + TM
01810	3 + TM
01820	3 + TM
01829	3 + TM
01830	3 + TM
01832	6 + TM
01840	6 + TM
01842	6 + TM
01844	6 + TM
01850	3 + TM
01852	4 + TM
01860	4 + TM
01916	5 + TM
01920	7 + TM
01922	8 + TM
01924	8 + TM
01925	8 + TM
01926	10 + TM
01930	5 + TM
01931	7 + TM
01932	7 + TM
01933	8 + TM
01935	8 + TM
01936	8 + TM

Anesthesia

CPT Code	BV + TM
01951	5 + TM
01953	2 + TM
01960	5 + TM
01961	7 + TM
01962	5 + TM
01963	10 + TM
01967	5 + TM
01968	3 + TM
01969	5 + TM
01990	5 + TM
01991	3 + TM
01992	5 + TM
01995	5 + TM
01996	5 + TM

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3. Surgical team.

   Reimbursement for a surgical team shall be made BR to each team member for each surgeon's surgical service. Each team member shall identify the specific procedure with modifier 66 added to the code.

C. Reimbursement for multiple procedures.

1. Reimbursement shall be made for all medically necessary procedures when more than one (1) procedure is performed during a single operative session.

2. Reimbursement for the primary surgical procedure shall be the MRA in Part B, Section XI in this manual or the agreed upon contract price.

3. Reimbursement for an additional procedure shall be made at fifty percent (50%) of the listed MRA in Part B, Section XI in this manual or the agreed upon contract price. The additional procedure shall be identified when modifier 51 is added to the code to indicate the performance of multiple procedures.

D. Reimbursement for bilateral procedures.

1. Reimbursement shall be made for bilateral procedures that are performed during the same operative session.

2. Reimbursement for a bilateral procedure that contains the word "bilateral" in the descriptor shall be made at the listed MRA in Part B, Section XI in this manual or the agreed upon contract price.

3. Reimbursement for a bilateral procedure that does not indicate that it is bilateral shall be made when the procedure is billed twice as follows:

   a. Reimbursement for the first procedure shall be made at the listed MRA, in Part B, Section XI in this manual or the agreed upon contract price.

   b. Reimbursement for the second procedure identified by adding modifier 50 to the procedure code, shall be made at fifty percent (50%) of the listed MRA in Part B, Section XI in this manual or the agreed upon contract price.

SECTION X: ANESTHESIA SERVICES.

A. Reimbursement for anesthesia services shall be made to a physician or to non-physician anesthesia providers limited to certified registered nurse anesthetists (CRNAs) and anesthesia assistants (AAs) rendering services within scope of state licensure.

1. Reimbursement shall be based on application of the following values, physical status modifiers and certain qualifying circumstances.

a. Basic value (BV) or base unit.

(1) The usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services (ECG, temperature, blood pressure, oximetry, capnography and mass spectrometry) are included in the BV.

(2) When multiple surgical procedures are performed during an operative session, the BV for the anesthesia procedure with the highest value is billed and reimbursed.

(3) The BV units, listed in Part A, Section XI under Anesthesia, for each anesthesia procedure code are used in calculating reimbursement.

(4) When a surgeon provides regional or general anesthesia for a surgical procedure that he or she actually performs, modifier 47 is appended to the surgical code to indicate that the operating surgeon performed the anesthesia. Reimbursement shall be at the BV for the anesthesia service rendered.

b. Time (TM) units.

(1) Anesthesia time begins when the provider starts to prepare the injured employee for anesthesia care in the operating room or in an equivalent area and stops when the provider is no longer in personal attendance.

(2) Anesthesia time shall be billed as the total number of minutes of anesthesia. For example, one (1) hour and fifteen (15) minutes of anesthesia must be billed as seventy-five (75) minutes of anesthesia.

(3) The minutes of anesthesia must be converted into TM units as follows:

(a) For anesthesiologists, each ten (10) minutes of anesthesia time equals one (1) unit of anesthesia and each minute over a unit has a value of one-tenth (1/10) unit.

(b) For CRNAs/AAs, each fifteen (15) minutes of anesthesia time equals one (1) unit and each minute over a unit has a value of one-fifteenth (1/15) unit.

(c) For codes providing BV + TM, time units shall be calculated and added to the listed BV to determine the reimbursement for the anesthesia services.

(d) Only the BV units apply for codes without a TM unit after the base unit. For some anesthesia services, time is not reported additionally. Therefore, additional units of time are not calculated for these codes when determining reimbursement.

c. Physical status modifiers.

(1) Anesthesia services shall warrant additional reimbursement for units based upon the injured employee's condition and the complexity of the anesthesia service provided.

(2) A physical status modifier shall be determined to rank the injured employee's condition. Additional reimbursement shall be based on the unit value for the specific physical status modifier.

Physical Status Modifiers		Unit Values
P1	A normal healthy patient	0
P2	A patient with mild systemic disease	0
P3	A patient with severe systemic disease	1
P4	A patient with severe systemic disease that is a constant threat to life	2
P5	A moribund patient who is not expected to survive without the operation	3
P6	A declared brain-dead patient whose organs are being removed for donor purposes	0

d. Qualifying circumstances.

Anesthesia services, which are provided under particularly difficult circumstances, may warrant additional reimbursement for unit values based on unusual events. This subsection includes a list of important qualifying circumstances that impact the anesthesia service provided. These procedures are not reported alone but are reported as additional procedure numbers qualifying an anesthesia procedure for additional reimbursement. The listed unit value must be added to the basic unit values to obtain the reimbursement. List each of the following codes separately in addition to the procedure code for the primary anesthesia procedure.

Qualifying Circumstances		Unit Values
99100	Anesthesia for patient of extreme age, under one year and over seventy	1
99116	Anesthesia complicated by utilization of total body hypothermia	5
99135	Anesthesia complicated by utilization of controlled hypotension	5
99140	Anesthesia complicated by emergency conditions (specify)	2

2. Reimbursement for anesthesia services shall be made at the anesthesia reimbursement allowance (ARA) calculated using the BV and TM values listed in Part A, Section XI in this manual or the agreed upon contract price.

a. Methodology for calculating the ARA for procedures that are listed basic value (BV) + time (TM).

(1) Select the applicable anesthesia procedure code and basic value from the schedule in Section XI.

(2) Determine the time units according to Section X.A.1.b.(3) (ten [10] minutes = one [1] time unit for an anesthesiologist and fifteen [15] minutes = one [1] time unit for a CRNA/AA).

(3) Any minutes that exceed a whole unit are counted as partial units (fractions of units), such as one (1) minute is one-tenth (1/10) unit for an anesthesiologist and one-fifteenth (1/15) unit for a CRNA/AA.

(4) Determine any additional units that are justified by the physical status modifiers or qualifying circumstances addressed above in Section X.A.1.c. and X.A.1.d.

(5) Add the basic value, time units, physical status modifier and any applicable qualifying circumstances to determine the total anesthesia value.

(6) Multiply the total anesthesia value by the conversion factor of $29.49 to obtain the anesthesia reimbursement allowance.

b. Methodology for calculating the ARA for procedures that are listed only basic value (BV) and no time.

Multiply the basic value by the conversion factor of $29.49 to obtain the anesthesia reimbursement allowance.

c. Methodology for calculating the ARA for monitored anesthesia care.

(1) Follow the guidelines, as applicable, in Section X.A.2.a. as though anesthesia was administered (basic value + time).

(2) Multiply the total anesthesia value by the conversion factor of $29.49 to obtain the ARA.

B. Reimbursement for medical direction of CRNAs/AAs by an anesthesiologist.

1. Reimbursement shall be made to the anesthesiologist only for direct supervision of anesthesia services which are provided by the anesthesiologist and billed under the name and license number of the physician-employer.

a. Reimbursement shall be made to an anesthesiologist for providing medical direction, including preoperative and postoperative evaluations or specific consultation to a CRNA/AA when necessitated by a specific procedure or condition(s) previously identified by the parties to the protocol, as required.

(1) When medical direction by an anesthesiologist is required, the CRNA/AA shall bill by appending the HCPCS Level II Modifier QX to the anesthesia procedure code.

(2) Reimbursement for a CRNA/AA requiring medical direction by an anesthesiologist shall be fifty percent (50%) of the anesthesia reimbursement allowance listed in Part A, Section XI in this manual or the agreed upon contract price.

(3) Medical direction shall be billed by the anesthesiologist by appending the HCPCS Level II modifier QY to the anesthesia procedure code.

(4) Reimbursement for medical direction by anesthesiologists shall be fifty percent (50%) of the anesthesia reimbursement allowance listed in Part A, Section XI in this manual or the agreed upon contract price.

b. Reimbursement shall not be made to either the anesthesiologist or the anesthetist/anesthesia assistant until the insurer has received and reviewed the bill and anesthesia report from both providers.

2. No additional reimbursement shall be made for general supervisory services rendered by the anesthesiologist or other physician.

C. Anesthesia services for which time units are not allowed.

CRNAs and AAs who provide anesthesia for which no time units are used to determine the ARA shall be limited to eighty-five percent (85%) of the ARA allowed for an anesthesiologist.

Greenville Anesthesiology, P.A.

1007 Grove Road
Suite B
Greenville, SC 29605

Phone: 864-242-4602
Fax: 864-240-0129

J. Michael Evans, MD
B.T. Kennerly, MD
William J. Burk, MD
Inho Yoon, MD
Chris G. Boukedes, MD
R. Alan Carithers, MD
Richard F. Knox, MD
J. Carson Johnson, MD
Stuart P. Lane, MD
Steven H. Pusker, MD
Steven Z. Lysak, MD
C. Wendell James, MD
Mark D. Mathis, MD
Randall D. Wilhoit, MD
Mark E. Carithers, MD
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Harry C. Sherman, MD
John P. Kim, MD
Vernon E. Merchant, MD
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Jonathan P. Wright, MD
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Theodore E. Rothman, MD
Vito A. Cancellaro, MD
Carlos L. Bracale, MD
Richard J. Oeser, MD

June 10, 2009

Medical Services Division
Attn: Mr. Gary Thibeau
South Carolina Worker's Compensation Commission
P.O. Box 1715
Columbia, SC 29202-1715

Dear Mr. Thibeau:

I am writing on behalf of the thirty-one physician members of Greenville Anesthesiology, P.A. to urge you to consider a long-overdue rate increase in the unit value for our services. Our understanding is that you and the Commission will be revising the Medical Services Provider Manual in the near future, and we would appreciate your consideration of our request during this process.

The current rate of $24/unit represents an enormous undervaluation of our services in numerous ways as you are undoubtedly aware via the meetings and conversations that you have had with members of our Society in recent years. It is significantly less than every other state in the Southeast, it is based on Medicare reimbursement rates that arbitrarily devalue our services relative to every other physician specialty practice, and it represents less than half of what we are paid via the South Carolina State Health Plan.

I know that you will be meeting with our representatives again in the near future, and I hope that you will take action during the upcoming revision to remedy the significant imbalance in Worker's Compensation rates for our specialty. Financial times are admittedly challenging, but that situation does not mitigate the fact that our reimbursement rates have languished for many years prior to this downturn.

Thank you in advance for your consideration, and if I may be of service or assistance in any way, please do not hesitate to contact me at (864) 242-4602.

Respectfully,

Robert R. Morgan, Jr., M.D.
Past President
South Carolina Society of
Anesthesiologists

PUBLIC HEARING
on the
MEDICAL SERVICES PROVIDER MANUAL

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

1333 Main Street
Columbia, South Carolina

CHAIRMAN COMMISSIONER ANDREA C. ROCHE PRESIDING

COMMISSIONER DAVID HUFFSTETLER

Friday, June 19, 2009 - 10:00 a.m.

WORKERS' COMPENSATION COMMISSION PUBLIC HEARING TAKEN BEFORE CORA ELLIS BRUTON, A NOTARY PUBLIC IN AND FOR THE STATE OF SOUTH CAROLINA, COMMENCING AT THE HOUR OF 10:00 AM ON FRIDAY, JUNE 19, 2009, 1333 MAIN STREET, COLUMBIA, SOUTH CAROLINA.

CORA ELLIS BRUTON, Independent Court Reporter
131 BROWNING COURT
LEXINGTON, SC 29073
(803) 397-0189

PUBLIC COMMENTS

JEFF McLEOD, PRACTICE ADMINISTRATOR
PEE DEE ORTHOPEDIC ASSOCIATES

CARL BUTLER, CEO
LOW COUNTRY ORTHOPAEDICS &
SPORTS MEDICINE

REGINA HITCHCOCK
DIRECTOR OF GOVERNMENTAL AFFAIRS
SOUTH CAROLINA MEDICAL ASSOCIATION

FRASER COBBE, EXECUTIVE DIRECTOR
SOUTH CAROLINA ORTHOPAEDIC ASSOCIATION

THE COURT: Good morning. It's about 10:01 and today's date is Friday, June the 19th, 2009. My name is Andrea Roche and I am chairman of the South Carolina Workers' Compensation Commission.

We're here today on the Commission's public hearing on the Medical Services Provider Manual.

Also here is Commissioner David Huffstetler.

The Commission is seeking comments on the current fee schedule, including payment and billing policies. The fee schedule sets the maximum allowable fees physicians and other medical providers may be paid for authorized services provided to a workers' compensation patient. It does not include fees for hospital inpatient and outpatient services, services which are included in a separate schedule.

The next edition of the Medical Services Provider Manual will be a complete revision and include updates to evaluation and management services, anesthesia, surgery, radiology, pathology and lab services, medicine and injections, physical medicine, special reports, supplies and durable medical equipment. All procedural codes and prices will be updated.

The Medical Services Provider Manual, provided for by Regulation 67-1302, is based on the Center for Medicare and Medicaid Services Resource Based Relative

Value Scale, or RBRVS. RBRVS establishes a relative value for most medical services and is a well recognized and established method for determining price based on the work involved, the expense associated with providing that service, and malpractice insurance costs. RBRVS attempts to insure that fees are based on the resources used to provide each service and utilize one of the most systematic methods for setting prices. The relative value of each procedure is multiplied by a conversion factor to arrive at the maximum allowable payment. The Commission's current conversion factor is $52.00.

All comments and recommendations are welcomed.

The hearing has now begun and we're happy now to hear from anybody who would like to present.

Mr. Thibault, if you would check the lobby one more time.

COMMISSIONER HUFFSTETLER: Madam Chair, am I correct that notice is properly served in the State Register and the other venues that we would normally use for a Public Hearing?

MR. THIBAULT: It is. It was published in the State Register last month and on the website. But I'll check the hallway.

THE COURT: And I do believe we've gotten some feedback from some groups that may be presenting written

comments. All right. It appears that no one has come to speak today at the hearing. We are continuing to receive written comments. All parties have until June 30th to submit written comments and we anticipate the Commission will consider the revisions to the Medical Services Provider Manual at its September 28th, 2009 business meeting. The effective date of the next edition will be set at the September meeting and is likely to be early 2010.

MR. THIBAULT: We have -- of course, Mr. Lightsey joining us, but he just published a comment and won't speak, and there's no one else in the lobby area.

MR. THIBAULT: Are you here for the Medical Services Provider Manual hearing? I'll get you to sign in. Do any of you want to speak?

COMMISSIONER HUFFSTETLER: Madam Chair, we started on time and there was no one here. It appears we now have some folks who have arrived for the hearing, and I suggest that we revisit your opening comments to make sure everyone hears it.

THE COURT: We'll start over. Good morning everybody. My name is Andrea Roche and I am chairman of the South Carolina Workers' Compensation Commission.

We welcome everybody to the Commission's public hearing on the Medical Services Provider Manual.

With me also is Commissioner David Huffstetler today.

The Commission is currently seeking comments on the current fee schedule, including payment and billing policies. The Fee schedule sets the maximum allowable fees physicians and other medical providers may be paid for authorized services provided to a workers' compensation patient. It does not include fees for hospital inpatient and outpatient services, services which are included in a separate schedule.

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to insure that fees are based on the resources used to provide each service and utilizes one of the most systematic methods for setting prices. The relative value of each procedure is multiplied by a conversion factor to arrive at the maximum allowable payment. The Commission's current conversion factor is $52.00.

All comments and recommendations are welcomed.

Has everyone who wishes to speak already signed up to do so?

Commissioner Beck do you want to --

COMMISSIONER BECK: I've got hearings to start here in a few minutes. I'll just sit here and sort of slip out.

THE COURT: Commissioner Scott Beck has also joined us and he's in the middle of hearings in the other hearing room, so he's going to sit in the back.

Thank you. All right. Mr. McLeod. Step to the podium, please. Please state your full name and who you represent.

JEFF McLEOD: Yes, my name is Jeff McLeod. I'm with Pee Dee Orthopaedic Associates in Florence, South Carolina. I'm here today to promote the fee schedule increase, if one can be obtained. At Pee Dee Orthopaedic Associates about 15 percent of our total volume is with workers' compensation patients. In dealing with workers'

comp it is far more difficult from an administrative standpoint than from your regular patient load. At Pee Dee Orthopaedics I have three full time individuals that are fully dedicated towards workers' comp patients. I've got two workers' comp specialists who deal specifically with the Employees, the Employers, work notices, things of that nature. And I also have a full time billing coordinator with workers' compensation. So all in all I've got about $150,000.00 in salary and benefits directly attributable to workers' comp patients.

The benefit of surgical specialists is that it saves the entire process a great deal of money. I have a report that I will give you, but Dr. Savoy did a study regarding early referrals to surgical specialists. It was a retrospective study on 50 patients that had full thickness rotator cuff tears. That study was divided into two groups. Group one were those employees that had early referrals to surgical specialists and the second group had delayed referrals. The mean time out of work for the first group was 6.6 months. The mean time out of work for the second group was 17.1 months. Total average medical costs for the first group were $13,513.00 and for the second group $35,537.00. Work comp payments, which is described as Work Comp Support Plus Settlement Costs, for the first group was $12,358.00; for the second group

$65,373.00; a difference of a little over $53,000.00. Total combined medical expenses for both groups, $25,871.00 for those receiving early referrals; and $100,911.00 for the second group. So clearly his study shows that early referrals to surgical specialists is very crucial in: 1) reducing the amount of time that employees were injured or out of work; and 2) considerably lowering the medical expenses for those patients. Now, in order for medical practices to be able to provide that type of infrastructure to get those patients back it is critical that we keep the fee schedule where it is if we -- actually an increase would be nice, because since it has been a number of years since the last increase, inflation is catching up and for practices that are not as large as we are it is very difficult for them to maintain the infrastructure in order to be able to support this type of patient volume.

So I would urge the Commission to increase the fee schedule.

Thank you.

THE COURT: Thank you. Mr. Butler.

CARL BUTLER: I'm Carl Butler from Low Country Orthopaedics and Sports Medicine in Charleston, South Carolina and I'm just going to kind of follow the steps of what Mr. McLeod says. We're a large practice as well,

and we too have about three full time employees just on the front end that follow-up with really just getting the approvals, the authorizations and all the paperwork that goes -- every -- pretty much every appointment that we have with the work comp patient you always have to follow-up almost double the work in that you have to send information to the adjuster as well as to the Carrier, the insurance Carrier. And so it's a lot of duplicative work that goes on, and so it is very labor intensive to do work comp.

THE COURT: Do you know what percentage of y'all's business is workers' comp?

CARL BUTLER: Sure. We're at about 27 percent work comp. We see a large volume of work comp in our practice, and we kind of cater to work comp. That's why we have full time people just doing the front end.

THE COURT: Who's in y'all's practice?

CARL BUTLER: Physician wise? We've got Dr. Cox is a senior -- Dr. McCoy, Dr. Spearman, Dr. Stovall, Dr. Zimlich, Dr. Jaskwhich, Dr. Patel, Dr. Burgoyne. And we've got four more coming on this fall.

And so, just again, just to reiterate what Jeff is saying it is, it's a nice -- it's nice to have the fee schedule where it is. I was driving up with my business office manager today and she said there are some fee

schedules for the Codes that we utilize that are actually under what some of our other payers pay. So I would like to see some of those brought up to -- to be more competitive as well, you know, as a possible increase on the fee schedule.

Thank you. Any questions you guys have.

COMMISSIONER HUFFSTETLER: I didn't quite understand. You said you send two -- you're double reporting to the adjuster and the insurance company, but the adjuster works for the insurance company. I'm not sure I understand that.

CARL BUTLER: The claims adjuster, sometimes we'll have to send them the notes as well, as well as sending the claims to the Carrier.

COMMISSIONER HUFFSTETLER: But the adjuster works for the Carrier. Who else? That's what I'm not understanding. Who else at the Carrier gets the -- do you send it to?

CARL BUTLER: You know -- go ahead.

MARILYN SIZEMORE: (OFFICE MANAGER - LOWCOUNTRY ORTHOPAEDICS & SPORTS MEDICINE) I don't know whether I can -- if I can say anything or not. What happens is in the -- the adjuster wants the HICFA and the notes, so we send it to them and then the -- say it's Companion. Companion also wants it to be sent to their Claims

Receiving address, so we have to send it twice. We have to fax it -- everything to the adjuster and then we have to mail the exact same thing to Companion or whoever it may be. And then sometimes it's -- communication is a problem because if the adjuster changes they don't tell us. And then --

COMMISSIONER HUFFSTETLER: Okay. Is Companion the only one that asks for that?

MARILYN SIZEMORE: I'm sorry?

CARL BUTLER: Is Companion the only one that asks for that?

MARILYN SIZEMORE: Oh, they all do it.

COMMISSIONER HUFFSTETLER: Okay.

CARL BUTLER: And then like she was saying a lot of times our problems with it, the adjusters change and so when the adjusters change they never forward the information to the new adjuster so we have to send all that stuff again to the new adjuster once we figure out who the new adjuster is. And so it's just -

COMMISSIONER HUFFSTETLER: I mean I expect that health insurance has adjusters changing, but my real question was -- I think you've answered it. Frankly, it's a little difficult to understand why -- the adjuster works for the Carrier, why there would be another copy. But I think you answered what I asked. Thank you.

CARL BUTLER: It's a good question; right?

THE COURT: Thank you.

THE COURT: All right. Ms. Hitchcock.

REGINA HITCHCOCK: Good morning. My name is Regina Hitchcock and I'm with the Medical Association and I appreciate the opportunity to come before you today. I am, with your permission, standing in for Dr. Will Floyd who is a physician member of ours who Chairs our Occupational Medical Medicine Committee and could not be here today. I will actually relay Dr. Floyd's comments to you now and will be happy to provide you a copy of his comments as well.

COMMISSIONER HUFFSTETLER: Again, if I could. Are you speaking on behalf of Dr. Floyd --

REGINA HITCHCOCK: I am.

COMMISSIONER HUFFSETLER: -- or are you speaking on behalf of the Medical Association?

REGINA HITCHCOCK: Well, actually both I guess. As for the Medical Association --

COMMISSIONER HUFFSTETLER: Because I had understood the Medical --

REGINA HITCHCOCK: -- and Dr. Floyd as a member.

COMMISSIONER HUFFSTETLER: I had understood the Medical Association was taking no position on this.

REGINA HITCHCOCK: Well, I'm basically here

on behalf of the Association and relaying the comments from this Committee that Dr. Floyd Chairs.

COMMISSIONER HUFFSTETLER: Are you representing the Medical Association?

REGINA HITCHCOCK: To answer that quickly I would say I'm here for Dr. Floyd.

COMMISSIONER HUFFSTETLER: Thank you.

REGINA HITCHCOCK: Okay. The Occupational Medical Committee of the Medical Association is extremely proud of the service our physicians provide the workers' comp -- the workers of South Carolina under the compensation system. Other than the workers themselves, the physician's role is the most pivotal in this system. It is the physicians who aggressively treat injured workers in an attempt to minimize permanent impairment and disability which are the real cost drivers in a workers' compensation system. In addition to making the best medical decisions and giving quality medical treatment which is the extent of what is needed to treat patients with Medicare or private insurance, the demands on a physician are much more in the workers' compensation system. Dealing with attorneys, insurance carrier's agents, return to workers' comp -- excuse me, return to work issues, including appropriate modified duty, providing fitness for duty evaluations, completing short

and long term disability paperwork; determining impairment ratings, sittings for legal depositions, and trying to meet employers' expectations; in addition to providing quality care for the patient is what makes providing workers' compensation care so much more difficult. At the same time physicians have been functioning in our system without dated codes and some -- excuse me, in some cases no codes since 2003 as well as a fee schedule which has not been upgraded in nearly seven years. This includes almost seven years with no cost of living increases that we must provide for our staff, including nurses -- excuse me, increased costs of supplies, malpractice rates and other overhead required of operating a medical practice which has, of course, increased significantly since 2003. It is at this point that some of the best physicians, including most ENT specialist and neurologist especially here within the Columbia area won't treat South Carolina Workers' Compensation patients. Our two closest neighbors Georgia and North Carolina have both updated their Provider Manual on an annual basis. Also in both of these states the manual is available online easily accessible to the physician user as well as both having changes made to the various Codes in their manuals to conform to changes that are made in coding nationwide. The recommendation of the

SCMA's Occupational Medicine Committee is that the Compensation Provider's Manual be updated from its current 2003 form. Specifically we would recommend; Number 1, a task force of stake holders to be assembled, including members of the SCMA's Occupational Medicine Committee for the sole purpose of updating the manual. Number 2, --

COMMISSIONER HUFFSTETLER: Can I interrupt you one second?

REGINA HITCHCOCK: Yes.

COMMISSIONER HUFFSTETLER: Because again I had understood the Occupational Medical Committee was not taking a position. Do you represent them?

REGINA HITCHCOCK: I am here for Dr. Floyd on behalf of the Committee. I think that's the best answer I can give you.

COMMISSIONER HUFFSTETLER: I take from that you do not represent the Committee?

REGINA HITCHCOCK: Okay.

COMMISSIONER HUFFSTETLER: I'm just asking. Sometimes I --

REGINA HITCHCOCK: Well, and Dr. Floyd would have been here in the capacity as Chair.

COMMISSIONER HUFFSTETLER: You'll forgive me, I have a tendency to ask direct questions.

REGINA HITCHCOCK: Well, I'm glad you do. I'm glad you do. Dr. --

COMMISSIONER HUFFSTETLER: Well, I take it from that you represent -- you're here on behalf of Dr. Floyd, you do not represent that Committee?

REGINA HITCHCOCK: That's correct.

COMMISSIONER HUFFSTETLER: Thank you.

REGINA HITCHCOCK: Yes, Dr. Floyd would have been here as Chair of the Committee, so I'm representing him. Also, Number 2, have a fee schedule for physicians that increase cost of living increases for each of the various Codes to account for cost of living, the cost of doing business relative to the 2003 values; Number 3, have a built in annual cost of living assessment; Number 4, have the manual be made available online and easily accessible for the physician user. This will also allow for fees and Codes to be easily updated as needed and allow for corrections to be easily made to the manual, if necessary. And on behalf of the Committee of the SCMA, thank you for your time and attention, and your consideration. Thank you.

THE COURT: Thank you very much. Is it Mr. Cobbe?

FRASER COBBE: Thank you very much for this opportunity. My name is Fraser Cobbe; I'm the Executive Director of the South Carolina Orthopaedic Association,

and I appreciate the opportunity to address the Commission this morning on this matter. I'm not going to duplicate a lot of the testimony that you've already heard this morning from a number of the physician practices, but I do want to make sure we go on the record and say the South Carolina Orthopaedic Association does support an increase in the fee schedule acknowledging that the fees have not changed since 2003. So what that means for our physicians is the same price you were paid to fix a tibia back in 2003 is the same price they will get paid, saying they'll be compensated in 2009. This is something we're extremely concerned with as our costs of overhead continue to go up and our reimbursement remains static. In the long term that's just not sustainable to our practices, so we would urge you to consider increasing the fee schedule as you go through this review process. I do also want to go on record and support some of the recommendations from Dr. Floyd, including making the fee schedule available online; some sort of annual increase for inflation; and also the formation of an Ad Hoc Committee to look at the fee schedule as well and take a real direct targeted look at the fee schedule and the Codes that are utilized and where the reimbursement is currently. I will say there are examples across the country of states that have lowered their fee schedule or

have not maintained them to a point that physicians do pull back their participation in the program and that increase costs the system as we have already heard in testimony this morning. So I urge your support of an increase in the fee schedule and would be happy to answer any questions that you may have.

COMMISSIONER HUFFSTETLER: Could you extend on what you just said, "physicians backing out"? I'm not --

FRASER COBBE: Well, there's certain --

COMMISSIONER HUFFSTETLER: I'm not sure what you mean by that.

FRASER COBBE: Well, two examples come to mind. In Texas a few years ago they lowered their fee schedule from where it was existing and I believe they cut it back to about 125 percent of Medicare and they -- there was a number of studies that how the physicians could no longer schedule workers' comp patients because the reimbursement was so low when they're filling --

COMMISSIONER HUFFSTETLER: Let me -- let me be a little more direct because I was earlier. Again, I have a tendency to be direct. I don't mean to be offensive, just to be -- just try to get to the point. We had a statement made at a senate hearing a couple of years ago by some folks who purported to represent hospitals. I'm not saying the hospitals said this, but we had folks --

someone who made a comment that all the hospitals were going to get together and just not treat workers' compensation patients, which in my mind would violate the antitrust laws. Is that what you're suggesting with doctors?

FRASER COBBE: No, no. No, no. I'm saying, you know, independent physician practices take a look at their appointment schedule and they make, you know, business decisions on how many patients of each type of payor they can -- they can put together in their -- in their practice. And so as all of the payors, you know, adjust their fee schedules accordingly then the practices make those independent decisions on scheduling, things like that.

COMMISSIONER HUFFSTETLER: But you would agree with me that it would not be proper for physicians to agree on that?

FRASER COBBE: Absolutely.

COMMISSIONER HUFFSTETLER: Thank you.

THE COURT: All right, Mr. Cobbe, thank you so much. I think some folks came in after we started. Is anybody else here that wishes to speak today.

COMMISSIONER HUFFSTETLER: Madam Chair, I see a representative from the State Fund here. I'm looking to see if there is anyone else here to represent the

business community, either the Chamber of Commerce or anyone from business, anyone from the insurance industry, self-insureds; is there anyone other than the State Fund who is a payor for this system who has appeared to give any input at all to this question? I see no hands.

THE COURT: I see no hands as well. All right, thank you. If that is our last speaker then I'm going to review --

COMMISSIONER HUFFSTETLER: There's someone in the back.

FRASER COBBE: I'd just like to recognize who came from around the state. Mary Elkins is here with the Carolina Orthopeadic Associates in Rock Hill, and also Ann Margaret with Midlands Orthopaedics. I would just mention that -- or recognize other of my colleagues.

THE COURT: All right. Thank you so much. All right. From this point forward the Commission is going to review all the comments that we received. In addition parties have until June 30th to submit written comments, if you'd like to do that as well. And we anticipate that the Commission is going to consider the revisions at its September 28th, 2009 business meeting. I can't promise that, but that's the anticipated date at this point. And the effective date of the next edition will be set at that meeting or whatever meeting we take it up and it's

likely to be in early 2010, to be the effective date of the new manual. So if there are no further comments I want to thank everybody for coming this morning, and the hearing is now adjourned.

(The hearing adjourned at 10:28 a.m.)

STATE OF SOUTH CAROLINA)
) CERTIFICATE
COUNTY OF LEXINGTON)

BE IT KNOWN THAT I TOOK THE FOREGOING WORKERS' COMPENSATION HEARING;

THAT I WAS THEN AND THERE A NOTARY PUBLIC IN AND FOR THE STATE OF SOUTH CAROLINA-AT-LARGE;

THE FOREGOING TRANSCRIPT CONSISTING OF **22** TYPEWRITTEN PAGES REPRESENTS A TRUE, ACCURATE AND COMPLETE TRANSCRIPTION OF THE TESTIMONY SO GIVEN AT THE TIME AND PLACE AFFORESAID TO THE BEST OF MY SKILL AND ABILITY;

THAT I AM NOT RELATED TO NOR AN EMPLOYEE OF ANY OF THE PARTIES HERETO, NOR A RELATIVE OR EMPLOYEE OF ANY ATTORNEY OR COUNSEL EMPLOYED BY THE PARTIES HERETO, NOR INTERESTED IN THE OUTCOME OF THIS ACTION.

WITNESS MY HAND AND SEAL THIS 2ND DAY OF JULY, 2009.

Cora Ellis Bruton

CORA ELLIS BRUTON
NOTARY PUBLIC FOR SOUTH CAROLINA
MY COMMISSION EXPIRES JANUARY 18TH, 2015.

Attachment 4

Effect of Adopting 2009 Relative Values

Effect of Adopting 2009 Relative Values

Top 200 Workers' Compensation Procedures In South Carolina

Sorted by Total Expenditures

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V
	CPT Code	Procedure Description	# Procedures	Total CPT Code	Aggregate Sum	% of Total	Aggreg %	2002 Relative Values				2009 Relative Values								Total		% Change
								Non-Facility	Facility	3:1 NF		Work	Practice Expense		Malprac	Total NF	Total Fac	3:1 NF		2003	2009	
										RVU	Price		Non-Facility	Facility				RVU	Price			
		Total All Procedures	**381,101**	**$ 34,188,802**																		
		Total Top 200	**290,897**	**$ 27,538,743**																**$ 27,538,743**	**$ 28,394,786**	**3.1%**
1	97110	THERAPEUTIC PROCEDURE	71,257	$ 2,704,916	$ 2,704,916	7.9%	7.9%	0.73	0.73	0.73	$ 38	0.45	0.32		0.02	0.79		0.79	$ 41	$ 2,704,916	$ 2,927,238	
2	99213	ESTAB E/M OFFICE VISIT	24,309	1,614,847	4,319,763	4.7%	12.6%	1.39	0.94	1.28	66	0.92	0.77	0.30	0.03	1.72	1.25	1.60	83	1,614,847	2,025,669	
3	99214	ESTAB E/M OFFICE VISIT	11,016	1,158,553	5,478,315	3.4%	16.0%	2.18	1.55	2.02	105	1.42	1.10	0.46	0.05	2.57	1.93	2.41	125	1,158,553	1,380,525	
4	97140	MANUAL THERAPY	25,583	904,615	6,382,930	2.6%	18.7%	0.68	0.68	0.68	35	0.43	0.29		0.01	0.73		0.73	38	904,615	971,131	
5	99203	NEW E/M OFFICE VISIT	5,705	707,534	7,090,464	2.1%	20.7%	2.54	1.92	2.39	124	1.34	1.12	0.45	0.09	2.55	1.88	2.38	124	707,534	706,792	
6	73721	MRI LWR EXTRE JOINT W/ DYE	1,022	681,306	7,771,770	2.0%	22.7%	12.82		12.82	667	1.35	13.59		0.45	15.49		15.49	805	681,306	823,201	
7	72148	MRI LUMBAR SPINE W/O DYE	907	680,105	8,451,875	2.0%	24.7%	14.42		14.42	750	1.48	12.27		0.71	14.46		14.46	752	680,105	681,991	
8	97530	THERAPEUTIC ACTIVITY	13,831	654,483	9,106,358	1.9%	26.6%	0.91	0.91	0.91	47	0.44	0.38		0.01	0.83		0.83	43	654,483	596,946	
9	73221	MRI JOINT UPPR EXTREMITY W/O	909	605,976	9,712,334	1.8%	28.4%	12.82		12.82	667	1.35	13.37		0.45	15.17		15.17	789	605,976	717,056	
10	29826	ARTHROSCOPY SHOULDER	546	593,393	10,305,727	1.7%	30.1%		20.90	20.90	1,087	9.05		6.37	1.55		16.97	16.97	882	593,393	481,812	
11	99283	ER DPT VISIT MOD	5,442	464,094	10,769,820	1.4%	31.5%		1.64	1.64	85	1.34		0.25	0.09		1.68	1.68	87	464,094	475,413	
12	29881	ARTHROSCOPY, KNEE, SURG; WIT	494	446,457	11,216,278	1.3%	32.8%		17.38	17.38	904	8.56		6.30	1.34		16.20	16.20	842	446,457	416,146	
13	72141	MRI NECK SPINE W/O DYE	627	435,589	11,651,867	1.3%	34.1%	13.36		13.36	695	1.60	12.32		0.66	14.58		14.58	758	435,589	475,366	
14	97001	PHYSICAL THERAPY EVALUATION	4,512	425,256	12,077,123	1.2%	35.3%	1.86	1.67	1.81	94	1.20	0.67		0.05	1.92		1.92	100	425,256	450,478	
15	99204	NEW E/M OFFICE VISIT	2,308	410,155	12,487,278	1.2%	36.5%	3.61	2.84	3.42	178	2.30	1.51	0.75	0.12	3.93	3.17	3.74	194	410,155	448,860	
16	99212	ESTAB E/M OFFICE VISIT	7,293	345,105	12,832,383	1.0%	37.5%	1.00	0.64	0.91	47	0.45	0.55	0.16	0.03	1.03	0.64	0.93	48	345,105	353,638	
17	29827	WITH ROTATOR CUFF REPAIR	228	341,097	13,173,480	1.0%	38.5%		28.77	28.77	1,496	15.44		9.67	2.67		27.78	27.78	1,445	341,097	329,360	
18	72158	MRI LUMBAR SPINE W/O CONTRAS	220	320,663	13,494,143	0.9%	39.5%	28.03		28.03	1,458	2.36	17.48		1.41	21.25		21.25	1,105	320,663	243,100	
19	70450	CT OF HEAD/BRAIN W/O CONTRAS	1,027	314,016	13,808,159	0.9%	40.4%	5.88		5.88	306	0.85	4.87		0.29	6.01		6.01	313	314,016	320,958	
20	99284	ER DPT VISIT HIGH	2,236	297,656	14,105,815	0.9%	41.3%		2.56	2.56	133	2.56		0.48	0.14		3.18	3.18	165	297,656	369,745	
21	99244	OFFICE CONSULTATION	1,170	263,285	14,369,100	0.8%	42.0%	4.54	3.69	4.33	225	3.02	1.96	1.14	0.16	5.14	4.32	4.94	257	263,285	300,245	
22	22612	ARTHRODESIS,POSTERIOR/POSTER	125	260,195	14,629,295	0.8%	42.8%		40.03	40.03	2,082	23.38		12.99	4.47		40.84	40.84	2,124	260,195	265,460	
23	97032	ELECTRICAL STIMULATION	9,450	230,958	14,860,253	0.7%	43.5%	0.47	0.47	0.47	24	0.25	0.20		0.01	0.46		0.46	24	230,958	226,044	
24	62311	INJECT SPINE L/S (CD)	906	230,260	15,090,513	0.7%	44.1%	5.85	2.00	4.89	254	1.54	2.67	0.55	0.09	4.30	2.18	3.77	196	230,260	177,612	
25	29824	ARTHROSCOPY SHOULDER	253	222,205	15,312,718	0.6%	44.8%		16.89	16.89	878	8.82		6.70	1.42		16.94	16.94	881	222,205	222,863	
26	29877	ARTHROSCOPY,KNEE,SURG;DEBRID	256	221,911	15,534,629	0.6%	45.4%		16.67	16.67	867	8.15		6.13	1.28		15.56	15.56	809	221,911	207,135	
27	22630	ARTHRODESIS,POSTERIOR INTERB	102	215,555	15,750,183	0.6%	46.1%		40.64	40.64	2,113	21.89		12.91	4.73		39.53	39.53	2,056	215,555	209,667	
28	97014	PHYS MED TRTMT-1 AREA	10,901	215,404	15,965,587	0.6%	46.7%	0.38	0.38	0.38	20	0.18	0.18		0.01	0.37		0.37	19	215,404	209,735	
29	90806	PSYTX, OFF, 45-50 MIN	1,559	212,195	16,177,783	0.6%	47.3%	2.65	2.52	2.62	136	1.86	0.53	0.34	0.04	2.43	2.24	2.38	124	212,195	193,145	
30	99243	OFFICE CONSULTATION	1,348	211,865	16,389,648	0.6%	47.9%	3.20	2.49	3.02	157	1.88	1.46	0.71	0.13	3.47	2.72	3.28	171	211,865	230,090	
31	99202	NEW E/M OFFICE VISIT	2,516	208,023	16,597,671	0.6%	48.5%	1.70	1.26	1.59	83	0.88	0.85	0.32	0.05	1.78	1.25	1.65	86	208,023	215,546	
32	64483	INJ FORAMEN EPIDURAL L/S	707	201,834	16,799,505	0.6%	49.1%	6.46	2.58	5.49	285	1.90	3.80	0.78	0.11	5.81	2.79	5.06	263	201,834	185,842	
33	12001	SIMP REPAIR SCALP NECK TRUNK	1,080	198,666	16,998,171	0.6%	49.7%	3.96	2.27	3.54	184	1.72	1.70	0.73	0.15	3.57	2.60	3.33	173	198,666	186,872	
34	99215	ESTAB E/M OFFICE VISIT	1,196	188,131	17,186,302	0.6%	50.3%	3.20	2.50	3.03	157	2.00	1.40	0.65	0.08	3.48	2.73	3.29	171	188,131	204,767	
35	29823	ARTHROSCOPY SHOULDER	183	185,181	17,371,483	0.5%	50.8%		19.46	19.46	1,012	8.24		6.21	1.41		15.86	15.86	825	185,181	150,924	
36	29807	SHOULDER ARTHROSCOPY/SURGERY	131	183,720	17,555,203	0.5%	51.3%		26.97	26.97	1,402	14.48		9.53	2.42		26.43	26.43	1,374	183,720	180,041	
37	29822	ARTHROSCOPY SHOULDER	183	173,382	17,728,584	0.5%	51.9%		18.22	18.22	947	7.49		5.71	1.28		14.48	14.48	753	173,382	137,792	
38	97112	NEUROMUSCULAR RE-ED MOVE	4,371	172,742	17,901,326	0.5%	52.4%	0.76	0.76	0.76	40	0.45	0.35		0.01	0.81		0.81	42	172,742	184,107	
39	72125	CT, CERVICAL SPINE, W/O CONT	436	169,813	18,071,140	0.5%	52.9%	7.49		7.49	389	1.16	6.41		0.36	7.93		7.93	412	169,813	179,789	
40	63030	LAMINOTOMY W DECOMP NRV RTS;	133	166,883	18,238,023	0.5%	53.3%		24.13	24.13	1,255	13.03		8.75	3.01		24.79	24.79	1,289	166,883	171,448	
41	27447	TOTAL KNEE ARTHROPLASTY	76	165,312	18,403,335	0.5%	53.8%		41.83	41.83	2,175	23.04		13.14	3.80		39.98	39.98	2,079	165,312	158,001	
42	97035	ULTRASOUND THERAPY	10,589	165,188	18,568,523	0.5%	54.3%	0.30	0.30	0.30	16	0.21	0.10		0.01	0.32		0.32	17	165,188	176,201	
43	63075	DISKECTOMY,ANTE.W/DECOMP COR	81	155,718	18,724,241	0.5%	54.8%		36.97	36.97	1,922	19.47		11.28	4.63		35.38	35.38	1,840	155,718	149,021	
44	22554	ARTHRODESIS,ANT.INTERBDY TEC	81	151,927	18,876,168	0.4%	55.2%		36.07	36.07	1,876	17.54		10.87	4.46		32.87	32.87	1,709	151,927	138,448	
45	63047	LAMINECTOMY	102	151,907	19,028,074	0.4%	55.7%		28.64	28.64	1,489	15.22		9.58	3.24		28.04	28.04	1,458	151,907	148,724	
46	29880	ARTHROSCOPY,KNEE,SURG;W/MENI	150	145,392	19,173,466	0.4%	56.1%		18.64	18.64	969	9.30		6.62	1.47		17.39	17.39	904	145,392	135,642	
47	99285	ER DPT VISIT HIGH	691	143,728	19,317,194	0.4%	56.5%		4.00	4.00	208	3.80		0.68	0.23		4.71	4.71	245	143,728	169,240	
48	64721	NEUROPLASTY	239	141,151	19,458,345	0.4%	56.9%	11.47	11.02	11.36	591	4.84	4.76	4.70	0.73	10.33	10.27	10.32	536	141,151	128,195	
49	74160	CT ABDOMEN W/ DYE	313	139,485	19,597,831	0.4%	57.3%	8.57		8.57	446	1.27	8.73		0.42	10.42		10.42	542	139,485	169,596	
50	29888	ARTHROSCOPICALLY AIDED ANTER	93	137,101	19,734,931	0.4%	57.7%		28.35	28.35	1,474	14.14		8.87	2.42		25.43	25.43	1,322	137,101	122,979	
51	72193	CT PELVIS W/ DYE	313	137,044	19,871,975	0.4%	58.1%	8.42		8.42	438	1.16	7.48		0.41	9.05		9.05	471	137,044	147,298	
52	20610	DRAIN,INJECT, JOINT,BURSA	1,528	135,075	20,007,050	0.4%	58.5%	1.83	1.31	1.70	88	0.79	1.06	0.41	0.11	1.96	1.31	1.80	93	135,075	142,822	
53	72100	X-RAY SPINE,LUMBOSACRAL	2,433	123,986	20,131,036	0.4%	58.9%	0.98		0.98	51	0.22	0.80		0.05	1.07		1.07	56	123,986	135,372	
54	12002	SIMP REPAIR SCALP NECK TRUN	597	121,227	20,252,263	0.4%	59.2%	4.22	2.96	3.91	203	1.88	1.76	0.83	0.17	3.81	2.88	3.58	186	121,227	111,060	
55	22851	APPLY SPINE PROSTH DVC	194	114,600	20,366,862	0.3%	59.6%		11.36	11.36	591	6.70		2.71	1.49		10.90	10.90	567	114,600	109,959	
56	23412	REPAIR RUPTURE-SUPRASPINATUS	77	112,993	20,479,855	0.3%	59.9%		28.22	28.22	1,467	11.77		7.97	2.32		22.06	22.06	1,147	112,993	88,328	
57	22845	ANTERIOR INSTRUMENTATION	102	109,050	20,588,906	0.3%	60.2%		20.56	20.56	1,069	11.94		4.78	2.86		19.58	19.58	1,018	109,050	103,852	
58	90808	PSYTX, OFF, 75-80 MIN	522	105,522	20,694,428	0.3%	60.5%	3.92	3.79	3.89	202	2.79	0.69	0.51	0.06	3.54	3.36	3.50	182	105,522	94,868	
59	22558	ARTHRODESIS,ANTER.INTERBODY	49	103,780	20,798,208	0.3%	60.8%		40.73	40.73	2,118	23.33		12.01	3.16		38.50	38.50	2,002	103,780	98,098	
60	71260	CT THORAX W/ DYE	222	100,895	20,899,103	0.3%	61.1%	8.74		8.74	454	1.24	7.92		0.42	9.58		9.58	498	100,895	110,592	
61	73222	MRI/UPPER EXTREMITY	118	94,433	20,993,536	0.3%	61.4%	15.39		15.39	800	1.62	14.14		0.54	16.30		16.30	848	94,433	100,017	
62	90807	PSYTX, OFF, 45-50 MIN, W/ E&	632	92,923	21,086,459	0.3%	61.7%	2.86	2.73	2.83	147	2.02	0.70	0.37	0.05	2.77	2.44	2.69	140	92,923	88,322	
63	63042	LAMINOTOMY, SINGLE LUMBAR	53	92,409	21,178,867	0.3%	61.9%		33.53	33.53	1,744	18.61		10.88	4.26		33.75	33.75	1,755	92,409	93,015	
64	27096	INJECT SACROILIAC JOINT	216	92,243	21,271,110	0.3%	62.2%	10.34	1.83	8.21	427	1.40	2.54	0.36	0.08	4.02	1.84	3.48	181	92,243	39,031	
65	22840	POSTERIOR INSTRUMENT; W/O SE	82	91,292	21,362,402	0.3%	62.5%		21.41	21.41	1,113	12.52		5.09	2.79		20.40	20.40	1,061	91,292	86,986	
66	20680	REMOVE IMPLANT DEEP WIRE PIN	198	91,120	21,453,522	0.3%	62.8%	8.85	8.85	8.85	460	5.90	8.07	4.14	0.56	14.53	10.60	13.55	704	91,120	139,485	
67	99245	OFFICE CONSULTATION	309	90,503	21,544,025	0.3%	63.0%	5.88	4.89	5.63	293	3.77	2.30	1.38	0.21	6.28	5.36	6.05	315	90,503	97,211	
68	64475	INJECTION ANESTHETIC	379	87,947	21,631,972	0.3%	63.3%	5.32	1.89	4.46	232	1.41	3.61	0.60	0.10	5.12	2.11	4.37	227	87,947	86,075	

Effect of Adopting 2009 Relative Values

Top 200 Workers' Compensation Procedures In South Carolina

Sorted by Total Expenditures

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V
								2002 Relative Values				2009 Relative Values								Total		%
	CPT		#	Total	Aggregate	% of	Aggreg			3:1 NF		Work	Practice Expense		Malprac	Total NF	Total Fac	3:1 NF		2003	2009	Change
	Code	Procedure Description	Procedures	CPT Code	Sum	Total	%	Non-Facility	Facility	RVU	Price		Non-Facility	Facility				RVU	Price			
69	99349	HOME VISIT, EST PATIENT	519	85,282	21,717,254	0.2%	63.5%	3.16		3.16	164	2.33	0.76		0.09	3.18		3.18	165	85,282	85,822	
70	73030	X-RAY SHOULDER,COMPLETE,	1,995	85,067	21,802,321	0.2%	63.8%	0.82		0.82	43	0.18	0.57		0.05	0.80		0.80	42	85,067	82,992	
71	62290	INJECTION DISKOGRAPHY	209	84,607	21,886,928	0.2%	64.0%	8.88	4.50	7.79	405	3.00	4.48	1.20	0.23	7.71	4.43	6.89	358	84,607	74,881	
72	70553	MRI BRAIN W/O & W/ DYE	58	84,508	21,971,436	0.2%	64.3%	28.02		28.02	1,457	2.36	17.87		1.41	21.64		21.64	1,125	84,508	65,266	
73	99232	SUBSQT HOSPITAL CARE	1,091	83,963	22,055,400	0.2%	64.5%		1.48	1.48	77	1.39		0.44	0.04		1.87	1.87	97	83,963	106,089	
74	72156	MRI NECK SPINE W/O & W/ DYE	57	83,940	22,139,340	0.2%	64.8%	28.32		28.32	1,473	2.57	17.57		1.42	21.56		21.56	1,121	83,940	63,904	
75	99282	ER DPT VISIT LOW	2,097	79,602	22,218,942	0.2%	65.0%		0.73	0.73	38	0.88		0.18	0.04		1.10	1.10	57	79,602	119,948	
76	72146	MRI,SPINAL CANAL/CONTENTS,TH	104	78,849	22,297,791	0.2%	65.2%	14.58		14.58	758	1.60	12.33		0.71	14.64		14.64	761	78,849	79,173	
77	29879	ARTHROSCOPY,KNEE,SURG;ABRAS.	84	77,969	22,375,760	0.2%	65.4%		17.85	17.85	928	8.84		6.42	1.39		16.65	16.65	866	77,969	72,727	
78	72131	CT, LUMBAR SPINE, W/O CONTRA	196	76,338	22,452,098	0.2%	65.7%	7.49		7.49	389	1.16	6.37		0.36	7.89		7.89	410	76,338	80,415	
79	64476	INJECTION ANESTHETIC	367	76,336	22,528,434	0.2%	65.9%	4.90	1.30	4.00	208	0.98	1.11	0.24	0.07	2.16	1.29	1.94	101	76,336	37,071	
80	73610	X-RAY ANKLE; COMPLETE,	1,889	75,636	22,604,069	0.2%	66.1%	0.77		0.77	40	0.17	0.66		0.03	0.86		0.86	45	75,636	84,476	
81	73130	X-RAY HAND;MINIMUM OF 3 VIEW	1,864	74,635	22,678,704	0.2%	66.3%	0.77		0.77	40	0.17	0.65		0.03	0.85		0.85	44	74,635	82,389	
82	97003	OCCUPATIONAL THERAPY EVALUAT	773	74,262	22,752,966	0.2%	66.6%	1.94	1.57	1.85	96	1.20	0.77		0.06	2.03		2.03	106	74,262	81,598	
83	26356	FLEX.TENDON REPAIR/ADVANCE-N	46	73,219	22,826,185	0.2%	66.8%		30.61	30.61	1,592	10.22		13.68	1.21		25.11	25.11	1,306	73,219	60,063	
84	26951	AMPUTATION FINGER/THUMB,PRI/	77	72,913	22,899,098	0.2%	67.0%		18.21	18.21	947	5.85		8.34	0.71		14.90	14.90	775	72,913	59,660	
85	62310	INJECT SPINE C/T	274	69,958	22,969,056	0.2%	67.2%	5.73	2.45	4.91	255	1.91	3.04	0.60	0.12	5.07	2.63	4.46	232	69,958	63,546	
86	29846	ARTHROSCOPY WRIST	68	68,280	23,037,336	0.2%	67.4%		19.31	19.31	1,004	6.80		5.22	1.07		13.09	13.09	681	68,280	46,286	
87	23410	REPAIR RUPTURED ROTATOR CUFF	49	68,083	23,105,418	0.2%	67.6%		26.72	26.72	1,389	11.23		7.73	2.17		21.13	21.13	1,099	68,083	53,839	
88	26418	EXTEN TEN REPAIR,FINGER DORS	62	67,994	23,173,413	0.2%	67.8%		21.09	21.09	1,097	4.33		8.08	0.67		13.08	13.08	680	67,994	42,170	
89	98941	CHIROPRACTIC MANIPULATION	1,324	67,471	23,240,884	0.2%	68.0%	0.98	0.98	0.98	51	0.65	0.28	0.18	0.01	0.94	0.84	0.92	48	67,471	62,996	
90	29876	ARTHROSCOPY,KNEE,SURG;SYNOVE	71	67,268	23,308,152	0.2%	68.2%		18.22	18.22	947	8.72		6.36	1.37		16.45	16.45	855	67,268	60,733	
91	99205	NEW E/M OFFICE VISIT	295	67,266	23,375,418	0.2%	68.4%	4.59	3.77	4.39	228	3.00	1.81	0.96	0.15	4.96	4.11	4.75	247	67,266	72,827	
92	64415	INJECTION ANESTHETIC	356	67,152	23,442,570	0.2%	68.6%	4.21	1.88	3.63	189	1.48	1.40	1.75	0.09	2.97	3.32	3.06	159	67,152	56,600	
93	72295	DISKOGRAPHY LUMBAR RAD	144	67,092	23,509,663	0.2%	68.8%	8.96		8.96	466	0.83	1.46		0.46	2.75		2.75	143	67,092	20,592	
94	97002	PHYSICAL THERAPY RE-EVALUATI	1,304	65,774	23,575,436	0.2%	69.0%	0.99	0.91	0.97	50	0.60	0.41		0.02	1.03		1.03	54	65,774	69,842	
95	64484	INJ FORAMEN EPIDURAL L/S ADD	275	65,029	23,640,466	0.2%	69.1%	5.46	1.81	4.55	236	1.33	1.65	0.35	0.08	3.06	1.76	2.74	142	65,029	39,111	
96	22842	POSTERIOR INSTRUMENTATION; W	56	62,462	23,702,928	0.2%	69.3%		21.45	21.45	1,115	12.56		5.12	2.75		20.43	20.43	1,062	62,462	59,492	
97	49505	REPAIR HERNIA	94	62,163	23,765,091	0.2%	69.5%	12.83	12.38	12.72	661	8.91		4.22	1.14		14.27	14.27	742	62,163	69,752	
98	95904	SENSE NERVE CONDUCTION TEST	1,173	61,606	23,826,697	0.2%	69.7%	1.01		1.01	53	0.34	0.84		0.04	1.22		1.22	63	61,606	74,415	
99	73718	MRI LOWER EXTREMITY W/O DYE	90	59,998	23,886,695	0.2%	69.9%	12.82		12.82	667	1.35	14.10		0.45	15.90		15.90	827	59,998	74,412	
100	73140	X-RAY FINGER OR FINGERS,MINI	1,916	59,779	23,946,474	0.2%	70.0%	0.60		0.60	31	0.13	0.67		0.03	0.83		0.83	43	59,779	82,695	
101	73630	X-RAY FOOT;COMPLETE,	1,440	57,658	24,004,131	0.2%	70.2%	0.77		0.77	40	0.17	0.64		0.03	0.84		0.84	44	57,658	62,899	
102	29806	SHOULDER ARTHROSCOPY/SURGERY	40	57,637	24,061,768	0.2%	70.4%		27.71	27.71	1,441	14.95		9.70	2.50		27.15	27.15	1,412	57,637	56,472	
103	73110	X-RAY WRIST;COMPLETE,	1,428	57,177	24,118,945	0.2%	70.5%	0.77		0.77	40	0.17	0.76		0.03	0.96		0.96	50	57,177	71,286	
104	71020	X-RAY CHEST, TWO VIEWS;	1,180	57,065	24,176,010	0.2%	70.7%	0.93		0.93	48	0.22	0.57		0.05	0.84		0.84	44	57,065	51,542	
105	11012	SKIN,SUBCUTANEOUS TISSUE,MUS	84	56,773	24,232,783	0.2%	70.9%	13.29	12.12	13.00	676	6.87	9.01	3.30	1.16	17.04	11.33	15.61	812	56,773	68,195	
106	97750	PHYS PERFORMANCE TEST	1,516	55,971	24,288,754	0.2%	71.0%	0.71	0.71	0.71	37	0.45	0.33		0.02	0.80		0.80	42	55,971	63,066	
107	63090	VERTEBRAL CORPECTOMY	21	55,201	24,343,955	0.2%	71.2%		50.55	50.55	2,629	30.78		14.98	4.22		49.98	49.98	2,599	55,201	54,578	
108	73560	X-RAY KNEE;ANTEROPSTRIOR	1,373	54,975	24,398,929	0.2%	71.4%	0.77		0.77	40	0.17	0.57		0.03	0.77		0.77	40	54,975	54,975	
109	97022	WHIRLPOOL	2,371	54,248	24,453,178	0.2%	71.5%	0.44	0.44	0.44	23	0.17	0.33		0.01	0.51		0.51	27	54,248	62,879	
110	99291	CRITICAL CARE E/M	178	52,736	24,505,914	0.2%	71.7%	5.77	5.48	5.70	296	4.50	2.24	1.13	0.21	6.95	5.84	6.67	347	52,736	61,761	
111	93971	DUPLEX SCN EXTREM VEINS	289	52,147	24,558,061	0.2%	71.8%	3.47		3.47	180	0.45	4.00		0.30	4.75		4.75	247	52,147	71,383	
112	72132	CT LUMBAR SPINE W/ DYE	114	51,751	24,609,813	0.2%	72.0%	8.73		8.73	454	1.22	7.90		0.42	9.54		9.54	496	51,751	56,553	
113	23120	CLAVICULECTOMY; PARTIAL	56	51,397	24,661,209	0.2%	72.1%		17.65	17.65	918	7.23		6.03	1.23		14.49	14.49	753	51,397	42,195	
114	70486	CT, MAXILLOFACIAL AREA, W/O	151	49,311	24,710,520	0.1%	72.3%	6.28		6.28	327	1.14	6.73	6.34	0.30	8.17	7.78	8.07	420	49,311	63,385	
115	72040	X-RAY SPINE,CERVICAL;	1,034	48,929	24,759,449	0.1%	72.4%	0.91		0.91	47	0.22	0.76		0.05	1.03		1.03	54	48,929	55,381	
116	90801	PSYCHIATRIC INTERVIEW	238	48,854	24,808,303	0.1%	72.6%	4.00	3.79	3.95	205	2.80	1.45	0.61	0.06	4.31	3.47	4.10	213	48,854	50,742	
117	73562	X-RAY KNEE;ANTEROPOSTER	1,096	47,303	24,855,606	0.1%	72.7%	0.83		0.83	43	0.18	0.72		0.05	0.95		0.95	49	47,303	54,142	
118	72110	X-RAY SPINE,LUMBOSACRAL;	663	46,543	24,902,149	0.1%	72.8%	1.35		1.35	70	0.31	1.14		0.07	1.52		1.52	79	46,543	52,404	
119	95860	ELECTROMYGRPHY/1 EXTREM	407	46,349	24,948,498	0.1%	73.0%	2.19		2.19	114	0.96	1.13		0.07	2.16		2.16	112	46,349	45,714	
120	23430	TENODESIS FOR RUPTURE OF LON	39	45,691	24,994,189	0.1%	73.1%		22.53	22.53	1,172	10.05		6.98	1.74		18.77	18.77	976	45,691	38,066	
121	63650	PERCUT.IMPLANT-NEUROSTIMULAT	86	45,570	25,039,759	0.1%	73.2%		10.19	10.19	530	7.15		2.71	0.53		10.39	10.39	540	45,570	46,464	
122	97033	IONTOPHORESIS	2,154	44,803	25,084,562	0.1%	73.4%	0.40	0.40	0.40	21	0.26	0.44		0.01	0.71		0.71	37	44,803	79,526	
123	29825	ARTHROSCOPY SHOULDER	46	44,204	25,128,766	0.1%	73.5%		18.48	18.48	961	7.68		5.78	1.32		14.78	14.78	769	44,204	35,354	
124	97124	MASSAGE	1,489	44,134	25,172,900	0.1%	73.6%	0.57	0.57	0.57	30	0.35	0.27		0.01	0.63		0.63	33	44,134	48,780	
125	23350	INJECTION PROCEDURE FOR SHOU	127	43,273	25,216,173	0.1%	73.8%	8.27	1.40	6.55	341	1.00	2.72	0.37	0.06	3.78	1.43	3.19	166	43,273	21,083	
126	26055	TENDON SHEATH INCISION FOR T	75	43,144	25,259,317	0.1%	73.9%	11.17	10.74	11.06	575	3.00		3.63	0.43		7.26	7.26	378	43,144	28,314	
127	97012	PHYS MED TRTMT-1 AREA	2,238	43,059	25,302,376	0.1%	74.0%	0.37	0.37	0.37	19	0.25	0.14		0.01	0.40		0.40	21	43,059	46,550	
128	78465	HEART IMAGE (3D), MULTIPLE	60	42,994	25,345,369	0.1%	74.1%	13.78		13.78	717	1.46	10.96		0.67	13.09		13.09	681	42,994	40,841	
129	22614	SPINE FUSION,EXTRA SEG	74	42,405	25,387,774	0.1%	74.3%		11.02	11.02	573	6.43		2.62	1.38		10.43	10.43	542	42,405	40,135	
130	62284	INJ PROC MYELOGRAPHY/CT SPIN	137	42,210	25,429,984	0.1%	74.4%	7.17	2.19	5.93	308	1.54	3.77	0.75	0.13	5.44	2.42	4.69	244	42,210	33,376	
131	63056	TRANSPEDICULAR W DECOMP CORD	21	41,649	25,471,633	0.1%	74.5%		38.14	38.14	1,983	21.73		11.69	4.76		38.18	38.18	1,985	41,649	41,693	
132	95900	NERVE CONDUCTION/EA NRV	676	41,479	25,513,112	0.1%	74.6%	1.18		1.18	61	0.42	0.90		0.04	1.36		1.36	71	41,479	47,807	
133	64831	SUTURE OF DIGITAL NERVE, HAN	43	40,293	25,553,405	0.1%	74.7%		18.02	18.02	937	9.00		6.77	1.41		17.18	17.18	893	40,293	38,414	
134	73700	CT, LOWER EXTREMITY,W/O CONT	120	40,186	25,593,590	0.1%	74.9%	6.44		6.44	335	1.09	6.35		0.30	7.74		7.74	402	40,186	48,298	
135	72192	CT, PELVIC, W/O CONTRAST	104	39,965	25,633,556	0.1%	75.0%	7.39		7.39	384	1.09	5.98		0.36	7.43		7.43	386	39,965	40,181	
136	71010	X-RAY CHEST;SINGLE VIEW;	1,065	39,874	25,673,429	0.1%	75.1%	0.72		0.72	37	0.18	0.44		0.03	0.65		0.65	34	39,874	35,997	
137	72050	X-RAY SPINE,CERVICAL;	555	38,384	25,711,813	0.1%	75.2%	1.33		1.33	69	0.31	1.07		0.07	1.45		1.45	75	38,384	41,847	
138	29870	KNEE ARTHROSCOPY, DX	60	37,471	25,749,284	0.1%	75.3%		12.01	12.01	625	5.11		4.28	0.85		10.24	10.24	532	37,471	31,949	

Effect of Adopting 2009 Relative Values

Top 200 Workers' Compensation Procedures In South Carolina

Sorted by Total Expenditures

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V
								2002 Relative Values				2009 Relative Values								Total		%
	CPT		#	Total	Aggregate	% of	Aggreg			3:1 NF			Practice Expense		Malprac	Total NF	Total Fac	3:1 NF				Change
	Code	Procedure Description	Procedures	CPT Code	Sum	Total	%	Non-Facility	Facility	RVU	Price	Work	Non-Facility	Facility				RVU	Price	2003	2009	
139	63685	INSERT OR REPLACE OF SPINAL	58	36,644	25,785,929	0.1%	75.4%		12.15	12.15	632	6.00		2.90	1.05		9.95	9.95	517	36,644	30,009	
140	99223	INITIAL HOSPITAL CARE	168	36,429	25,822,358	0.1%	75.5%		4.17	4.17	217	3.78		1.11	0.13		5.02	5.02	261	36,429	43,855	
141	93510	LEFT HEART CATHETER	16	35,967	25,858,325	0.1%	75.6%	43.23		43.23	2,248	4.32	26.93		2.61	33.86		33.86	1,761	35,967	28,172	
142	73564	X-RAY EXAM, KNEE, 4 OR MORE	728	35,585	25,893,910	0.1%	75.7%	0.94		0.94	49	0.22	0.85		0.05	1.12		1.12	58	35,585	42,399	
143	27814	TREATMENT OF ANKLE FRACTURE	29	34,850	25,928,760	0.1%	75.8%		23.11	23.11	1,202	10.46		7.44	1.86		19.76	19.76	1,028	34,850	29,798	
144	25270	REPAIR TENDON/MUSCLE,EXTENSO	29	34,382	25,963,142	0.1%	75.9%		22.80	22.80	1,186	6.06		5.10	0.95		12.11	12.11	630	34,382	18,262	
145	64718	NEUROPLASTY	54	34,117	25,997,259	0.1%	76.0%		12.15	12.15	632	7.06		6.28	1.05		14.39	14.39	748	34,117	40,407	
146	90805	PSYTX, OFF, 20-30 MIN W/ E&M	332	33,708	26,030,967	0.1%	76.1%	1.99	1.84	1.95	102	1.37	0.59	0.25	0.03	1.99	1.65	1.91	99	33,708	32,888	
147	70551	MRI BRAIN W/O DYE	48	32,947	26,063,914	0.1%	76.2%	13.20		13.20	686	1.48	14.28		0.66	16.42		16.42	854	32,947	40,984	
148	97113	AQUATIC THERAPY	786	32,698	26,096,612	0.1%	76.3%	0.80	0.80	0.80	42	0.44	0.53		0.01	0.98		0.98	51	32,698	40,055	
149	73223	MRI JOINT UPR EXTR W/O & W/	23	32,663	26,129,275	0.1%	76.4%	27.31		27.31	1,420	2.15	17.42		0.94	20.51		20.51	1,067	32,663	24,530	
150	99233	SUBSQT HOSPITAL CARE	296	32,477	26,161,752	0.1%	76.5%		2.11	2.11	110	2.00		0.62	0.06		2.68	2.68	139	32,477	41,251	
151	95903	MOTOR NERVE CONDUCTION TEST	543	32,471	26,194,223	0.1%	76.6%	1.15		1.15	60	0.60	1.00		0.05	1.65		1.65	86	32,471	46,589	
152	26765	TREAT FINGER FRACTURE, EACH	49	32,360	26,226,583	0.1%	76.7%		12.70	12.70	660	5.70		5.50	0.66		11.86	11.86	617	32,360	30,219	
153	25260	REPAIR TENDON/MUSCLE,FLEXOR;	24	32,298	26,258,881	0.1%	76.8%		25.88	25.88	1,346	7.89		6.44	1.19		15.52	15.52	807	32,298	19,369	
154	29898	ARTHROSCPY,ANKLE-TIB/FIB JTS	34	32,266	26,291,147	0.1%	76.9%		18.25	18.25	949	8.38		5.28	1.28		14.94	14.94	777	32,266	26,414	
155	74150	CT, ABD, W/O CONTRAST	85	32,178	26,323,325	0.1%	77.0%	7.28		7.28	379	1.19	6.02		0.35	7.56		7.56	393	32,178	33,415	
156	27506	TREATMENT OF THIGH FRACTURE	18	32,152	26,355,476	0.1%	77.1%		34.35	34.35	1,786	19.42		11.82	3.04		34.28	34.28	1,783	32,152	32,086	
157	22585	ARTHRODESIS, ANTERIOR/-LATER	64	31,450	26,386,926	0.1%	77.2%		9.45	9.45	491	5.52		2.19	1.25		8.96	8.96	466	31,450	29,819	
158	97535	SELF CARE MGMT TRAINING	735	31,340	26,418,266	0.1%	77.3%	0.82	0.82	0.82	43	0.45	0.38		0.01	0.84		0.84	44	31,340	32,105	
159	26410	EXT TEN REPAIR,HAND DORSUM,P	28	31,246	26,449,512	0.1%	77.4%		21.46	21.46	1,116	4.68		7.61	0.73		13.02	13.02	677	31,246	18,957	
160	99231	SUBSQT HOSPITAL CARE	665	31,122	26,480,634	0.1%	77.5%		0.90	0.90	47	0.76		0.25	0.03		1.04	1.04	54	31,122	35,963	
161	12011	SIMP REPAIR FACE EAR NOSE LI	160	31,096	26,511,730	0.1%	77.5%	4.20	2.35	3.74	194	1.78	1.85	0.75	0.16	3.79	2.69	3.52	183	31,096	29,245	
162	99242	OFC CONSULT-NEW/EST PAT	262	31,029	26,542,759	0.1%	77.6%	2.41	1.88	2.28	118	1.34	1.10	0.51	0.10	2.54	1.95	2.39	124	31,029	32,595	
163	64472	INJECTION ANESTHETIC	135	30,800	26,573,559	0.1%	77.7%	5.28	1.71	4.39	228	1.29	1.23	1.51	0.08	2.60	2.88	2.67	139	30,800	18,743	
164	64450	INJECTION ANESTHETIC	213	30,736	26,604,295	0.1%	77.8%	3.14	1.68	2.78	144	1.27	1.25	0.49	0.13	2.65	1.89	2.46	128	30,736	27,247	
165	29882	ARTHROSCOPY,KNEE,SURG;W MENI	31	30,225	26,634,520	0.1%	77.9%		18.75	18.75	975	9.45		6.65	1.50		17.60	17.60	915	30,225	28,371	
166	28415	TREAT HEEL FRACTURE	17	29,994	26,664,514	0.1%	78.0%		33.93	33.93	1,764	15.96		10.33	2.67		28.96	28.96	1,506	29,994	25,601	
167	73200	CT, UPPER EXTREMITY,W/O CONT	88	29,469	26,693,983	0.1%	78.1%	6.44		6.44	335	1.09	6.33		0.30	7.72		7.72	401	29,469	35,327	
168	90804	PSYTX, OFFICE, 20-30 MIN	322	29,093	26,723,076	0.1%	78.2%	1.77	1.64	1.74	90	1.21	0.54	0.23	0.03	1.78	1.47	1.70	89	29,093	28,507	
169	64470	INJECTION ANESTHETIC	107	28,404	26,751,480	0.1%	78.2%	5.99	2.45	5.11	265	1.85	3.81	0.73	0.11	5.77	2.69	5.00	260	28,404	27,820	
170	99211	ESTAB E/M OFFICE VISIT	1,133	28,280	26,779,760	0.1%	78.3%	0.56	0.24	0.48	25	0.17	0.32	0.06	0.01	0.50	0.24	0.44	23	28,280	25,628	
171	63655	LAMINEC-IMPLANT-NEUROSTIMUL.	28	28,246	26,808,006	0.1%	78.4%		19.40	19.40	1,009	11.43		7.79	2.44		21.66	21.66	1,126	28,246	31,537	
172	26735	TREAT FINGER FRACTURE, EACH	34	27,828	26,835,835	0.1%	78.5%		15.74	15.74	818	7.26		6.26	0.95		14.47	14.47	752	27,828	25,583	
173	26445	TENOLYSIS,EXTEN.TENDON,DORSU	23	27,652	26,863,486	0.1%	78.6%		23.12	23.12	1,202	4.36		8.13	0.65		13.14	13.14	683	27,652	15,715	
174	29874	ARTHROSCOPY,KNEE,SURG;FOR RE	33	27,576	26,891,062	0.1%	78.7%		16.07	16.07	836	7.10		5.28	1.11		13.49	13.49	701	27,576	23,149	
175	25447	INTERPOS. ARTHROPLASTY,INTER	23	27,484	26,918,546	0.1%	78.7%		22.98	22.98	1,195	10.95		8.08	1.61		20.64	20.64	1,073	27,484	24,685	
176	25310	TENDON TRANSPLANT/TXFER;FLEX	20	26,645	26,945,191	0.1%	78.8%		25.62	25.62	1,332	7.94		6.25	1.21		15.40	15.40	801	26,645	16,016	
177	29125	APPLY SHORT ARM SPLINT (FORE	362	26,589	26,971,780	0.1%	78.9%	1.53	1.06	1.41	73	0.59	0.95	0.42	0.07	1.61	1.08	1.48	77	26,589	27,812	
178	72265	CONTRAST X-RAY, LOWER SPINE	98	26,499	26,998,279	0.1%	79.0%	5.20		5.20	270	0.83	2.53		0.26	3.62		3.62	188	26,499	18,448	
179	29873	WITH LATERAL RELEASE	38	26,261	27,024,540	0.1%	79.0%		13.29	13.29	691	6.09		5.69	1.04		12.82	12.82	667	26,261	25,332	
180	27245	TREAT THIGH FRACTURE	13	26,209	27,050,749	0.1%	79.1%		38.77	38.77	2,016	18.00		10.82	3.53		32.35	32.35	1,682	26,209	21,869	
181	73218	MRI UPPER EXTREMITY W/O DYE	39	25,999	27,076,748	0.1%	79.2%	12.82		12.82	667	1.35	14.47		0.45	16.27		16.27	846	25,999	32,996	
182	76000	FLUOROSCOPY--TO 1 HR DR TIME	321	25,873	27,102,620	0.1%	79.3%	1.55		1.55	81	0.17	2.72		0.08	2.97		2.97	154	25,873	49,575	
183	72070	X-RAY EXAM OF THORACIC SPINE	517	25,809	27,128,429	0.1%	79.3%	0.96		0.96	50	0.22	0.64		0.05	0.91		0.91	47	25,809	24,464	
184	26952	AMPUTATION,FINGER/THUMB,PRIM	23	25,738	27,154,167	0.1%	79.4%		21.52	21.52	1,119	6.37		7.90	0.95		15.22	15.22	791	25,738	18,203	
185	71275	CT ANGIOGRAPHY, CHEST	43	25,647	27,179,814	0.1%	79.5%	11.47		11.47	596	1.92	11.61		0.48	14.01		14.01	729	25,647	31,326	
186	72170	X-RAY PELVIS; ANTEROPS-	626	24,740	27,204,553	0.1%	79.6%	0.76		0.76	40	0.17	0.50		0.03	0.70		0.70	36	24,740	22,786	
187	20550	INJECT TENDON/LIGAMENT/CYST,	290	24,543	27,229,096	0.1%	79.6%	1.77	1.20	1.63	85	0.75	0.62	0.29	0.09	1.46	1.13	1.38	72	24,543	20,773	
188	97116	GAIT TRAINING	749	24,537	27,253,633	0.1%	79.7%	0.63	0.63	0.63	33	0.40	0.28		0.01	0.69		0.69	36	24,537	26,874	
189	15100	SPLIT GRAFT TRUNK SCALP ARM	29	24,516	27,278,150	0.1%	79.8%	16.26	16.26	16.26	845	9.74	9.78	6.79	1.28	20.80	17.81	20.05	1,043	24,516	30,239	
190	28725	SUBTALAR ARTHRODESIS	19	24,423	27,302,573	0.1%	79.9%		24.72	24.72	1,285	11.97		6.84	1.87		20.68	20.68	1,075	24,423	20,432	
191	28485	TREAT METATARSAL FRACTURE	32	24,411	27,326,984	0.1%	79.9%		14.67	14.67	763	7.28		5.51	0.83		13.62	13.62	708	24,411	22,664	
192	99222	INITIAL HOSPITAL CARE	156	24,255	27,351,239	0.1%	80.0%		2.99	2.99	155	2.56		0.74	0.10		3.40	3.40	177	24,255	27,581	
193	29884	ARTHROSCOPY,KNEE,SURG;LYSIS	27	24,191	27,375,430	0.1%	80.1%		17.23	17.23	896	8.13		6.11	1.27		15.51	15.51	807	24,191	21,776	
194	73590	X-RAY;TIBIA & FIBULA,	611	24,147	27,399,576	0.1%	80.1%	0.76		0.76	40	0.17	0.53		0.03	0.73		0.73	38	24,147	23,194	
195	25000	TENDON SHEATH INCIS;AT RADIA	41	24,134	27,423,711	0.1%	80.2%		11.32	11.32	589	3.44		4.01	0.55		8.00	8.00	416	24,134	17,056	
196	95861	ELECTROMYGRPHY/2 EXTREM	151	24,027	27,447,738	0.1%	80.3%	3.06		3.06	159	1.54	1.62		0.13	3.29		3.29	171	24,027	25,833	
197	93307	ECG TRANSTHORACIC	87	23,434	27,471,172	0.1%	80.4%	5.18		5.18	269	0.92	3.56		0.26	4.74		4.74	246	23,434	21,444	
198	64622	DESTR PARAVERTEBRL NERVE L/S	65	23,432	27,494,604	0.1%	80.4%	7.94	3.91	6.93	360	3.02	4.09	1.31	0.18	7.29	4.51	6.60	343	23,432	22,291	
199	20552	INJECT SINGLE OR MULTIPLE TR	280	23,332	27,517,936	0.1%	80.5%	1.70	1.31	1.60	83	0.66	0.58	0.26	0.05	1.29	0.97	1.21	63	23,332	17,618	
200	64520	INJECTION ANESTHETIC AGENT;	97	20,807	27,538,743	0.1%	80.5%	4.92	1.74	4.13	215	1.35	2.64	0.55	0.08	4.07	1.98	3.55	184	20,807	17,894	

Attachment 5

WCRI Medical Price Index for Workers' Compensation
The MPI-WC
Second Edition

Workers Compensation Research Institute
Cambridge, Massachusetts

WCRI MEDICAL PRICE INDEX FOR WORKERS' COMPENSATION, SECOND EDITION (MPI-WC)

Stacey M. Eccleston

with the assistance of:

Juxiang Liu

WC-08-29

June 2008

Workers Compensation Research Institute

MPI-WC—2006 Interstate Comparisons

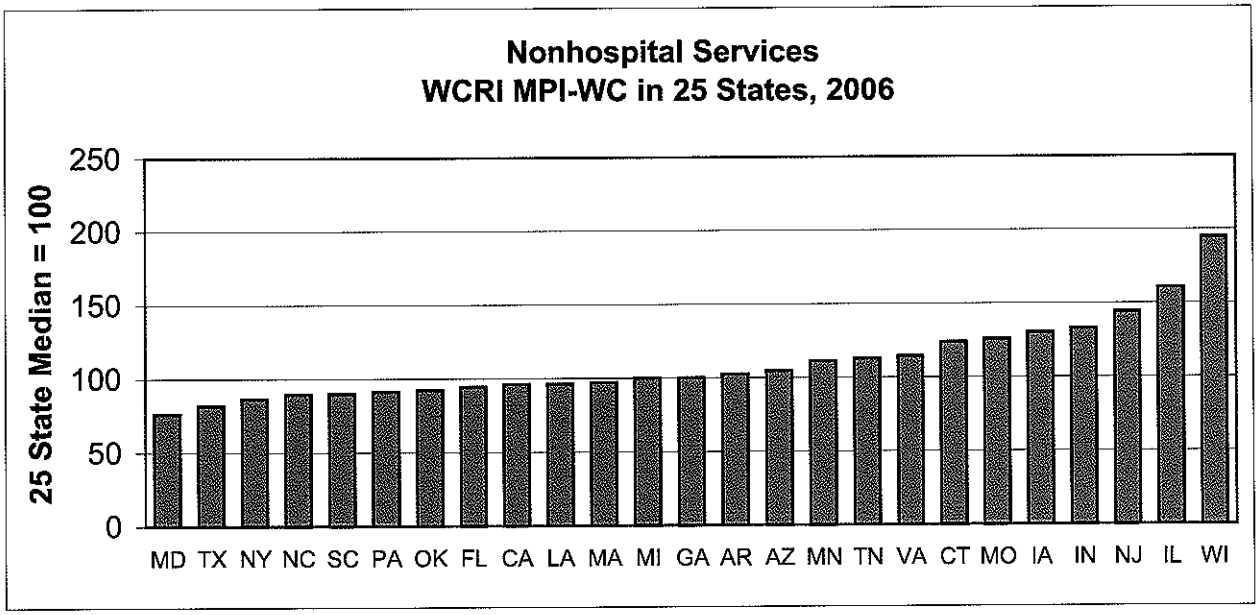
Nonhospital Services	Overall	Emergency	Evaluation & Management	Major Radiology	Minor Radiology	Neurological Testing	Physical Medicine	Major Surgery	Surgical Treatment
Arkansas	103	83	96	107	85	85	101	89	124
Arizona[a]	105	110	87	100	100	100	106	103	83
California	96	99	74	77	78	115	109	91	70
Connecticut	124	138	104	108	130	161	92	160	92
Florida	94	79	88	71	72	73	80	102	122
Georgia	100	84	96	111	100	92	88	96	111
Iowa[b]	130	154	110	155	128	136	114	130	138
Illinois[c]	161	205	121	163	183	167	148	167	160
Indiana[b]	133	185	110	122	161	152	125	127	145
Louisiana	96	125	99	105	109	94	99	73	99
Massachusetts	97	70	89	72	57	72	77	121	100
Maryland	76	78	90	70	63	77	84	49	87
Michigan	100	97	108	83	71	91	122	67	86
Minnesota[a]	111	140	122	123	104	101	115	80	115
Missouri[b]	126	168	113	125	152	133	107	131	129
North Carolina	90	98	82	95	85	72	91	77	95
New Jersey[a,b]	144	237	101	94	148	153	99	202	151
New York[a]	86	94	66	83	105	131	74	100	63
Oklahoma[a]	92	100	85	98	70	93	94	85	77
Pennsylvania	91	78	79	87	85	91	106	74	74
South Carolina	90	96	105	83	77	74	100	62	85
Tennessee[c]	113	130	117	114	100	109	96	110	128
Texas[d]	82	87	100	78	66	85	87	56	89
Virginia[b]	114	168	105	139	116	121	107	101	120
Wisconsin[b]	195	220	150	224	202	217	166	211	194

[a] The data for this state may be less representative than in other states because it is missing at least one dominant private insurer or state fund. To the extent that prices paid differ significantly for the missing payors compared to other payors in the state, this may bias the results up or down.

[b] Denotes states without a workers' compensation fee schedule in 2006.

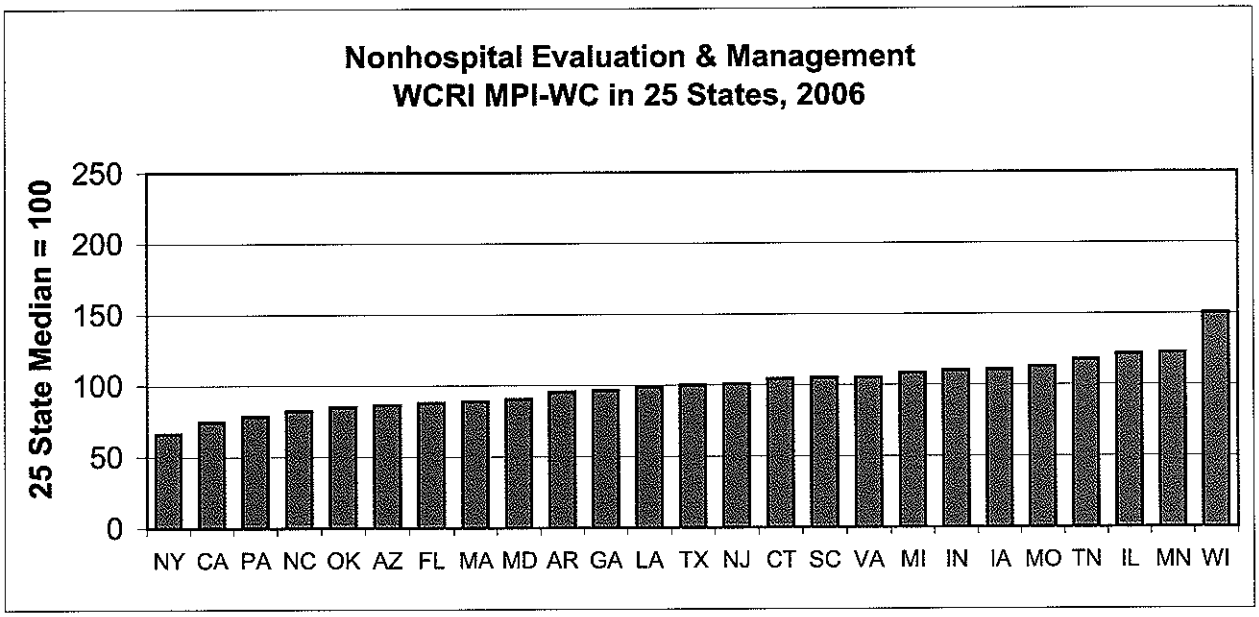
[c] Tennessee implemented a fee schedule in July 2005 and Illinois implemented fee schedules in February 2006.

[d] Texas increased its fee schedule effective in 2008.



Notes:

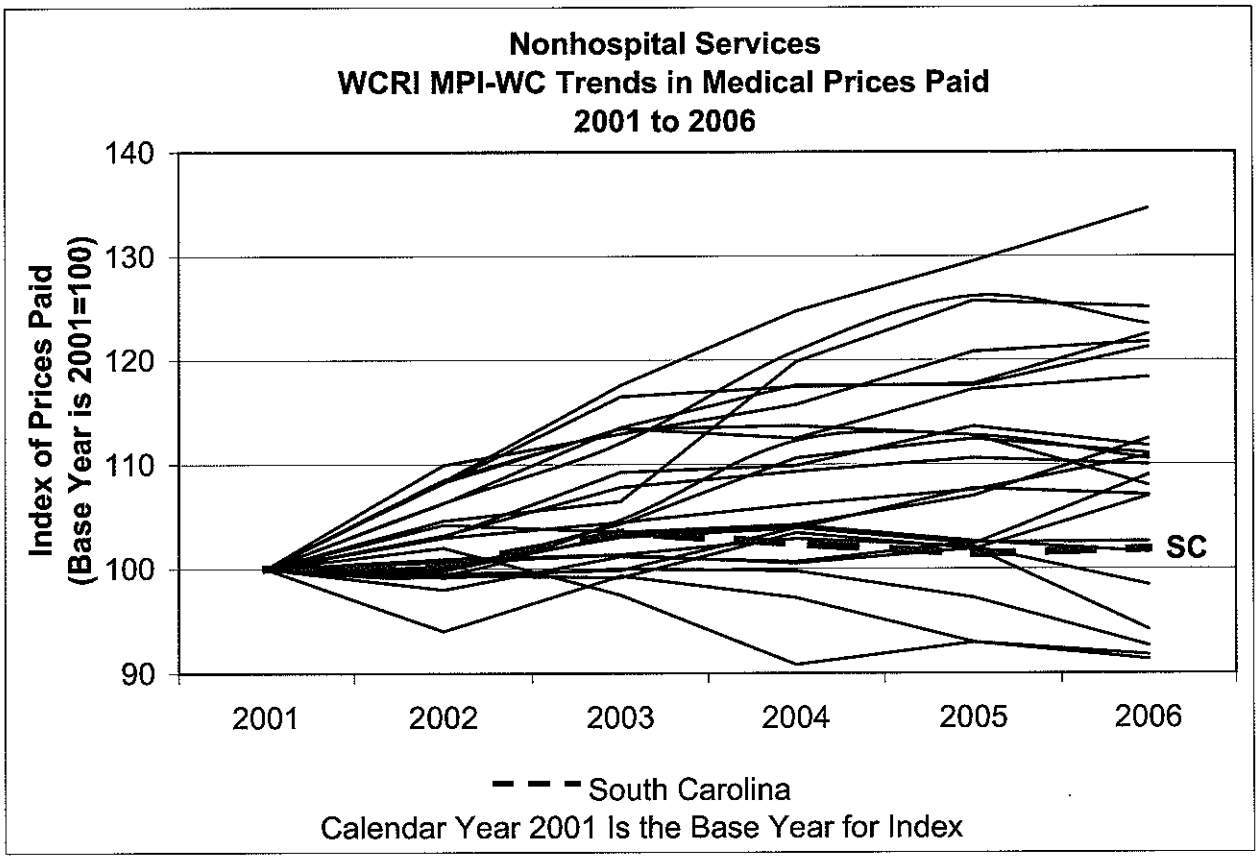
AZ, MN, NJ, NY, OK: The data for these states may be less representative than in other states because it is missing at least one dominant private insurer or state fund. To the extent that prices paid differ significantly for the missing payors compared to other payors in the state, this may bias the results up or down.

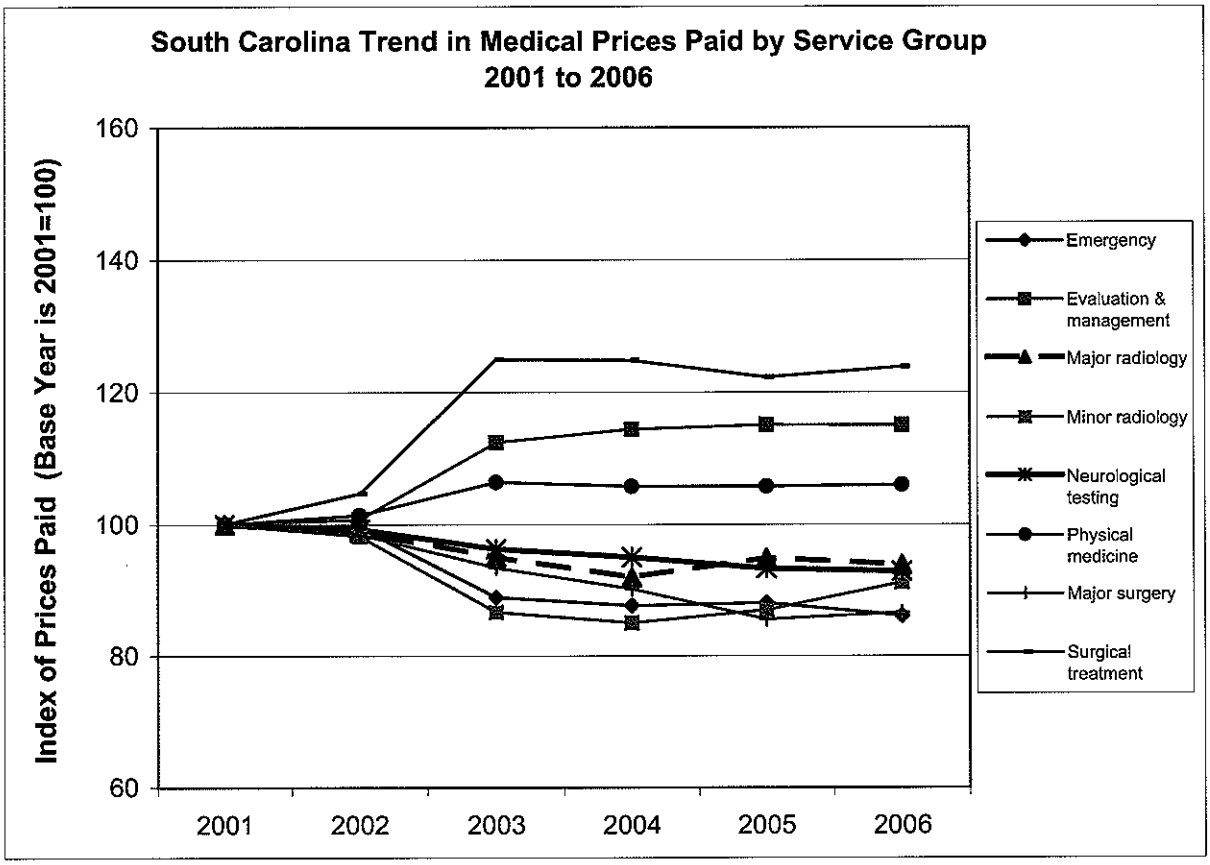


Evaluation & management: The services in this group are new and established patient office visits. These consist of an office or other outpatient visit which requires at least two of three parts: a problem focused history, a problem focused examination, and straightforward medical decision making of various complexities. See Table TA.2 for detailed description of all included services codes in this group.

Notes:

AZ, MN, NJ, NY, OK: The data for these states may be less representative than in other states because it is missing at least one dominant private insurer or state fund. To the extent that prices paid differ significantly for the missing payors compared to other payors in the state, this may bias the results up or down.


Nonhospital Services
WCRI MPI-WC Trends in Medical Prices Paid
2001 to 2006
Index of Prices Paid
(Base Year is 2001=100)
140
130
120
110
100
90
2001
2002
2003
2004
2005
2006
SC
South Carolina
Calendar Year 2001 Is the Base Year for Index



South Carolina Trend in Medical Prices Paid by Service Group 2001 to 2006						
Nonhospital Services	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**
Emergency	100	100	89	88	88	86
Evaluation & management	100	101	112	114	115	115
Major radiology	100	99	95	92	95	94
Minor radiology	100	98	87	85	87	91
Neurological testing	100	99	96	95	93	93
Physical medicine	100	101	106	106	106	106
Major surgery	100	98	93	90	86	87
Surgical treatment	100	105	125	125	122	124
Overall	100	100	103	102	101	102

Attachment 6

2009 Geographic Adjustment Factors

2009 Geographic Practice Cost Indices by State and Medicare Locality

Centers for Medicare and Medicaid Services

ADDENDUM D: 2009 Geographic Adjustment Factors (GAFs)

Contractor	Locality	Locality name	2009 GAF
00831	01	Alaska	1.288
01102	06	San Mateo, CA	1.204
01102	05	San Francisco, CA	1.201
13202	01	Manhattan, NY	1.164
13202	02	NYC Suburbs/Long I., NY	1.162
01102	09	Santa Clara, CA	1.148
12402	01	Northern NJ	1.134
31143	01	Metropolitan Boston	1.134
01102	07	Oakland/Berkley, CA	1.131
13292	04	Queens, NY	1.130
01192	26	Anaheim/Santa Ana, CA	1.128
12202	01	DC + MD/VA Suburbs	1.121
01192	17	Ventura, CA	1.121
00590	04	Miami, FL	1.114
01192	18	Los Angeles, CA	1.112
01102	03	Marin/Napa/Solano, CA	1.112
13102	00	Connecticut	1.100
00952	16	Chicago, IL	1.085
12402	99	Rest of New Jersey	1.082
12502	01	Metropolitan Philadelphia, PA	1.075
00953	01	Detroit, MI	1.072
00952	15	Suburban Chicago, IL	1.063
01202	01	Hawaii/Guam	1.057
00590	03	Fort Lauderdale, FL	1.056
00524	01	Rhode Island	1.045
31143	99	Rest of Massachusetts	1.041
12302	01	Baltimore/Surr. Cntys, MD	1.035
13202	03	Poughkpsie/N NYC Suburbs, NY	1.034
00836	02	Seattle (King Cnty), WA	1.033
00528	01	New Orleans, LA	1.017
01302	00	Nevada	1.016
04402	18	Houston, TX	1.016
12102	01	Delaware	1.014
01102	99	Rest of California*	1.012
01192	99	Rest of California*	1.012
04402	11	Dallas, TX	1.010
00511	01	Atlanta, GA	1.005
00590	99	Rest of Florida	1.001
31144	40	New Hampshire	0.996
00952	12	East St. Louis, IL	0.995
04402	31	Austin, TX	0.992
31142	03	Southern Maine	0.991
00973	50	Virgin Islands	0.991
04402	15	Galveston, TX	0.991

Contractor	Locality	Locality name	2009 GAF
00835	01	Portland, OR	0.987
12302	99	Rest of Maryland	0.987
04402	09	Brazoria, TX	0.985
04402	28	Fort Worth, TX	0.984
05302	02	Metropolitan Kansas City, MO	0.983
04102	01	Colorado	0.982
00883	00	Ohio	0.977
00836	99	Rest of Washington	0.977
03102	00	Arizona	0.974
31145	50	Vermont	0.973
05392	01	Metropolitan St Louis, MO	0.973
12502	99	Rest of Pennsylvania	0.970
00953	99	Rest of Michigan	0.969
00954	00	Minnesota	0.963
00904	00	Virginia	0.961
03502	09	Utah	0.960
04402	20	Beaumont, TX	0.959
00952	99	Rest of Illinois	0.956
04202	05	New Mexico	0.955
05535	00	North Carolina	0.953
04402	99	Rest of Texas	0.950
00630	00	Indiana	0.948
00835	99	Rest of Oregon	0.948
13282	99	Rest of New York	0.943
00528	99	Rest of Louisiana	0.943
00511	99	Rest of Georgia	0.943
00951	00	Wisconsin	0.942
00884	16	West Virginia	0.938
00880	01	South Carolina	0.937
05440	35	Tennessee	0.936
31142	99	Rest of Maine	0.933
05202	00	Kansas	0.932
05130	00	Idaho	0.932
00512	00	Mississippi	0.929
03602	21	Wyoming	0.927
00660	00	Kentucky	0.926
05402	00	Nebraska	0.923
05392	99	Rest of Missouri*	0.922
05302	99	Rest of Missouri*	0.922
05102	00	Iowa	0.922
03202	01	Montana	0.921
04302	00	Oklahoma	0.920
03402	02	South Dakota	0.918
00510	00	Alabama	0.917
00520	13	Arkansas	0.912
03302	01	North Dakota	0.908

Contractor	Locality	Locality name	2009 GAF
00973	20	Puerto Rico	0.837

GAF equation: (0.52466 * work GPCI) + (0.43669 * pe GPCI)+(0.038658 * mp GPCI).
GAF values contain a 1.000 floor on physician work GPCI (1.500 work floor in Alaska).
* Indicates multiple contractors.

ADDENDUM E: 2009 Geographic Practice Cost Indices (GPCIs) by State and Medicare Locality***

Contractor	Locality	Locality name	Work** GPCI	PE GPCI	MP GPCI
00510	00	Alabama	1.000	0.853	0.496
00831	01	Alaska	1.500	1.090	0.646
03102	00	Arizona	1.000	0.957	0.822
00520	13	Arkansas	1.000	0.846	0.446
01192	26	Anaheim/Santa Ana, CA	1.034	1.269	0.811
01192	18	Los Angeles, CA	1.041	1.225	0.804
01102	03	Marin/Napa/Solano, CA	1.034	1.265	0.432
01102	07	Oakland/Berkley, CA	1.053	1.286	0.425
01102	05	San Francisco, CA	1.059	1.441	0.414
01102	06	San Mateo, CA	1.072	1.433	0.394
01102	09	Santa Clara, CA	1.083	1.294	0.377
01192	17	Ventura, CA	1.027	1.265	0.766
01102	99	Rest of California*	1.007	1.058	0.549
01192	99	Rest of California*	1.007	1.058	0.549
04102	01	Colorado	1.000	0.992	0.641
13102	00	Connecticut	1.038	1.185	0.980
12202	01	DC + MD/VA Suburbs	1.047	1.218	1.032
12102	01	Delaware	1.011	1.046	0.678
00590	03	Fort Lauderdale, FL	1.000	1.018	2.250
00590	04	Miami, FL	1.000	1.069	3.167
00590	99	Rest of Florida	1.000	0.939	1.724
00511	01	Atlanta, GA	1.009	1.014	0.836
00511	99	Rest of Georgia	1.000	0.883	0.829
01202	01	Hawaii/Guam	1.000	1.161	0.665
05130	00	Idaho	1.000	0.883	0.546
00952	16	Chicago, IL	1.025	1.080	1.940
00952	12	East St. Louis, IL	1.000	0.919	1.793
00952	15	Suburban Chicago, IL	1.017	1.068	1.629
00952	99	Rest of Illinois	1.000	0.880	1.219
00630	00	Indiana	1.000	0.918	0.599
05102	00	Iowa	1.000	0.870	0.434
05202	00	Kansas	1.000	0.882	0.557
00660	00	Kentucky	1.000	0.860	0.652
00528	01	New Orleans, LA	1.000	1.044	0.956
00528	99	Rest of Louisiana	1.000	0.878	0.892
31142	03	Southern Maine	1.000	1.025	0.492
31142	99	Rest of Maine	1.000	0.893	0.492
12302	01	Baltimore/Surr. Cntys, MD	1.012	1.057	1.086
12302	99	Rest of Maryland	1.000	0.982	0.874
31143	01	Metropolitan Boston	1.029	1.291	0.764
31143	99	Rest of Massachusetts	1.007	1.106	0.764
00953	01	Detroit, MI	1.036	1.040	1.906
00953	99	Rest of Michigan	1.000	0.923	1.083

Contractor	Locality	Locality name	Work** GPCI	PE GPCI	MP GPCI
00954	00	Minnesota	1.000	0.983	0.245
00512	00	Mississippi	1.000	0.854	0.808
05302	02	Metropolitan Kansas City, MO	1.000	0.945	1.188
05392	01	Metropolitan St Louis, MO	1.000	0.931	1.075
05392	99	Rest of Missouri*	1.000	0.821	0.997
05302	99	Rest of Missouri*	1.000	0.821	0.997
03202	01	Montana	1.000	0.847	0.673
05402	00	Nebraska	1.000	0.890	0.245
01302	00	Nevada	1.002	1.026	1.083
31144	40	New Hampshire	1.000	1.039	0.462
12402	01	Northern NJ	1.057	1.228	1.116
12402	99	Rest of New Jersey	1.042	1.126	1.116
04202	05	New Mexico	1.000	0.890	1.096
13202	01	Manhattan, NY	1.064	1.298	1.010
13202	02	NYC Suburbs/Long I., NY	1.051	1.289	1.235
13202	03	Poughkpsie/N NYC Suburbs, NY	1.014	1.077	0.822
13292	04	Queens, NY	1.032	1.239	1.220
13282	99	Rest of New York	1.000	0.921	0.425
05535	00	North Carolina	1.000	0.925	0.634
03302	01	North Dakota	1.000	0.844	0.387
00883	00	Ohio	1.000	0.927	1.232
04302	00	Oklahoma	1.000	0.850	0.627
00835	01	Portland, OR	1.002	1.015	0.472
00835	99	Rest of Oregon	1.000	0.927	0.472
12502	01	Metropolitan Philadelphia, PA	1.016	1.097	1.617
12502	99	Rest of Pennsylvania	1.000	0.925	1.081
00973	20	Puerto Rico	1.000	0.694	0.250
00524	01	Rhode Island	1.013	1.088	0.996
00880	01	South Carolina	1.000	0.906	0.446
03402	02	South Dakota	1.000	0.864	0.420
05440	35	Tennessee	1.000	0.889	0.608
04402	31	Austin, TX	1.000	0.984	0.969
04402	20	Beaumont, TX	1.000	0.875	1.346
04402	09	Brazoria, TX	1.019	0.922	1.223
04402	11	Dallas, TX	1.009	1.001	1.110
04402	28	Fort Worth, TX	1.000	0.953	1.110
04402	15	Galveston, TX	1.000	0.959	1.223
04402	18	Houston, TX	1.016	0.986	1.345
04402	99	Rest of Texas	1.000	0.879	1.065
03502	09	Utah	1.000	0.907	1.026
31145	50	Vermont	1.000	0.983	0.489
00904	00	Virginia	1.000	0.942	0.657
00973	50	Virgin Islands	1.000	0.978	1.009
00836	02	Seattle (King Cnty), WA	1.014	1.085	0.706
00836	99	Rest of Washington	1.000	0.974	0.693

Contractor	Locality	Locality name	Work** GPCI	PE GPCI	MP GPCI
00884	16	West Virginia	1.000	0.827	1.353
00951	00	Wisconsin	1.000	0.921	0.409
03602	21	Wyoming	1.000	0.842	0.889

* Indicates multiple contractors.
** 2009 work GPCI reflects the 1.000 floor (1.500 floor in Alaska).
*** 2009 GPCIs are the second year of the update transition and reflect the fully implemented updated GPCIs.

Attachment 7

Workers' Compensation Premium Over Medicare
by Service Group
July 2006

Workers Compensation Research Institute
Cambridge, Massachusetts

BENCHMARKS FOR DESIGNING WORKERS' COMPENSATION MEDICAL FEE SCHEDULES: 2006

STACEY ECCLESTON

TE-CHUN LIU

WC-06-14

November 2006

WORKERS COMPENSATION RESEARCH INSTITUTE

CAMBRIDGE, MASSACHUSETTS

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Table 3 Workers' Compensation Fee Schedule Premium over Medicare Fee Schedule, by Service Group, July 2006

State	Percentage Greater Than or Less Than Medicare Fee Schedule					
	Overall	Surgery	Radiology	General Medicine	Physical Medicine	Evaluation and Management
Alabama	83	203	77	42	47	12
Alaska	236	417	273	287	153	127
Arizona	73	163	89	59	39	13
Arkansas	57	111	121	32	26	29
California	21	56	5	46	13	–13
Colorado	45	74	59	56	25	32
Connecticut	99	253	114	132	25	27
Florida[a]	17	40	10	10	10	10
Georgia	58	134	103	36	20	22
Hawaii	10	10	10	10	10	10
Idaho	108	249	159	98	25	85
Illinois[a]	163	354	175	170	91	52
Kansas	51	94	88	50	25	30
Kentucky	48	106	34	23	30	28
Louisiana	81	106	106	70	77	44
Maine	65	75	63	41	64	65
Maryland	15	36	6	7	9	7
Massachusetts	-13	-6	-7	-5	-23	-4
Michigan	33	33	33	33	33	32
Minnesota	62	94	90	59	40	55
Mississippi	81	131	83	51	71	44
Montana	67	153	151	31	25	0
Nebraska	93	186	164	50	48	43
Nevada	105	207	166	56	67	24
New Mexico	77	152	104	68	47	27
New York[a]	36	110	43	69	5	-19
North Carolina	39	106	69	21	7	6
North Dakota	45	72	87	29	30	14
Ohio	43	96	45	18	37	-13
Oklahoma	57	124	80	65	24	17
Oregon	102	161	86	103	80	85
Pennsylvania[a]	39	85	51	21	23	6
Rhode Island[b]	116	204	90	50	N/C	18
South Carolina	47	58	48	26	45	46
South Dakota	54	114	101	28	30	-2
Tennessee	77	168	100	60	30	61
Texas	25	25	25	25	25	25
Utah	33	60	50	22	20	21
Vermont	34	89	59	35	15	-17
Washington	43	43	43	43	43	43
West Virginia	13	12	13	12	14	13
Wyoming	55	108	120	43	26	10
Median state	55	106	82	43	26	23

Note: General medicine is largely composed of neurology and neurological testing.

[a] Florida, Illinois, New York and Pennsylvania have distinct fee schedules for different parts of the state. For each, we created a single statewide index by averaging the different sub-state fee schedules using employment in each sub-state region as weights. Medicare establishes distinct sub-state fee schedules in 14 states. For each, we created a single statewide index using the same procedure.

[b] Rhode Island has different billing codes for physical medicine than other states. For Rhode Island the overall index is based on the fee schedule levels for only surgery, radiology, general medicine, and evaluation and management.

Key: N/C: noncomparable.

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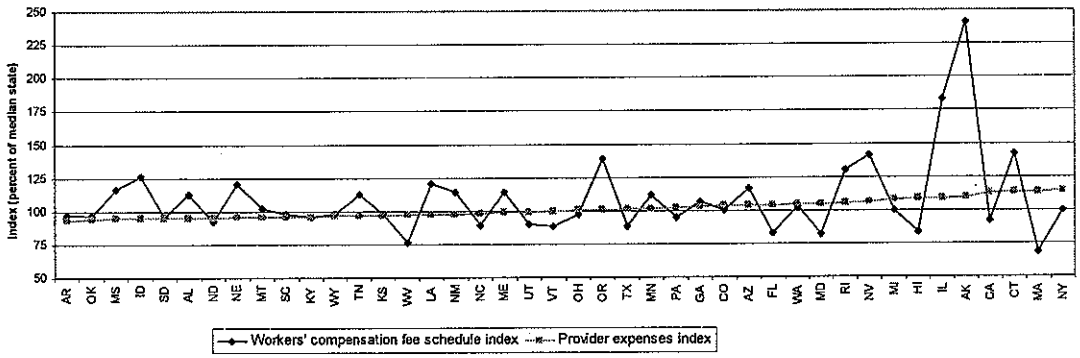
greater than the lowest. However, the highest workers' compensation fee schedule is 254 percent higher than the lowest. For example, the Medicare fee schedule rates in Connecticut and Massachusetts are, on average, 13 to 14 percent greater than the Medicare fee schedule rates in the median state. By contrast, the Massachusetts workers' compensation fee schedule is 32 percent less than the median state, but the workers' compensation fee schedule rates in neighboring Connecticut are 42 percent greater than the median state. Idaho is another example. The Idaho Medicare fee schedule is 5 percent lower than the Medicare fee schedule in the median state. However, the Idaho workers' compensation fee schedule (as revised in 2006) is 27 percent greater than the workers' compensation fee schedule in the median state.

Figure 7 Workers' Compensation Fee Schedule Index Compared to Provider Expense[a] Index, July 2006



Notes: Florida, Illinois, New York, and Pennsylvania have distinct workers' compensation fee schedules for different parts of the state. For each, we created a single statewide index by averaging the different sub-state fee schedules using employment in each sub-state region as weights. Medicare establishes distinct sub-state fee schedules in 14 states. For each, we created a single statewide index using the same procedure. Rhode Island has different billing codes for physical medicine than other states. For Rhode Island the overall index is based on the fee schedule levels for only surgery, radiology, general medicine, and evaluation and management.

[a] The provider expense index is based on Medicare's resource-based relative value scale which reflects the provider's costs to produce services.

Most state fee schedules create financial incentives to underuse primary care and overuse invasive and specialty care. A few states follow the Medicare approach and avoid such incentives. If all services are reimbursed at the same premium over Medicare, the utilization incentives are neutral—not rewarding the provider more for the use of certain services over others. As can be seen from Table 3, few states have little or no difference in the relative reimbursement across service groups as they compare to

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Table 4 States with Workers' Compensation Fee Schedules That are at Least Double Medicare Fee Schedule Levels, July 2006

Surgery	Radiology	General Medicine	Physical Medicine	Evaluation and Management
Louisiana (106)	Tennessee (100)	Oregon (103)	Alaska (153)	Alaska (127)
Kentucky (106)	South Dakota (101)	Connecticut (132)		
North Carolina (106)	Georgia (103)	Illinois (170)[a]		
Wyoming (108)	New Mexico (104)	Alaska (287)		
New York (110)[a]	Louisiana (106)			
Arkansas (111)	Connecticut (114)			
South Dakota (114)	Wyoming (120)			
Oklahoma (124)	Arkansas (121)			
Mississippi (131)	Montana (151)			
Georgia (134)	Idaho (159)			
New Mexico (152)	Nebraska (164)			
Montana (153)	Nevada (166)			
Oregon (161)	Illinois (175)[a]			
Arizona (163)	Alaska (273)			
Tennessee (168)				
Nebraska (186)				
Alabama (203)				
Rhode Island (204)[b]				
Nevada (207)				
Idaho (249)				
Connecticut (253)				
Illinois (354)[a]				
Alaska (417)				

Note: Percentage greater than or less than Medicare is in parentheses.

[a] Florida, Illinois, New York and Pennsylvania have distinct fee schedules for different parts of the state. For each, we created a single statewide index by averaging the different sub-state fee schedules using employment in each sub-state region as weights. Medicare establishes distinct sub-state fee schedules in 14 states. For each, we created a single statewide index using the same procedure.

[b] Rhode Island has different billing codes for physical medicine than other states. For Rhode Island the overall index is based on the fee schedule levels for only surgery, radiology, general medicine, and evaluation and management.

A few states may have fee schedules that are so low as to raise concerns about access to quality care. Again, this question cannot be definitively answered without additional outcome measures. However, policymakers should certainly pay attention to questions of access to primary care services in the states where the fee schedule rates are, at least, less than the Medicare reimbursement levels. There may also be concern in states

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schedule based on resource-based relative value scale and the relative value unit. This new fee schedule became effective on April 1, 2006. In fact, some states change their fee schedule rates annually. Table 6 lists the characteristics of the medical fee schedule and the latest effective date for each state. This study simply presents the comparisons of workers' compensation medical fee schedules to state Medicare fee schedules as of July 2006. It does not directly analyze the differences in the statistics presented in this version compared to the 2001/2002 edition. A future publication will likely focus on how these state rankings have changed from 2001/2002 to 2006.

Table 6 Characteristics of Workers' Compensation Fee Schedules for Nonfacility Providers, July 2006

Jurisdiction	Relative Value Scale Used	Last Effective Date of Fee Schedule and/or Conversion Factors
Alabama	The initial fee schedule was based on BC/BS RVS in 1992. It is annually adjusted no more then annual increase in cost of living as reflected by the US Department of Labor consumer price index.	May 19, 2006
Alaska	UCR. Senate Bill 130 limits fees to the fee schedule established by the workers' compensation board on December 1, 2004 through 2007.	December 1, 2004
Arizona		October 1, 2005
Arkansas	RBRVS	April 1, 2006
California	CRVS. For physician services rendered on or after July 1, 2004 the maximum allowable reimbursement amount set forth in the OMFS 2003 for each procedure code is reduced by 5 percent, except that those procedures that are reimbursed under OMFS 2003 at a rate between 100-105% of the Medicare Rate will be reduced between zero and 5% so that the OMFS reimbursement will not fall below the Medicare rate. "OMFS Physician Services Fees for Services Rendered on or after May 15, 2005" lists the maximum reimbursable fee (=OMFS RVU x OMFS CF X reduction percent) for each individual procedure code.	May 14, 2005
Colorado	2005 RVP	January 1, 2006
Connecticut		May 1,2006
Florida	Medicare RBRVS: 40% above Medicare for surgery , 10% above Medicare for other procedures	April 28, 2006
Georgia	UCR	April 1, 2006
Hawaii	Medicare RBRVS: 10% above Medicare	January, 2006
Idaho	RBRVS	April 1, 2006
Illinois	Fee Schedule amounts were formulated by determining the 90% of the 80th percentile from healthcare provider fees from 8/1/02 through 8/1/04. Fee schedules were established for 29 geo-zips. An initial 4.96% increase was applied to the fee schedule amount for the period of 8/1/04 through 9/30/05. The Commission will automatically increase or decrease the maximum allowable payment based upon the CPI-U on an annual basis.	February 1, 2006
Kansas	RBRVS	December 1, 2005
Kentucky	2004 GPCI-adjusted RBRVS unit value	March 16, 2006

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Table 6 Characteristics of Workers' Compensation Fee Schedules for Nonfacility Providers, July 2006 (continued)

Jurisdiction	Relative Value Scale Used	Last Effective Date of Fee Schedule and/or Conversion Factors
Louisiana		March 1, 2004
Maine	RBRVS	July 1, 2002
Maryland	Medicare RBRVS: 44% above 2004 Medicare for orthopedic and neurological surgical procedures, 9% above 2004 Medicare except for orthopedic and neurological surgical procedures and the services rendered at ambulatory Surgical Centers	June 5, 2006
Massachusetts	The rates are determined by a regulatory process.	September 1, 2004
Michigan	RBRVS. Michigan creates their own RVU by adjusting GPCI from CMS	March 10, 2006
Minnesota		October 1, 2005
Mississippi	RBRVS	November 1, 2002
Montana	RVP	January 1, 2006
Nebraska	RBRVS. Nebraska uses GPCI adjusted relative value units.	July 1, 2006
Nevada	RVP	February 1, 2006
New Mexico		December 31, 2005
New York	New York relative value units	April 1, 2006
North Carolina	RBRVS	March 1, 2006
North Dakota	RVP	December 1, 2005
Ohio	RBRVS	January 1, 2006
Oklahoma	RBRVS	January 25, 2006
Oregon	RBRVS	April 1, 2006
Pennsylvania	RBRVS. Prior to January 1, 1995, the medical fees were capped at 113% of the Medicare. Medical fee update on and after January 1, 1995 are calculated based on the percentage changes in the Statewide average weekly wage annually. These updates shall be effective on January 1 of each year, and they are cumulative.	July 15, 2006
Rhode Island		July 1, 2006
South Carolina	RBRVS	January 1, 2003
South Dakota	RVP	June 14, 2006
Tennessee	Medicare RBRVS: 30% above Medicare for chiropractic care, 60% above Medicare for evaluation and management, 100% above Medicare for emergency care, radiology, and general surgery, 175% above Medicare for neurosurgery and orthopedic surgery. It must also be used with Medical Cost Containment Program Rules and the In-Patient Hospital Fee Schedule Rules.	May 1, 2006
Texas	Medicare RBRVS: 25% above Medicare	January, 2006
Utah	RBRVS	July 11, 2006
Vermont	A blend of several Blue Cross/Blue Shield fee schedules	May 15, 2006
Washington	RBRVS	July 1, 2006
West Virginia	RBRVS	January 1, 2006
Wyoming	RVP	September 30, 2005

Key: CRVS: California relative value studies, 1974; RBRVS: resource-based relative value scale (Medicare); RVP: Relative Value for Physicians, published by Ingenix, Inc.; UCR: usual, customary, and reasonable.

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Attachment 8

Consumer Price Index – Medical Care
South – Size Class B/C

Consumer Price Index – Medical Care Services
South Urban

Consumer Price Index – All Items
South – Size Class B/C

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Consumer Price Index - All Urban Consumers

Series Id: CUURX300SAM
Not Seasonally Adjusted
Area: South - Size Class B/C
Item: Medical care
Base Period: DECEMBER 1997=100

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Annual	HALF1	HALF2
2003	121.7	122.5	122.9	123.1	123.2	123.1	123.8	124.1	124.5	124.8	125.9	126.0	123.8	122.8	124.9
2004	126.6	127.4	127.7	127.8	128.2	129.1	129.3	129.5	130.1	130.6	130.8	131.5	129.1	127.8	130.3
2005	132.2	132.9	132.9	133.2	133.5	133.8	134.4	134.6	134.7	135.0	136.3	136.4	134.2	133.1	135.2
2006	136.6	137.2	137.8	138.1	138.4	138.5	138.9	138.9	139.1	139.4	140.1	140.2	138.6	137.8	139.4
2007	140.387	142.109	141.460	141.751	142.481	142.804	143.346	144.277	144.353	145.654	146.931	147.269	143.569	141.832	145.305
2008	148.494	149.287	149.498	150.244	149.581	149.930	150.012	150.084	149.794	149.910	150.275	150.493	149.800	149.506	150.095
2009	151.196	152.531	152.605	153.317	153.367	153.392	153.459							152.735	

12 Months Percent Change
Series Id: CUURX300SAM
Not Seasonally Adjusted
Area: South - Size Class B/C
Item: Medical care
Base Period: DECEMBER 1997=100

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Annual	HALF1	HALF2
2003	4.5	4.6	4.7	4.7	4.6	4.3	4.0	3.9	3.7	3.5	3.9	3.7	4.1	4.6	3.8
2004	4.0	4.0	3.9	3.8	4.1	4.9	4.4	4.4	4.5	4.6	3.9	4.4	4.3	4.1	4.3
2005	4.4	4.3	4.1	4.2	4.1	3.6	3.9	3.9	3.5	3.4	4.2	3.7	4.0	4.1	3.8
2006	3.3	3.2	3.7	3.7	3.7	3.5	3.3	3.2	3.3	3.3	2.8	2.8	3.3	3.5	3.1
2007	2.8	3.6	2.7	2.6	2.9	3.1	3.2	3.9	3.8	4.5	4.9	5.0	3.6	2.9	4.2
2008	5.8	5.1	5.7	6.0	5.0	5.0	4.7	4.0	3.8	2.9	2.3	2.2	4.3	5.4	3.3
2009	1.8	2.2	2.1	2.0	2.5	2.3	2.3							2.2	

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Consumer Price Index - All Urban Consumers

Series Id: CUUR0300SAM2
Not Seasonally Adjusted
Area: South urban
Item: Medical care services
Base Period: 1982-84=100

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Annual	HALF1	HALF2
2003	292.6	294.4	294.8	294.9	295.6	296.1	297.4	298.1	298.8	300.5	303.5	304.3	297.6	294.7	300.4
2004	305.3	306.6	307.5	308.0	308.5	310.7	311.7	312.2	312.9	314.4	315.7	318.2	311.0	307.8	314.2
2005	319.7	322.2	323.8	324.7	325.3	325.5	326.5	325.9	325.9	327.4	330.4	329.8	325.6	323.5	327.7
2006	330.1	331.4	333.1	333.3	334.1	335.4	335.2	335.8	336.7	338.9	341.1	341.8	335.6	332.9	338.3
2007	343.987	347.926	347.352	347.587	349.616	349.983	351.396	354.150	354.858	357.688	359.569	360.243	352.030	347.742	356.317
2008	363.450	365.090	365.614	367.413	367.763	368.165	368.519	369.851	370.008	370.929	371.380	371.058	368.270	366.249	370.291
2009	372.150	374.400	374.813	376.106	376.267	376.567	377.263							375.051	

12 Months Percent Change

Series Id: CUUR0300SAM2
Not Seasonally Adjusted
Area: South urban
Item: Medical care services
Base Period: 1982-84=100

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Annual	HALF1	HALF2
2003	5.6	5.8	5.3	4.8	4.7	4.6	4.5	4.4	4.2	3.9	4.4	4.3	4.7	5.1	4.3
2004	4.3	4.1	4.3	4.4	4.4	4.9	4.8	4.7	4.7	4.6	4.0	4.6	4.5	4.4	4.6
2005	4.7	5.1	5.3	5.4	5.4	4.8	4.7	4.4	4.2	4.1	4.7	3.6	4.7	5.1	4.3
2006	3.3	2.9	2.9	2.6	2.7	3.0	2.7	3.0	3.3	3.5	3.2	3.6	3.1	2.9	3.2
2007	4.2	5.0	4.3	4.3	4.6	4.3	4.8	5.5	5.4	5.5	5.4	5.4	4.9	4.5	5.3
2008	5.7	4.9	5.3	5.7	5.2	5.2	4.9	4.4	4.3	3.7	3.3	3.0	4.6	5.3	3.9
2009	2.4	2.6	2.5	2.4	2.3	2.3	2.4							2.4	

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Consumer Price Index - All Urban Consumers

Series Id: CUURX300SA0
Not Seasonally Adjusted
Area: South - Size Class B/C
Item: All items
Base Period: DECEMBER 1996=100

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Annual	HALF1	HALF2
2003	111.7	112.5	113.3	113.3	112.8	113.1	113.1	113.4	113.8	113.6	113.3	113.3	113.1	112.8	113.4
2004	113.8	114.3	114.9	115.6	116.4	117.0	116.9	116.9	116.9	117.4	117.4	117.1	116.2	115.3	117.1
2005	117.1	117.7	118.4	119.3	119.4	119.7	120.2	120.9	122.3	122.5	121.4	121.2	120.0	118.6	121.4
2006	122.0	122.1	123.0	124.1	124.6	125.0	125.5	125.4	124.4	123.7	123.4	123.8	123.9	123.5	124.4
2007	123.817	124.521	125.726	127.000	127.893	128.265	128.226	127.833	128.263	128.600	129.556	129.368	127.422	126.204	128.641
2008	129.937	130.351	131.442	132.516	133.714	134.980	135.643	135.004	135.093	133.285	130.324	129.099	132.616	132.157	133.075
2009	129.615	130.380	130.873	131.370	131.777	133.056	132.736							131.179	

12 Months Percent Change

Series Id: CUURX300SA0
Not Seasonally Adjusted
Area: South - Size Class B/C
Item: All items
Base Period: DECEMBER 1996=100

Year	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Annual	HALF1	HALF2
2003	2.3	2.9	3.0	2.3	1.9	2.0	1.9	2.3	2.3	1.8	1.3	1.5	2.1	2.4	1.8
2004	1.9	1.6	1.4	2.0	3.2	3.4	3.4	3.1	2.7	3.3	3.6	3.4	2.7	2.2	3.3
2005	2.9	3.0	3.0	3.2	2.6	2.3	2.8	3.4	4.6	4.3	3.4	3.5	3.3	2.9	3.7
2006	4.2	3.7	3.9	4.0	4.4	4.4	4.4	3.7	1.7	1.0	1.6	2.1	3.3	4.1	2.5
2007	1.5	2.0	2.2	2.3	2.6	2.6	2.2	1.9	3.1	4.0	5.0	4.5	2.8	2.2	3.4
2008	4.9	4.7	4.5	4.3	4.6	5.2	5.8	5.6	5.3	3.6	0.6	-0.2	4.1	4.7	3.4
2009	-0.2	0.0	-0.4	-0.9	-1.4	-1.4	-2.1							-0.7	

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Attachment 9

Increase in the Medicare Economic Index
Update for CY 2009

Centers for Medicare and Medicaid Services

is comprised of two broad categories: (1) Physician's own time; and (2) physician's PE.

The physician's own time component represents the net income portion of business receipts and primarily reflects the input of the physician's own time into the production of physicians' services in physicians' offices. This category consists of two subcomponents: (1) Wages and salaries; and (2) fringe benefits.

The physician's PE category represents nonphysician inputs used in the production of services in physicians' offices. This category consists of wages and salaries and fringe benefits for nonphysician staff and other nonlabor inputs. The physician's PE component also includes the following categories of nonlabor inputs: Office expense; medical materials and supplies; professional liability insurance; medical equipment; prescription drugs; and other expenses. The components are adjusted to reflect productivity growth in physicians' offices by the 10-year moving average of productivity in the private nonfarm business sector.

Table 32 presents a listing of the MEI cost categories with associated weights and percent changes for price proxies for the 2009 update. For CY 2009, the increase in the MEI is 1.6 percent, which includes a 1.4 percent productivity offset based on the 10-year moving average of multifactor productivity. This is the result of a 3.6 percent increase in physician's own time and a 2.4 percent increase in physician's PE. Within the physician's PE, the largest increase occurred in prescription drugs, which increased 6.0 percent, and employee benefits, which increased 4.3 percent.

TABLE 32—INCREASE IN THE MEDICARE ECONOMIC INDEX UPDATE FOR CY 2009 [1]

Cost categories and price measures	CY 2000 weights [2]	CY 2009 percent changes
Medicare Economic Index Total, productivity adjusted [3]	N/A	1.6
Productivity: 10-year moving average of multifactor productivity, private nonfarm business sector [3]	N/A	1.4
Medicare Economic Index Total, without productivity adjustment	100.000	3.0
1. Physician's Own Time [4]	52.466	3.6
a. Wages and Salaries: Average Hourly Earnings, private Nonfarm	42.730	3.8
b. Fringe Benefits: Employment Cost Index, benefits, private Nonfarm [4]	9.735	2.7
2. Physician's Practice Expense [4]	47.534	2.4
a. Nonphysician Employee Compensation	18.653	3.6
(1) Wages and Salaries: Employment Cost Index, wages and salaries, weighted by occupation	13.808	3.4
(2) Fringe Benefits: Employment Cost Index, fringe benefits, weighted by occupation	4.845	4.3
b. Office Expense: Consumer Price Index for Urban Areas (CPI–U), housing	12.209	3.1
c. Drugs and Medical Materials and Supplies	4.319	4.1
(1) Medical Materials and Supplies: Producer Price Index (PPI), surgical appliances and supplies/CPI–U, medical equipment and supplies (equally weighted)	2.011	1.4
(2) Pharmaceuticals: Producer Price Index (PPI ethical prescription drugs)	2.308	6.0
d. Professional Liability Insurance: Professional liability insurance Premiums [5]	3.865	−2.7
e. Medical Equipment: PPI, medical instruments and equipment	2.055	0.5
f. Other Expenses	6.433	2.3

[1] The rates of historical change are estimated for the 12-month period ending June 30, 2008, which is the period used for computing the CY 2009 update. The price proxy values are based upon the latest available Bureau of Labor Statistics data as of September 5, 2008.

[2] The weights shown for the MEI components are the 2000 base-year weights, which may not sum to subtotals or totals because of rounding. The MEI is a fixed-weight, Laspeyres-type input price index whose category weights indicate the distribution of expenditures among the inputs to physicians' services for CY 2000. To determine the MEI level for a given year, the price proxy level for each component is multiplied by its 2000 weight. The sum of these products (weights multiplied by the price index levels) over all cost categories yields the composite MEI level for a given year. The annual percent change in the MEI levels is an estimate of price change over time for a fixed market basket of inputs to physicians' services.

[3] These numbers may not sum due to rounding and the multiplicative nature of their relationship.

[4] The measures of productivity, average hourly earnings, Employment Cost Indexes, as well as the various Producer and CPIs can be found on the BLS Web site at *http://stats.bls.gov.*

[5] Derived from data collected from several major insurers (the latest available historical percent change data are for the period ending second quarter of 2008).

C. The Update Adjustment Factor (UAF)

Section 1848(d) of the Act provides that the PFS update is equal to the product of the percentage change in the MEI and the update adjustment factor (UAF). The UAF is applied to make actual and target expenditures (referred to in the statute as "allowed expenditures") equal. Allowed expenditures are equal to actual expenditures in a base period updated each year by the sustainable growth rate (SGR). The SGR sets the annual rate of growth in allowed expenditures and is determined by a formula specified in section 1848(f) of the Act.

The PFS update is set under a formula specified in section 1848(d)(4) of the Act. Section 101 of the MIEA–TRHCA provided a 1-year increase in the CY 2007 CF and specified that the CF for CY 2008 must be computed as if the 1-year increase had never applied. Section 101 of the MMSEA provided a 6-month increase in the CY 2008 CF, from January 1, 2008, through June 30, 2008, and specified that the CF for the remaining portion of 2008 and the CFs for CY 2009 and subsequent years must be computed as if the 6-month increase had never applied. Section 131 of the MIPPA extended the increase in the CY 2008 CF that was applicable for the first half of the year to the entire year, provided for a 1.1 percent increase to the CY 2009 CF, and specified that the CFs for CY 2010 and subsequent years must be computed as if the increases for CYs 2007, 2008, and 2009 had never applied.

1. Calculation Under Current Law

Under section 1848(d)(4)(B) of the Act, the UAF for a year beginning with CY 2001 is equal to the sum of the following—

• *Prior Year Adjustment Component.* An amount determined by—

+ Computing the difference (which may be positive or negative) between

Attachment 10

Medicare Economic Index
2003 – 2009

Centers for Medicare and Medicaid Services

Medicare Economic Index
2003 - 2009

Year	Percent
2003	3.0
2004	2.9
2005	3.1
2006	2.8
2007	2.1
2008	1.8
2009	1.6

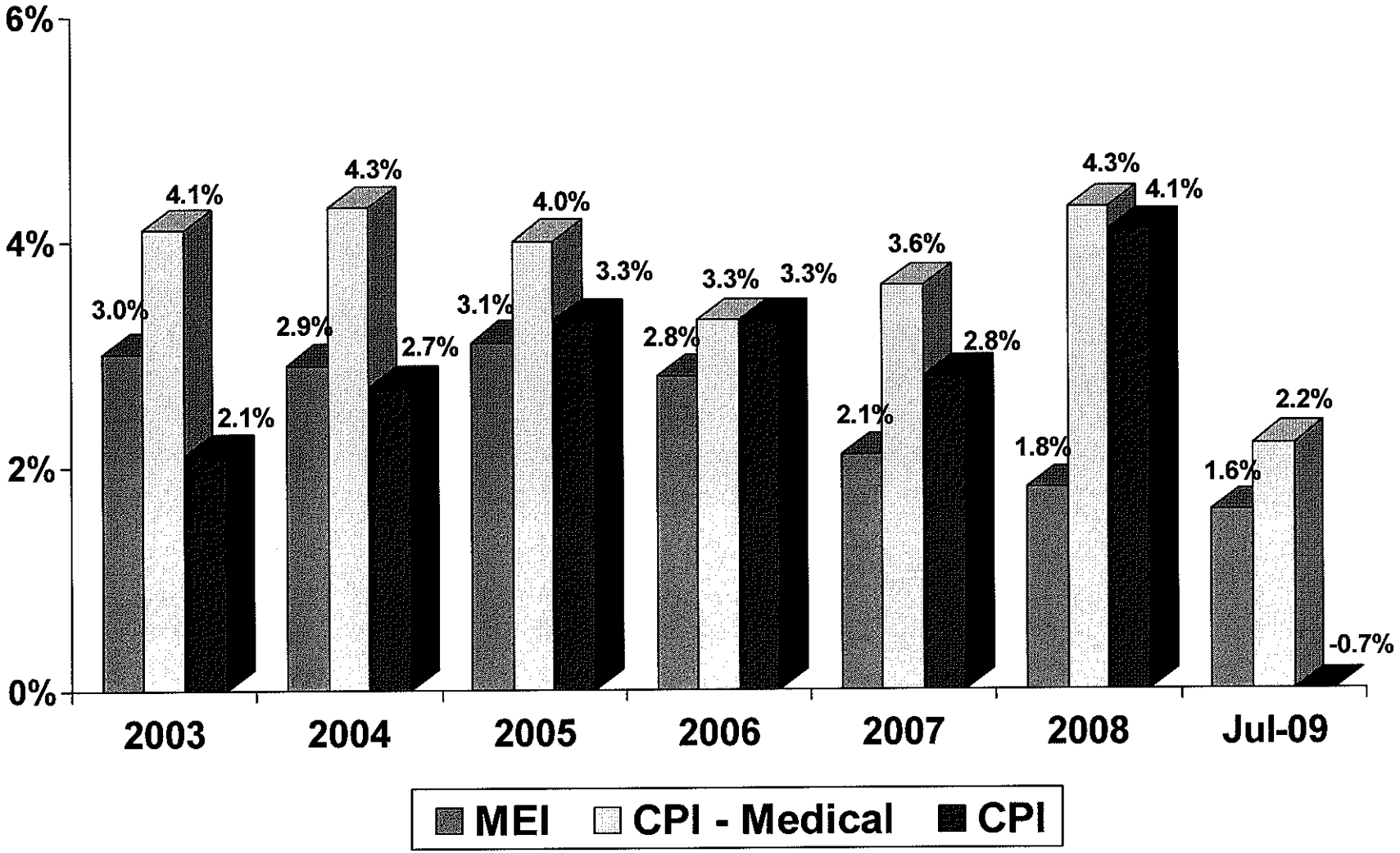
Attachment 11

Medicare Economic Index
Consumer Price Index – Medical
Consumer Price Index
2003 - 2009

Centers for Medicare and Medicaid Services

Bureau of Labor Statistics

Medicare Economic Index & CPI
2003 – 2009



Attachment 12

"Settlement to Reduce Brand-Name Drug Prices in Many States"
Workcompcentral, September 1, 2009

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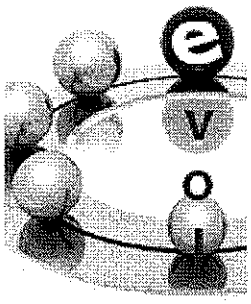

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N/A -- Settlement to Reduce Brand-Name Drug Prices in Many States: *Top*
09/01/09

Insurers and employers in at least 32 states whose worker's compensation pharmacy fee schedules are tied to average wholesale prices are poised to enjoy a 4% reduction in the prices of brand-name drugs on Sept. 26, thanks to the settlement of a federal lawsuit against average wholesale price publishers First Databank and Medispan.

Some pharmacy benefit managers are scrambling to renegotiate contracts with payers because their reimbursement levels are tied to a percentage of the average wholesale price, industry experts say. Pharmacy benefit managers may even be pushed out of the market in states with exceptionally low drug fee schedules, such as Arizona, Kansas, Oregon, North Dakota, Massachusetts, New York, Washington and West Virginia, said Joe Paduda, owner of Health Strategy Associates.

"PBMs are being squeezed in the middle," Paduda said. "The states that I have heard about have given no indication that they are going to make any accommodation. New York was asked and Florida was asked and they said they are not going to do anything."

The reduction in published average wholesale prices stems from a lawsuit filed by the New England Carpenters Health Benefit Fund and several other parties against McKesson and its subsidiary, First Databank, filed in the U.S. District Court for Massachusetts. The unions accused the companies of colluding to artificially inflate the wholesale acquisition price of 1,442 drugs.

The average wholesale price is actually a misnomer. The benchmark measures what drug manufacturers charge to a buyer who makes a one-time purchase, while most buyers actually purchase drugs through long-term contracts at prices set far lower.

Historically, First Databank had derived the average wholesale price by surveying drug manufacturers to determine the wholesale acquisition price and multiplying by 120% or 125%, depending on the manufacturer's suggested markup. But starting in 2001, the company allegedly began using a 125% markup for all brand-name drugs, regardless of what the

manufacturer recommended, according to the lawsuit.

To settle the lawsuit, First Databank agreed to reduce the wholesale acquisition cost factor back to 120% for the 1,442 drugs that were subject to the lawsuit. Perhaps to avoid further litigation, the company later announced it would use the 120% multiplier for all drugs. Medispan, another average wholesale price publisher, also agreed to the same change in policy.

As a result, the average wholesale price of a drug with an average wholesale price of, say, $125, will be reduced to $120, or 4% less, on Sept. 26.

First Databank and Medispan have also decided to stop publishing the average wholesale price entirely in two years.

Generic drugs will not be affected because the wholesale acquisition cost was never used as a factor in the average wholesale price calculation, said Gregory Rucinski, president of the Tricast consulting firm in Milwaukee, Wis.

Rucinski said the National Association of Chain Drug Stores has threatened to file suit to block enforcement of the settlement terms, but its chances of success appear slim. He said drug retailers should be prepared to accept a 4% reduction in brand-name drug prices before the end of the month.

Rucinski said the settlement will have a much larger impact on group health care than workers' compensation, because worker's comp fee schedules are generally set higher than the contracted rates paid by group health care providers and government health programs, including Medicaid and Medicare.

"In many of those states it's a very fair rate to pharmacies," he said of workers' comp fee schedules in general.

But Paduda pointed out that some states already have very low fee schedule rates. New York, for example, recently adopted a fee schedule that sets drug prices at 75% of the average wholesale price for generics and 88% for brand-name drugs. Fee schedules in Arizona, Massachusetts and West Virginia cap drug prices at 85% of average wholesale price for both generics and brand-name drugs. Oregon's fee schedule caps brand-name drugs at 88% of the average wholesale price, while Kansas and Washington set the cap at 90%.

Paduda said pharmacy benefit managers (PBMs) in those states face severe reductions in reimbursement levels once the change takes place because their fees are based on the margin between the average wholesale price and any discounts they can get from pharmacies. He said pharmacies have been asking the PBMs to amend their contracts because of the reduction. The PBMs, in turn, will be forced to ask their clients to accept new contract terms.

"In some states, if the regulators aren't careful they may well squeeze PBMs out of the market," Paduda said.

In all, at least 32 states tie workers' compensation drug fee schedules to the published average wholesale price, according to data collected by CompPharma, a consortium of workers' compensation PBMs headed by Paduda. He said California's drug fee schedule is also tied indirectly to average wholesale prices because it is based on rates set by the state's Medi-Cal program, but the impact is more difficult to discern because California's fee schedule is much more complicated that other states.

So far, state regulators aren't promising any changes. Brian Keegan, spokesman for the New York State Workers' Compensation Board, said the board is aware of the coming change in average wholesale prices but has not decided on a course of action.

No one has yet asked the Oregon Workers' Compensation Division to change the state's drug fee schedule, said agency spokeswoman Lisa Morawski. "We go through rule making once a

year to set our fee schedule, and it is a lengthy process that involves quite a bit of public input," she wrote in an e-mail. "We generally don't make changes outside of that process."

To view court documents related to the federal lawsuit against McKesson, go here: http://www.mckessonawpsettlement.com/CourtDocuments.htm

By Jim Sams, Senior Editor
jim@workcompcentral.com

Attachment 13

"Analysis of Changes to the South Carolina Physician Fee Schedule Proposed to be Effective January 1, 2010"

National Council on Compensation Insurance, Inc.
September 17, 2009

Impacts Due to Combined Changes in RBRVS and Anesthesia CF				
Service Category	**Current CF**	**Proposed CF**	**Cost Distribution**	**Impact**
Anesthesia	$24.00	$30.00	2.9%	+25.0%
Surgery	$52.00	$52.00	33.1%	-9.8%
Radiology	$52.00	$52.00	17.1%	+8.2%
Pathology and Laboratory	$52.00	$52.00	0.1%	+27.1%
Medicine	$52.00	$52.00	3.2%	+10.7%
Physical Medicine	$52.00	$52.00	22.0%	+6.5%
Evaluation & Management	$52.00	$52.00	21.6%	+14.6%
Impact on Physician Costs			100.0%	**+3.8%**

		Impact (Change in RBRVS Only)	Impact (Combined changes in RBRVS and Anesthesia CF)
(1)	Impact on Physician Costs in South Carolina	+3.1%	+3.8%
(2)	Physician Costs as a Percentage of Medical Costs in South Carolina	41.0%	41.0%
(3)	**Impact on Medical Costs in South Carolina = (1) x (2)**	**+1.3%**	**+1.6%**
(4)	Medical Costs as a Percentage of Overall Workers Compensation System Costs in South Carolina	42.3%	42.3%
(5)	**Total Impact on Overall Workers Compensation System Costs in South Carolina = (3) x (4)**	**+0.5%**	**+0.7%**
(6)	**Dollar Impact on Overall Workers Compensation System Costs in South Carolina**	**$5.4M**	**$7.6M**

National Council on Compensation Insurance, Inc.

ANALYSIS OF CHANGES TO THE SOUTH CAROLINA PHYSICIAN FEE SCHEDULE PROPOSED TO BE EFFECTIVE JANUARY 1, 2010

NCCI estimates that the adoption of Medicare's 2009 Resource Based Relative Value Scale (RBRVS), with no change to the conversion factor, would result in an increase of 0.5% ($5.4M) on South Carolina's overall workers compensation system costs.

NCCI estimates that the combined impact of the adoption of Medicare's 2009 RBRVS and the proposed increase in conversion factors would result in an increase of 1.0% ($10.9M) on South Carolina's overall workers compensation system costs.

Background

The current South Carolina physician fee schedule, effective since 2003, is based on 2002 Medicare RBRVS, with conversion factors of $24.00 for anesthesia services and $52.00 for services other than anesthesia.

The proposed South Carolina physician fee schedule, proposed effective 1/1/2010, is based on 2009 Medicare RBRVS, and increases the conversion factors to $30.76 for anesthesia services and $53.04 for services other than anesthesia.

NCCI was requested to separately quantify the impact due to the changes in RBRVS only; as well as the impact due to the combined changes in RBRVS and conversion factors.

Actuarial Analysis of Proposed Changes

NCCI's methodology assumes that the difference between the current and proposed Maximum Allowable Reimbursements (MARs) for each medical procedure is a reasonable estimate of the actual difference in costs due to the changes in reimbursements to the South Carolina physician fee schedule.

For each medical procedure, the MARs under the current fee schedule were calculated based on the **2002** Medicare RBRVS and the current South Carolina conversion factor. The MARs under the proposed fee schedule were based on the **2009** Medicare RBRVS and the proposed South Carolina conversion factors.

Procedures other than Anesthesia
The formula used to calculate the facility and non-facility MARs for various medical procedures other than anesthesia under the current and proposed fee schedules are as follows:

Current Non-Facility MAR= [2002 Work RVU + 2002 Fully Implemented Non-Facility PE RVU + 2002 MP RVU] x Current South Carolina CF ($52.00)

Current Facility MAR= [2002 Work RVU + 2002 Fully Implemented Facility PE RVU + 2002 MP RVU] x Current South Carolina CF ($52.00)

Proposed Non-Facility MAR= [2009 Work RVU + 2009 Fully Implemented Non-Facility PE RVU + 2009 MP RVU] x Proposed South CF ($53.04)

Proposed Facility MAR= [2009 Work RVU + 2009 Fully Implemented Facility PE RVU + 2009 MP RVU] x Proposed South Carolina CF ($53.04)

Where: RVU = Relative Value Unit for Physicians,
PE = Practice Expense,
MP = Medical Malpractice insurance, and
CF = Conversion Factor

Anesthesia

For anesthesia procedures, the MARs under the current and proposed fee schedules were calculated using the following general formula:

Current MAR = (2002 Medicare Anesthesia Basic Unit + TVA) x Current South Carolina Anesthesia CF ($24.00)

Proposed MAR = (2009 Medicare Anesthesia Basic Unit + TVA) x Proposed South Carolina Anesthesia CF ($30.76)

Where: TVA = Time Value Amount (Each TVA is in 15 minute increments)

Under the current and proposed fee schedules, the facility and non-facility costs for each procedure is the MAR for that procedure multiplied by the number of occurrences for that procedure[1]. Procedures for which no RVU is assigned in either the current or proposed Medicare RBRVS schedules are excluded from this analysis.

The estimated impact on costs subject to the physician fee schedule is the ratio of the total facility and non-facility costs of procedures under the proposed South Carolina physician fee schedule to the total facility and non-facility costs of procedures under the current South Carolina physician fee schedule. The direct impact of the proposed changes to RBRVS only is +2.7%. The direct impact of the combined changes to RBRVS and the increase in conversion factors is +5.4%.

For those procedures in which the fee schedule maximum was reduced[2], the savings were adjusted to account for the anticipated increases in volume and shifts in the mix of services that will likely offset some of the reduction in fees. The magnitude of this adjustment is based on an analysis performed by the Centers for Medicare and Medicaid Services, which suggests that an increase in the volume and intensity of services is associated with a reduction in fee schedule reimbursement rates (refer to *Physician Volume and Intensity Response* on the CMS Web site at http://www.cms.hhs.gov/ActuarialStudies/downloads/PhysicianResponse.pdf). This study suggests that any savings due to revising the schedule (other than for surgical procedures) would be offset by 30%-50%. In our analysis, the midpoint of 40% was used. No adjustment

[1] Based on South Carolina workers compensation data licensed to NCCI, for service year 2007.

[2] Fees were reduced for some procedures in every physician service category due to decreased relative value units under the 2009 Medicare RBRVS.

was made for surgical procedures because we assume these procedures do not incur an increase in volume and intensity of services due to a reduction in the reimbursement level.

The following table shows the breakdown of impacts on physician costs (after adjustment for shifts in mix and volume of services) by category as a result of the change in RBRVS only—i.e., using the current conversion factors ($24.00 for anesthesia and $52.00 for services other than anesthesia) for both current and proposed schedules:

Impacts Due to Change in RBRVS Only		
Service Category	**Cost Distribution[1]**	**Impact**
Anesthesia	2.9%	0.0%
Surgery	33.1%	-9.8%
Radiology	17.1%	+8.2%
Pathology and Laboratory	0.1%	+27.1%
Medicine	3.2%	+10.7%
Physical Medicine	22.0%	+6.5%
Evaluation and Management	21.6%	+14.6%
Impact on Physician Costs	100.0%	**+3.1%**

The estimated impact of +3.1% (due to the changes in RBRVS only) is then multiplied by the South Carolina percentage of medical costs that are subject to the physician fee schedule (41.0%)[1] to arrive at the impact of +1.3% on medical. The impact on medical is then multiplied by the percentage of South Carolina benefit costs that are medical costs (42.3%)[3] to yield a +0.5% ($5.4M) impact on South Carolina's overall workers compensation system costs.

The following table shows the breakdown of impacts on physician costs (after adjustment for shifts in mix and volume of services) by category as a result of **the combined changes of RBRVS and increase in Conversion Factors**:

Impacts Due to Combined Changes in RBRVS and Conversion Factors				
Service Category	**Current CF**	**Proposed CF**	**Cost Distribution[1]**	**Impact**
Anesthesia	$24	$30.76	2.9%	+28.1%
Surgery	$52	$53.04	33.1%	-8.0%
Radiology	$52	$53.04	17.1%	+10.2%
Pathology and Laboratory	$52	$53.04	0.1%	+29.6%
Medicine	$52	$53.04	3.2%	+12.5%
Physical Medicine	$52	$53.04	22.0%	+8.5%
Evaluation & Management	$52	$53.04	21.6%	+16.8%
Impact on Physician Costs			100.0%	**+5.8%**

[1] Based on South Carolina workers compensation data licensed to NCCI, for service year 2007
[3] Based on policy years 2005 and 2006 Financial Call data projected to 1/1/2010.

National Council on Compensation Insurance, Inc.

The above impact of the combined changes in RBRVS and conversion factors on physician costs is estimated to be an increase of 5.8%. This impact is then multiplied by the South Carolina percentage of medical costs that are subject to the physician fee schedule (41.0%)[1] to arrive at a +2.4% impact on medical costs. This impact on medical costs is then multiplied by the percentage of South Carolina benefit costs that are medical costs (42.3%)[3] to yield a +1.0% impact on South Carolina's overall workers compensation system costs.

The impact due to the changes in the physician fee schedule, due to the change in RBRVS only as well as the combined change in RBRVS and conversion factors, is summarized in the following table:

		Impact (Change in RBRVS Only)	Impact (Combined changes in RBRVS and CFs)
(1)	Impact on Physician Costs in South Carolina	+3.1%	+5.8%
(2)	Physician Costs as a Percentage of Medical Costs in South Carolina[1]	41.0%	41.0%
(3)	**Impact on Medical Costs in South Carolina = (1) x (2)**	**+1.3%**	**+2.4%**
(4)	Medical Costs as a Percentage of Overall Workers Compensation System Costs in South Carolina[3]	42.3%	42.3%
(5)	**Total Impact on Overall Workers Compensation System Costs in South Carolina = (3) x (4)**	**+0.5%**	**+1.0%**

[1] Based on South Carolina workers compensation data licensed to NCCI, for service year 2007
[3] Based on policy years 2005 and 2006 Financial Call data projected to 1/1/2010.