2015 REPORT ON MEDICAL FEES AND DATA IN WORKERS' COMPENSATION

A Report to the Chairmen of the Commerce and Labor Committees of the House of Delegates and the Senate of Virginia pursuant to Chapter 456 of the 2015 Acts of Assembly of the Commonwealth of Virginia

Virginia Workers' Compensation Commission

Virginia Workers' Compensation Commission

2015 Report on Medical Fee Schedules in Workers' Compensation

December 15, 2015

OUR MISSION

To serve injured workers, victims of crimes, employers, and related industries by providing exceptional services, resolving disputes, and faithfully executing the duties entrusted to us by the Commonwealth of Virginia.

Wesley G. Marshall, Chairman

Roger L. Williams, Commissioner

R. Ferrell Newman, Commissioner

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Summary of House Bill 1820

On March 23, 2015, Virginia Governor Terry McAuliffe signed into law Chapter 456 of the Acts of Assembly, 2015, which originally was enacted by the General Assembly as House Bill 1820 ("HB 1820").[1] HB 1820 amended prior law as follows:

- The amendments added section "B" to Va. Code § 65.2-605 and directed the Virginia Workers' Compensation Commission ("the Commission") to determine the number and geographic areas of communities across the Commonwealth used in determining workers' compensation medical pricing. In establishing communities, the Commission was instructed to consider the ability to obtain relevant charge data based on geographic areas and other criteria consistent with the Virginia Workers' Compensation Act. The law required the Commission to promulgate regulations to implement the provisions of the act to be effective within 280 days of its enactment and to provide the opportunity for public comment prior to adoption.

- The amendments directed the Commission to convene a work group of stakeholder representatives of employers, health care service providers, claimants, and insurers to advise and assist in (i) reviewing, analyzing, and comparing information contained within and reports on all possible databases containing workers' compensation or health care data for medical services rendered in Virginia, (ii) reviewing, analyzing, and comparing information contained within and reports on how similar databases are used for the establishment of the pecuniary liability of the employer in other states, and (iii) making findings or recommendations as to how the databases reviewed and the contents thereof may serve to enhance or replace Virginia's current mechanisms for establishing the pecuniary liability of the employer. The Commission was instructed to report its findings and recommendations to the Chairmen of the House and Senate Commerce and Labor Committees by December 15, 2015.

The Stakeholder Working Group

Beginning in the Spring of 2015, the Virginia Workers' Compensation Commission, with the support and leadership of Delegate Peter Farrell (56th District), invited input to compose the Stakeholder Working Group. The participants included:

Legislative Representative

The Honorable Peter F. Farrell	Virginia House of Delegates

Virginia Workers' Compensation Commission

The Honorable Roger L. Williams	Chairman, Virginia Workers' Compensation Commission[2]
The Honorable Wesley G. Marshall	Commissioner, Virginia Workers' Compensation Commission
The Honorable R. Ferrell Newman	Commissioner, Virginia Workers' Compensation Commission

Physicians and Medical Providers

W. Scott Johnson, Esquire	Medical Society of Virginia
D. Calloway Whitehead, III, Esquire	Orthopaedic Society of Virginia
Michael Lundberg	Virginia Health Information
Steven J. Liebovic, M.D.	Orthopaedic Physician and Hand Surgeon

Hospitals

James B. Andrews, III	Virginia Hospital & Healthcare Association
Michael J. Paladino	VCU Health System

Employers

Michael Allen	Virginia Association of Automobile Dealers

Insurers

John G. Heard, Esquire	Virginia Self-Insured Association
Taylor Cosby	American Insurance Association
J. Christopher Lagow, Esquire	Property Casualty Insurers Association of America, Nationwide Insurance

Injured Workers and Attorneys

Gregory O. Harbison, Esquire	Virginia Trial Lawyers Association
D. Edward Wise, Jr., Esquire	Southwest Virginia Workers' Compensation Bar Association

Labor

Doris Crouse-Mays	Virginia AFL-CIO

Area of Inquiry

In recent years, Virginia's workers' compensation system has experienced notable growth in medical expenses paid for work related injuries. With rising costs funded by employer premiums, stakeholders in industry, labor, and the legal community have focused on the source of the growth and potential solutions.

Virginia's Statutory Framework for Medical Expenses in Workers' Compensation

Workers' compensation laws are legislatively enacted and do not result from development of the common law. In the early 20th century, virtually every state in the nation enacted some form of workers' compensation law which provided medical benefits and wage replacement for industrial accidents. In Fauver v. Bell, 192 Va. 518, 65 S.E.2d 575 (1951), the Virginia Supreme Court discussed "the objects and purposes of workmen's compensatory legislation and the changes which it has wrought in the rules of the common law." Id. at 521, 65 S.E.2d at 577. The Court stated:

> The legislation was for the beneficent purpose of providing compensation, in the nature of insurance, to a workman or his dependents, in the event of his injury or death, for the loss of his opportunity to engage in gainful employment when disability or death was occasioned by an accidental injury or occupational disease, to the hazard or risk of which he was exposed as an employee in the particular business, without regard to fault as to the cause of such injury or death. The pecuniary loss incident to the payment of the compensation is cast upon the employer as a part of the expenses of his business.
>
> Under the Act both employer and employee surrender former rights and gain certain advantages. The employee surrenders his right to bring an action at law against his employer for full damages and agrees to accept a sum fixed by statute, based on the extent of his injuries and the amount of his wages. He gains a wider security in line with the more inclusive recovery afforded. The employer surrenders his right of defense on the grounds of contributory negligence, assumption of risk and the fellow servant rule. He is relieved from liability for damages to the employee for which in an ordinary negligence case he might otherwise be liable to a much greater extent. Negligence is of no concern in a compensation case unless the injury is caused by the employee's wilful negligence or misconduct. Rules of evidence are relaxed and procedures simplified. Rights granted and obligations imposed are limited as granted or imposed by the Act and are in their nature contractual. Enacted for the purpose of attaining a humanitarian end, the legislation, although in derogation of the common law, is highly remedial and is to be liberally construed. 192 Va. at 521-22, 65 S.E.2d at 577.

Virginia Workers' Compensation Act includes a mandate for payment of medical expenses due to industrial accidents. Virginia Code § 65.2-605 states, in relevant part:

> The pecuniary liability of the employer for medical, surgical, and hospital service herein required when ordered by the Commission shall be limited to such charges *as prevail in the same community for similar treatment when such treatment is paid for by the injured person* and the employer shall not be liable in damages for malpractice by a physician or surgeon furnished by him pursuant to the provisions of § 65.2-603, but the consequences of any such malpractice shall be deemed part of the injury resulting from the accident and shall be compensated for as such. (emphasis added)

The medical expense payment rate is referred to in the workers' compensation community as "Prevailing Community Rate," or "PCR." The 2010 report of the Virginia Workers' Compensation Commission on medical expenses in workers' compensation discussed the history and development of the PCR in Virginia:

The predecessor of Code § 65.2-605 was Code § 65-86 (1950). That section read as follows:

> The pecuniary liability of the employer for medical, surgical and hospital service herein required when ordered by the Commission shall be limited to such charges *as prevail in the same community for similar treatment of injured persons of a like standard of living when such treatment is paid for by the injured person* and the employer shall not be liable in damages for malpractice by a physician or surgeon furnished by him pursuant to the provisions of the preceding section, but the consequences of any such malpractice shall be deemed part of the injury resulting from the accident and shall be compensated for as such. (emphasis added)

Pre-1994, North Carolina's statute contained similar language. N.C. Gen. Stat. § 92-76 provided:

> The pecuniary liability of the employer for medical, surgical, hospital service, nursing services, medicines, sick travel or other treatment required when ordered by the Commission, shall be limited to such charges *as prevail in the same community for similar treatment of injured persons of a like standard of living when such treatment is paid for by the injured person.* (emphasis added)

In a North Carolina case decided under that version of the statute, Charlotte-Mecklenburg Hosp. Auth. v. North Carolina Indus. Comm'n, 443 S.E.2d 716 (N.C. 1994), the North Carolina Supreme Court concluded that the legislature intended "that the employer not be charged more than his employee would have been had the employee paid for the services." Id. at 727. The court found that the legislature intended that the Commission's authority under the statute "be limited to review and approval of hospital charges to ensure, first, that the employer is charged only for those reasonably required services, and, second, that the employer is not charged more for such services than the prevailing charge for the same or similar hospital service in the same community." Id.

The court discussed the climate that existed before workers' compensation statutes were enacted:

> Before the 1930s, most people did not have private health insurance; the only extensive private health plans offered direct services, usually to employees in an industry. Paul Starr, *The Social Transformation of American Medicine* 294 (1982) [hereinafter "Starr"]. Hospitals generally provided three classes of service: wards for the poor and working-class, semi-private rooms for the middle-class, and private rooms for the wealthy. [Footnote 1: Few class distinctions could be more sharply delineated. While ward patients were attended by the hospital staff, private patients were attended by doctors of their choice. Ward and private patients usually received two different kinds of food, and ward patients were often not permitted to see friends and relatives as frequently as were private patients. Starr at 159.] In some communities, hospitals were segregated by race. Anne M. Dellinger, "A History of Hospitals in North Carolina," in *Hospital Law in North Carolina* 1-History, 7-History to 8-History (Anne M. Dellinger ed., 1985) [hereinafter "Dellinger"] (In Greensboro, L. Richardson Hospital, established in 1927, "remained the only facility open to blacks on a non-discriminatory basis until 1963, when Wesley Long and Cone Memorial hospitals were integrated by court order."). Physicians and hospitals could increase profits both by providing additional services and by charging according to the patient's ability to pay. *See* Starr at 291.

Thus, when the Virginia Workers' Compensation Act developed, most people did not have private health insurance. Hospitals provided different levels of service based on a person's class or race, and hospitals charged according to a patient's ability to pay. It was in this climate that the General Assembly enacted the provision regarding charges for services limiting the fees to those that prevailed in the same community for similar treatment of injured workers “of a like standard of living when such treatment is paid by the injured worker.” Va. Code § 65-86 (1950). The statute was designed to prohibit medical providers from charging more when an injured worker was covered by workers' compensation insurance. The statute was later amended to delete the language "of injured persons of a like standard of living" but still provides that rates be based on the payment an injured worker would pay.[3]

Viewed from an historical perspective, it is likely the General Assembly did not foresee any need to differentiate between workers’ compensation and other medical payments. With advancement of the workers’ compensation system and greater incentives to control medical costs, there are notable differences between workers’ compensation and other medical payment systems, notwithstanding the fact that the medical treatment does not differ.

Commission Rule 14

Considering the need to define a "community" for the purpose of Va. Code § 65.2-605, the Commission passed Rule 14 under its rulemaking authority. For many years, Rule 14 provided for 15 communities used to determine the PCR. These communities were derived from individual and combined geographic Planning District Commissions established pursuant to the Code of Virginia.[4]

While serving as a useful framework, the 15 communities under Rule 14 created some challenges. In some cases, employers who sought to challenge whether a provider's charge exceeded the PCR could not find sufficient data within a community to ascertain the PCR. Since 1996, Rule 14 provided the Commission could consider, "additional data," to determine the PCR when it deemed this "appropriate." In its judicial decisions, the Commission has resorted in those cases to considering data from adjacent communities. In one case, a divided Commission accepted data from adjacent communities which represented a substantial portion of the Commonwealth. A majority of the Commission applied the "additional data" provision of Rule 14 to consider adjacent communities. A dissenting Commissioner reasoned it was inconsistent with Va. Code § 65.2-605 to define the prevailing rate for a "community," by using data derived almost exclusively from beyond it.[5]

In HB1820, the General Assembly directed the Commission to establish the number and geographic area of the Commonwealth, and in doing so to consider the ability to obtain relevant charge data based on geographic area and such other criteria as are consistent with the purposes of the Workers' Compensation Act.

In the Spring of 2015, the Commission investigated the current viability of Rule 14. As a result of a request for proposal, the Commission originally considered adoption of a virtual community structure. This would have created geographic communities grouped and determined by the similarity of medical provider charges. The methodology suggested a benefit of eliminating the likelihood of insufficient data within a community to determine the Prevailing Community Rate. The Commission solicited stakeholder input as part of this process. While recognizing a potential benefit, a majority of interested stakeholders favored adoption of fewer communities defined solely by geography. One important consideration was that while defining virtual communities by charge patterns appeared to work well in trials for physicians and other medical practices, there was less predictability about the viability of applying this methodology to hospitals and other large-scale medical providers.

On October 26, 2015, the Commission adopted an amended Rule 14 which defined five geographic communities for determining the Prevailing Community Rate. (Appendix 1). The Rule was adopted as an emergency regulation and is currently in the process of adoption as a final Rule under the Administrative Process Act. The Commission anticipates the revised Rule will have a positive impact on eliminating instances where insufficient data within a community prevents calculation of a Prevailing Community Rate.

Virginia's Workers' Compensation Medical Costs Are Rising

Despite apparent increasing efficiencies in overall workers' compensation premiums, for the past several years stakeholders have expressed concern over increasing medical expenses in workers' compensation claims. This has become a focus of possible legislation for the past several years.

Anecdotally, many Stakeholder Working Group members from the employer and insurer community related that twenty to thirty years ago, the common understanding was that for the average workers' compensation claim, indemnity costs represented two-thirds and medical costs represented one-third of all claim costs. More recently, research establishes that medical costs are the prevalent cost driver in Virginia workers' compensation claims.

The National Council on Compensation Insurance reported as of 2012 medical costs represented approximately 65.2% of total workers' compensation benefit costs.[6]

On August 19, 2015, Bogdan Savych, Ph.D., a Public Policy Analyst with the Workers' Compensation Research Institute,[7] gave a presentation to the Virginia Stakeholder Working Group. As part of WCRI's Medical Cost Benchmark study program, research from Virginia experience revealed:

- Virginia medical payments per claim were amount the highest of a sixteen (16) state study[8] group.

- Virginia's higher medical payments per claim were most strongly driven by higher medical service prices.

- Generally, states with charge-based fee schedules had higher prices than states with fixed-amount fee schedules.

- Implementation of fee schedules may induce changes in provider behavior that may offset expected savings.

For a study period of 2011 through 2014, Virginia had an average medical payment per claim total of $21,659. The median state in the study group had average medical payments per claim of $16,289.

From 2011 to 2013, Virginia workers' compensation claims had higher payments per claim for both hospital and nonhospital care. Hospital outpatient payments per claim were 38% higher than the 16 state median. Inpatient payments per inpatient episode were 11% higher than the 16 state median. Nonhospital payments per claim were 25% higher than the 16 state median. Generally, this demonstrates medical costs are higher across the board for Virginia workers' compensation claims compared to other states. Higher costs and are not centralized within hospital versus nonhospital payments.

WCRI's research also demonstrated Virginia's higher than average medical costs per claim were more driven by higher prices paid than by overutilization. For Virginia's nonhospital

payments, the 25% increase over the median resulted from 18% higher prices paid and 9% higher utilization. The results were more distinct for hospital payments. The 38% increase over the median resulted from 52% higher than median payments per service, compared to -12% services per claim. While fewer than average services were rendered, the prices for the services were higher.

WCRI studies address the impact of medical fee schedules in workers' compensation systems at a high level. Research suggests that for nonhospital services, states without fee schedules, such as Virginia, have higher prices. For hospital services, states with charge-based fee schedules have higher prices than states with fixed-amount fee schedules. States with no fee schedules have higher prices than states with fixed-amount fee schedules.

Using 2013 data, WCRI used a 25 state study group to compare nonhospital workers' compensation prices. On a medical price index for professional services, the lowest price states were all states with fee schedules. The six states without medical fee schedules (Virginia, Iowa, Missouri, New Jersey, Indiana, and Wisconsin) all exceeded the median medical price index. Virginia had the lowest medical price index among the non-fee schedule states.

Analyzing data from 2002 to 2013, the trends were for medical prices to grow faster in states without fee schedules as compared to states with fee schedules. Virginia nonhospital prices over that period grew at rates similar to other non-fee schedule states.

WCRI has examined workers' compensation medical costs for hospitals. A general review reveals a number of approaches for determining medical pricing for hospitals. WCRI reports that most states have some type of hospital outpatient fee schedule:

TABLE 1

Workers' Compensation Hospital Outpatient Fee Cost Regulations[9]

Type of Hospital Outpatient Fee Regulations	Number of States
Fixed-Amount Fee Schedule	24
Percent of Charge Based Fee Regulation	12
Cost-to-Charge Ratio	4
No Fee Schedule	10

Using hospital cost indexes for 2013, WCRI demonstrated that most states with fixed amount fee schedules had lower hospital outpatient payments. States with no fee schedules had higher hospital outpatient payments than those with fixed amount fee schedules. States with charge-based fee schedules demonstrated higher hospital outpatient payments compared to fixed amount fee schedules and even some states without fee schedules. For instance, in 2013 Louisiana, Alabama, and Florida all had charge based fee schedules for hospital outpatient payments which exceeded those in Virginia, which had no fee schedule.[10]

For hospital outpatient surgery costs, Virginia trended toward the high end of a 25 state comparative study. Among the non-fee schedule states (Virginia, Iowa, Missouri, New Jersey, Indiana, and Wisconsin), Virginia and Wisconsin had the highest hospital cost index for outpatient surgery costs. As with the preceding comparison, some states with percent of charge based fee schedules (Florida, Louisiana, and Alabama) had higher costs than states with no fee schedule.[11]

WCRI also has studied the rate at which workers' compensation medical costs grow over time. The research demonstrates from 2006 to 2013, hospital outpatient surgery costs grew faster in states with no fee schedule, like Virginia, when compared to states which had fee schedules. From 2006 to 2013, Kentucky, which has a medical fee schedule, had approximately a 10% increase in hospital outpatient surgery costs. During the same time, WCRI's data suggests Virginia had a 60% cumulative increase in costs. Virginia was at the high end compared to other states with no fee schedules.[12]

WCRI noted that policymakers should give careful consideration to the possibility of negative consequences of enacting a fee schedule. They recited adaptive behavior of medical providers as utilization preferences changed after Florida reforms in 2003. Providers substantially increased the utilization of unscheduled radiology procedures versus scheduled radiology procedures because the unscheduled were priced higher under the fee schedule reform.

Are There Factors Which Control or Exert Downward Pressure on Virginia's Workers' Compensation Medical Costs?

Virginia has a charge based system. The definition of Prevailing Community Rate in Va. Code §65.2-605 provides a limit on medical payments for workers' compensation cases. The determination of Prevailing Community Rate is limited to such charges as prevail in the same community for similar treatment when such treatment is paid for by the injured person.[13]

Pursuant to common law principles accepted by Virginia courts, medical bills received by an injured employee are prima facie evidence that the charges are reasonable and necessary.[14] Defendants challenging a medical provider's bill have the burden of establishing the billed fees are excessive compared to the prevailing rate in the same community.

In practice, employers and insurers frequently challenge medical provider charges on the grounds that they exceed the Prevailing Community Rate. They employ medical bill reviewers and clearinghouses which compare provider charges to a calculated Prevailing Community Rate from statistical data.

The 2010 Saslaw Report noted that in 2000, the Commission reported 236 applications were filed seeking adjudication of a medical pricing dispute between employers or insurers and health care providers. By 2009, the number had risen to 1,298. From January through May 2010, the Commission received 656 of these applications.[15] More recent reviews by the Commission reveal the trend toward increased medical fee litigation has remained steady and strong, with over 1,000 cases currently filed.

In many cases, employers and insurers are able to obtain quality statistical data to challenge medical provider charges and to obtain limits on payment through adjudication. Anecdotal evidence suggests that this, together with the desire to avoid litigation and to obtain prompt payment, often leads to resolution through informal negotiation by the parties. The scope of successful resolution cannot easily be ascertained because many of these cases resolve before a formal claim is filed.

Network agreements also provide a limitation on medical fee payments in workers' compensation. Employers, workers' compensation insurers, and their agents may enter into contractual agreements to limit medical fee payments to an agreed rate. The Commission is often called upon to interpret contractual agreements between health care providers and insurance carriers. In the absence of fraud, mutual mistake, or violation of law or public policy, the Commission will uphold these contractual agreements. However, the employer and insurer have the burden to prove the existence and applicability of the contract upon which they claim a discount.[16]

During the Stakeholder Working Group meetings, anecdotal evidence was discussed regarding the prevalence of health care network contracts or Preferred Provider Organizations ("PPO's"). Some commenters suggested approximately one-third of medical bill payments in Virginia workers' compensation cases were subject to a network or PPO agreement. The prevalence of these relationships and the extent of discounts they afford could not be easily ascertained in the context of the Stakeholder Working Group due to considerations of confidentiality and trade secrets.

In September 2015, the Commission approached the National Council on Compensation Insurance. NCCI collects nationwide information relating to workers' compensation premiums, claims costs and other statistical data. The Commission asked NCCI to review its medical data call information to determine the relative percentages of workers' compensation payments which are and are not made pursuant to a network agreement or PPO. NCCI's response using its 2014 data is attached as Appendix 2 to this report.

NCCI found that for physician transactions, 69% were made pursuant to a network or PPO and 31% were not. Slight variances occurred for physician charges and payments, but these were consistent. NCCI reported for Virginia, average workers' compensation physician payments with a network or PPO were $113, versus $150 for out of network charges. This demonstrates network and PPO payments were approximately 25% lower than out of network payments. Similar differences were found for physician charges in and out of network.

With regard to pharmacy payments, 78% of payments and almost 81% of transactions were made pursuant to a network or PPO arrangement. As with physician payments, out of network payments for pharmacy items were notably higher than those made pursuant to a contractual arrangement.

NCCI's data establishes approximately two-thirds of all physician and pharmacy payments are made pursuant to network and PPO contractual arrangements. The network and PPO payments are notably lower than payments made for out of network providers and

pharmacies. This supports the general belief that network agreements have substantial penetration in Virginia workers' compensation medical payments and that they serve to control the cost of medical treatment.

Common Procedure Comparisons for Virginia

At the August 19, 2015 Stakeholder Working Group Meeting, Dr. Savych presented comparative analysis regarding common procedures. These demonstrated difference in payments for workers' compensation, group health, and the Medicare reimbursement rate for Virginia:

TABLE 2

Comparison of Medical Payments for Common Procedures
2009 Payments[17]

Median Prices Paid in 2009 In Virginia	Workers' Comp	Group Health (GH)	WC Prices Paid Over GH	Medicare Rate For VA
Common Knee Arthroscopy (CPT 29881)	$1,355	$788	72%	$561
Common Office Visit	$77	$66	18%	$59

These statistics demonstrate there are differences in pricing between workers' compensation and typical group health insurance payments for the same medical procedures.

Are Differences In Medical Payments for Workers' Compensation Versus Group Health Insurance Covered Treatment Justified?

During the Stakeholders Working Group meetings, participants challenged and defended differences in medical provider charges for workers' compensation versus group health insurance. In one judicial opinion in 2012, the Commission held a medical provider who maintained a separate fee schedule for workers' compensation which was substantially higher than its other charges was not entitled to a presumption that its charges were reasonable and necessary.[18] Nonetheless, at a Stakeholders Working Group meeting, a medical provider's representative stated the practice group maintained a separate charge schedule for workers' compensation which was different than group health insurance charges. A number of commenters suggested this practice was not uncommon, but its extent is unknown.

Employers and Insurers pointed to disparity in payments for the same procedure for a workers' compensation case as opposed to one covered under group health insurance. They suggested that the same medical service was being provided and therefore there was little or no justification for a significant difference in price.

Medical Providers explained there are real differences between treating workers' compensation patients and group health covered patients. In the latter cases, the provider performs the service, bills the insurer, and receives payment after bill review. The typical workers' compensation case requires much more. A commenter at the August 19, 2015 Stakeholder Working Group Meeting provided the following illustrations comparing a workers' compensation versus group health patient and payment timing:

TABLE 3

Comparison of Medical Treatment Workflow:
Non-Workers' Compensation versus Workers' Compensation Patients

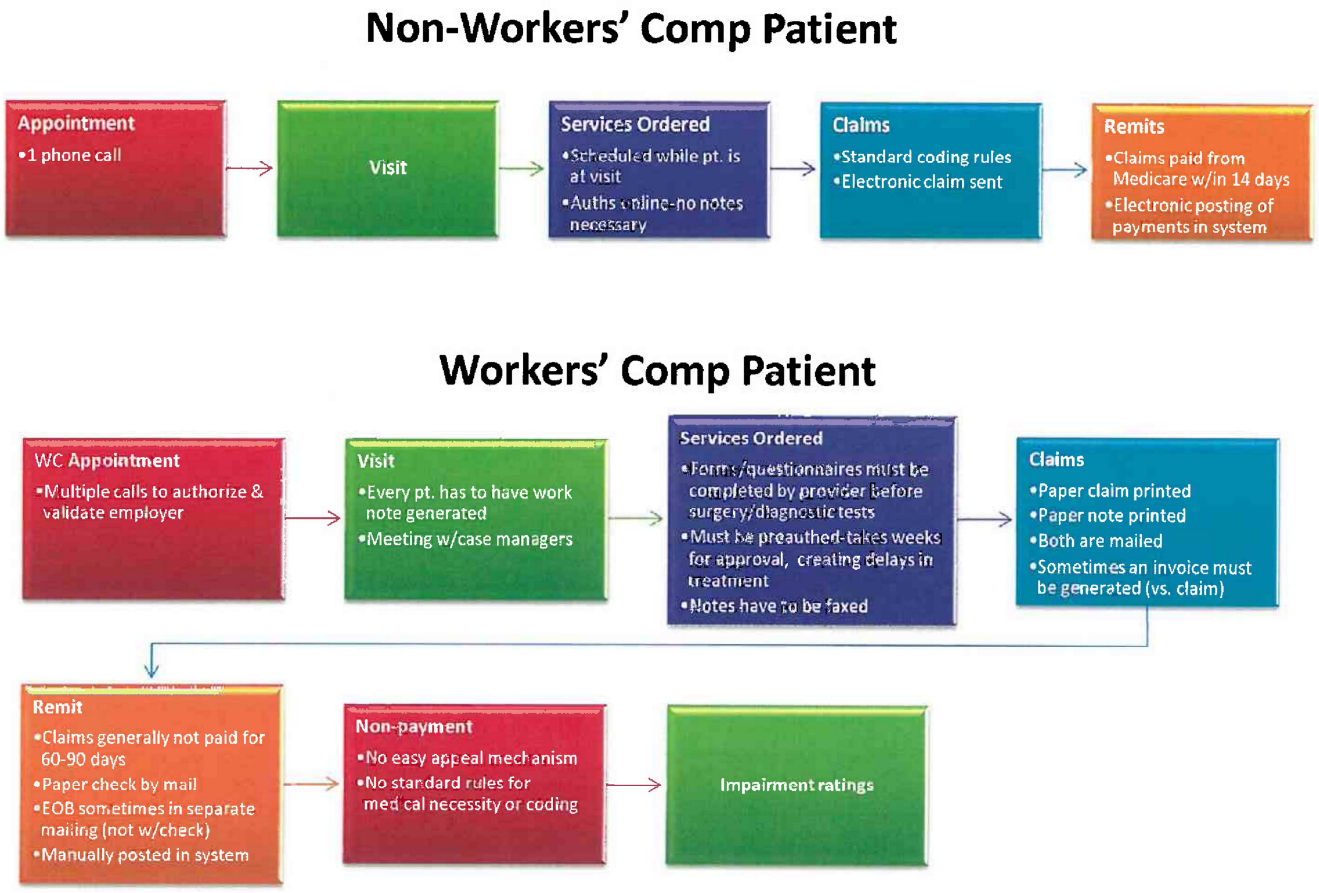
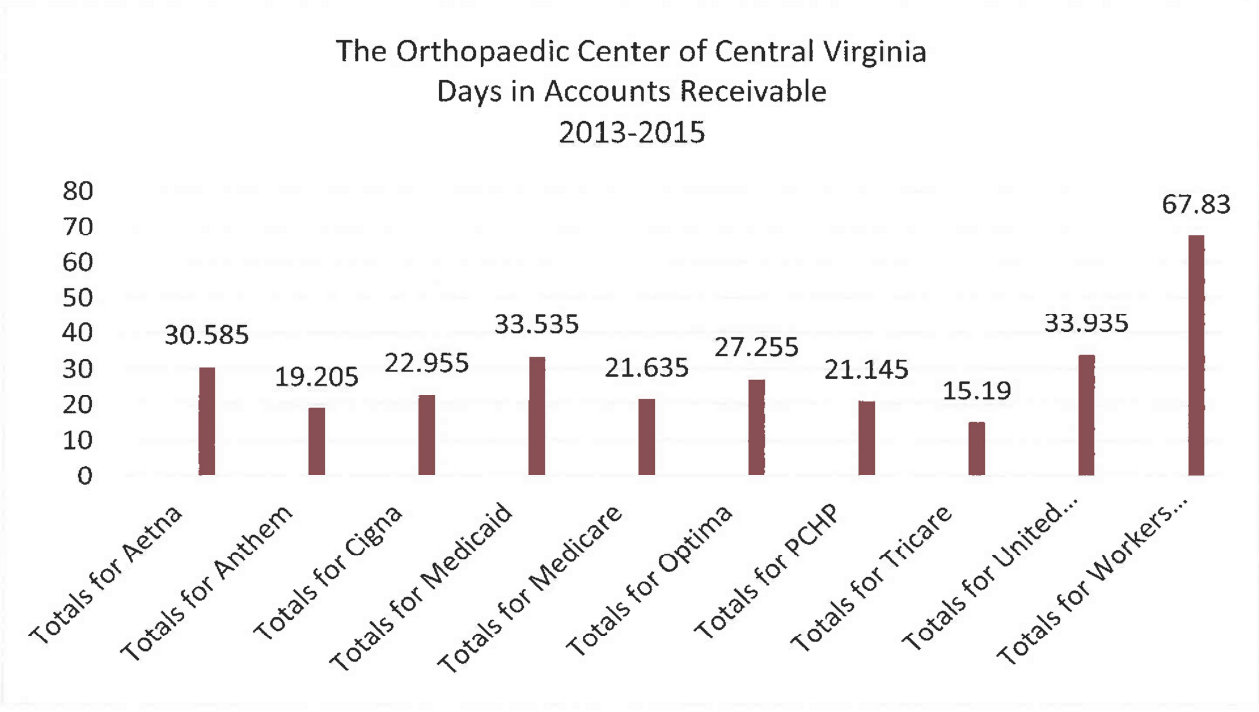


TABLE 4

Comparison of Medical Treatment Timeline of Accounts Receivable: Non-Workers' Compensation versus Workers' Compensation Patients



This chart demonstrates under current procedures for one Virginia Orthopaedic practice, the time from service to payment under Medicare and Medicaid averaged from 22 to 34 days. Payments from private insurers averaged from 15 to 34 days. Payments for workers' compensation average 68 days, or approximately two to three times longer than other payors.

Stakeholder Working Group Presentations

During the Stakeholder Working Group meetings, a number of speakers were invited to comment upon existing or possible fee schedule or other cost control mechanisms. They are summarized below

Virginia All Payers Claims Database

Michael Lundberg, Executive Director of Virginia Health Information, presented information regarding the All Payers Claims Database ("APCD"). Creation of the APCD was authorized by the General Assembly in 2012. Under authority of the Virginia Department of Health, Virginia Health Information is permitted to gather medical provider data for non-workers' compensation claims. The ACPD collects payment data, not provider charge data. It

adopted national data standards and all major commercial health insurers participate. The APCD amalgamates payment data and organizes it by payment, geography pursuant to Standard Metropolitan Statistical Area ("SMSA"), relative values and relative value units.

The APCD is in the implementation phase. It has collected four years of data and as of May 2015 it had "loaded" data through March 2015. Mr. Lundberg explained how the APCD could be used to either determine the Prevailing Community Rate under existing law or to set payment rates for a workers' compensation fee schedule. The APCD does use a proxy structure to approximate average payment rates. The APCD uses paid claims from commercial health insurance payments, Medicare, the Department of Medical Assistance, and other government sources, but not employers or workers' compensation insurers.

FAIR Health Database

The Stakeholder Working Group received a briefing from representatives of FAIR Health. FAIR Health is a national, independent, not-for-profit corporation whose mission is to bring transparency to healthcare costs and health insurance information. It develops robust, unbiased data products and solutions to meet the needs of health plans, policymakers, insurers, government officials, bill reviewers and administrators, healthcare systems, hospitals and other facilities, healthcare providers, pharmaceutical companies, researchers and consultants.

FAIR Health, Inc. was established in October 2009 as part of the settlement of an investigation by the state of New York into health insurance industry reimbursement practices which had been based on data compiled and controlled by a major insurer. FAIR Health was formed to create a conflict-free, robust, trusted and transparent source of data to support adjudication of healthcare claims and to promote sound decision-making by participants in the healthcare industry.

FAIR Health provides an independent database of health care payment information contributed by nationwide contributors. It maintains a free website to educate consumers about the cost of care in their geographic areas. FAIR Health is used by a number of states to set rates for workers' compensation medical fee schedules.

Jonathan Nutt, AIG Insurance

A presentation to the Stakeholder Working Group was offered by Jonathan Nutt, Head of Business Operations, Medical Management Services for AIG Property Casualty. Mr. Nutt offered observations regarding workers' compensation medical fee schedules from the perspective of a nationwide workers' compensation insurance carrier which operates in multiple jurisdictions. Because AIG issues coverage in many states, it has the opportunity to make interstate comparisons.

Mr. Nutt recommended considering a medical fee schedule as a mechanism to reduce the operational friction in a workers' compensation system. Providers may contend fee schedules are a mechanism to reduce the amount paid for the services they deliver. Insureds may favor fee schedules as a way to reduce excessive charges.

Mr. Nutt suggested effective workers' compensation fee schedules should:

- Provide fair reimbursement to medical providers for the services delivered
- Control costs of medical treatment in order to ensure that employers remain viable and competitive in Virginia
- Ensure that all stakeholders understand the methodology used and be transparent
- Allow for updates to fees to remain current
- Not add unnecessary cost to the system

Fee schedules incorporate various methods for fee calculation and have been adopted in various jurisdictions:

- Medicare including RBRVS and conversion factors
    - Utilized in many states including TN, WV, and NC
- Medicare with markup
    - Utilized in CO and UT. NV expected to move to this in the near future
- Local data based (typically charge based)
    - Charge based schedules in use in FL and KY
- RVP (Relative value for physicians)
- OWCP (US Dept. of Labor Office of Workers' Compensation Programs)
    - Used in CA previously but removed in recent revisions

The selection of an optimal fee schedule basis depends on the objectives sought. Mr. Nutt pointed out that successful medical fee schedules employ a clear, understood methodology; they make rates which are fair to all sides; and they allow for regular updates. They also ensure all services and providers are covered and minimize additional costs to the system. An effective fee schedule includes appropriate mechanisms for communication and education of stakeholders.

Karen Simonton, Executive Director, Orthopaedic Clinic of Central Virginia

At the invitation of the Stakeholder Working Group, Karen Simonton, Chief Administration Officer of the Orthopaedic Clinic of Central Virginia in Lynchburg, Virginia to offer a medical provider's perspective on medical payments in workers' compensation claims. Ms. Simonton provided the outline of workers' compensation medical payment processes and the accounts receivable timeline included in this report. These demonstrate that for an orthopaedic physician, the workflow from service to payment for workers' compensation patients as opposed to group health or other payors is more involved and complicated. The

payment timeline also demonstrated that workers' compensation payment procedures involve substantially longer periods of time to obtain payment.

Ms. Simonton discussed projects underway in the Medicare system to depart from a fee for service model and instead to provide a single payment for treatment of a condition. She described this as an innovative approach which would reward medical providers who obtained efficient and effective outcomes.

The Injured Workers' Perspective

The Stakeholders Working Group also heard testimonial evidence from an exemplary claimant who was injured in a Virginia occupational accident. The worker described her perception of substantial delay prior to being provided a physician panel pursuant to the Workers' Compensation Act. During the process of receiving medical care, she described denial of authorization to treat which led to a prolonged delay in access to medical treatment, with attendant physical and economic hardships as a result.

Medical Costs Peer Review Program

During the Stakeholder Working Group meetings, a number of participants commented on Virginia's Peer Review process for workers' compensation claims. Chapter 13 of the Virginia Workers' Compensation Act provides for peer review of medical costs for physician services rendered to injured workers. The peer review program falls under the direction of a nine-member Statewide Coordinating Committee appointed by the Speaker of the House of Delegates and the Senate Committee on Rules. The Statewide Coordinating Committee is comprised of five physician members and a representative of employers, employees, hospitals, and the insurance industry. Each physician member also serves as the chairman of the regional peer review committee in one of the five designated health systems areas in Virginia. Each regional committee has an additional four physician members appointed by the Statewide Coordinating Committee based on recommendations from the Medical Society of Virginia. The operations of the regional peer review committees are governed by regulations set forth at 16 VAC 30-60-10 et seq. The Statewide Coordinating Committee is governed by the regulations set forth at 16 VAC 30-70-10 et seq.

Virginia's peer review program has limited jurisdiction. It may address physicians services provided under an award from the Virginia Workers' Compensation Commission. Issues of the appropriateness, extent, and duration of prior treatment are within the program's jurisdiction for the purpose of determining acceptable costs. Decisions by the program on allowable cost are based on the standard of prevailing charges in the same community for similar treatment.

The peer review program does not have jurisdiction to determine the causal connection between an accident and a particular medical condition, the selection or change of a treating physician, and whether a current course of treatment should or should not be continued. The program does not address hospital charges, chiropractic services, prescriptions, charges by physicians who are not licensed in Virginia, or physical therapy that is not provided by or under the direct supervision of a physician.

Two primary challenges confront the peer review program: vacancies and a resulting inability or failure to act. Vacancies exist on the Statewide Coordinating Committee and the five regional committees. Currently four of the nine positions on the Statewide Coordinating Committee are vacant. On July 1, 2016, the positions of the physician member from Area IV, the hospital representative and the employer representative also will be vacant if not filled. Two of the five positions on the Area I Northwest), II (Northern) and IV (Central) regional committees are vacant. Four of the five positions on the Area III regional committee (Southwest) are vacant, and three of the five positions on the Area V regional committee (Eastern) are vacant. The Statewide Coordinating Committee has not met recently and does not have a current chairman. Seven cases are currently pending before regional committees for a hearing and decision and have been for several years, having been pending for a lengthy time.

Stakeholder Working Group members discussed the current process and generally agreed it is not fully meeting the intended legislative objectives. Some participants suggested abandoning the peer review process for workers' compensation cases. Stakeholders considered, however, that an effective peer review process could be an integral part of a medical fee schedule or other workers' compensation medical costs controls.

Considerations

A number of commenters observed that adoption of a medical fee schedule requires careful consideration:

Potential Benefits of a Medical Fee Schedule

1. *Medical Fee Schedules may serve as an effective system component to control medical costs associated with workers' compensation claims.* As of this report, forty-four states employ medical fee schedules as part of their workers' compensation systems. Only six states, including Virginia, do not utilize medical fee schedules. Research from WCRI demonstrates that states with medical fee schedules generally have lower workers' compensation medical payments than states without fee schedules.

2. *Medical Fee Schedules may have a positive effect in limiting excessive medical provider charges*. Under Virginia's workers' compensation system, medical payments are set at the Prevailing Community Rate. A medical provider's charge is prima facie evidence that the amount sought is reasonable. The legal burden shifts to an employer or insurer to provide statistical data and analysis to prove a medical provider's charge exceeds the Prevailing Community Rate. In some cases, insufficient data within one of Virginia's defined communities requires resorting to data from outside the relevant community, resulting in unpredictable results. The 2015 amendment to Commission Rule 14 may alleviate data insufficiency but is not, standing alone, a direct cost control measure. Problems of cost, timing, and efficiency that could be more effectively controlled through implementation of a comprehensive fee schedule.

3. *Medical Fee Schedules may reduce litigation over the rate of medical provider payments in workers' compensation cases.* The Commission in recent years has maintained in excess of 1,000 cases involving challenges to medical charges in workers' compensation claims. This presents a significant burden on the workers' compensation judicial system and diverts Commission resources away from deciding cases involving compensability of injury and occupational disease claims and other related matters. Implementation of an appropriate medical fee schedule may reduce litigation over medical provider charges and payments.

4. *Medical Fee Schedules May Insure Access to Quality Care*. If medical payment rates are set at a sufficient level, a medical fee schedule may insure access to quality health care treatment for injured workers. The state of Wisconsin has some of the highest workers' compensation payment rates in the United States. Anecdotal reports indicate there are few complaints about access to care because all of the best health care professionals seek out workers' compensation cases. A high fee schedule will promote access to care, just as a low fee schedule may impair it.

Potential Concerns for a Medical Fee Schedule

1. *Regulation of Medical Pricing through fee schedules may impair worker access to medical care*: There are some states where price regulation for medical services has led to difficulty in access to medical care. Under the Workers' Compensation Act, the employer has the obligation and responsibility to supply medical treatment that is prompt and adequate.[19] Some commenters related problems in other states where medical payments were limited to the point that quality medical providers elected not to take workers' compensation patients into their practices or to participate in workers' compensation networks. Some insurers reported difficulty in obtaining specialist treatment in jurisdictions with medical fee schedules including Maryland. In Massachusetts, a prior medical fee schedule set surgery rates at a rate which removed providers from the system. Some payors admitted to negotiating provider contracts to treat at rates above the fee schedule rate in order to secure care. Simply because you do not have to pay above the fee schedule rate does not mean you will never have to do so.

2. *Medical Providers May Exhibit Adaptive Behavior*: The adoption of a statutory or regulatory medical fee schedule may stimulate medical providers to engage in adaptive behavior. They may change their treatment or billing practice to maintain a perceived reasonable return from treatment in workers' compensation cases. In its August 19, 2015 presentation, WCRI provided an example of Florida's coding of MRI examinations. When Florida modified its fee schedule to permit higher charges for unscheduled MRI

examinations versus scheduled MRI examinations, providers began to code more procedures as unscheduled MRI examination in order to maximize revenues.

3. *Fee Schedules which are hard to implement or which create disincentives to participate may be ineffective.* One commenter discussed the Montana adoption of rules which reduced payment rates for designated treating physicians. Providers did not want to become designated physicians and administrator found it difficult to do so, and the rules were largely ignored.

4. *Charged Based Fee Schedules may be less effective at restraining growth in medical cost payments:* WCRI's research suggests generally that charge based fee schedules are less effective at limiting workers' compensation medical payments than fixed fee schedules or other options.

5. *Fee Schedules which do not address ancillary costs may result in excessive pricing*. Fee schedules must adequately address ancillary medical costs which do not fall within the traditional hospital or physician practice model. Various surgical implants and other durable medical equipment may not have CPT or other coding which is easily ascertainable. Failure to account for these costs can lead to excessive charges and payments

6. *Using Fee Schedules to set medical provider prices at too high a rate can negatively affect employment and business growth.* During the economic recession after 2008, California employers cited workers' compensation costs as a factor affecting decisions to liquidate business. Virginia's low cost workers' compensation system is an attractive feature promoting positive economic development.

7. *Adoption of a Fee Schedule may increase rather than decrease litigation.* If a medical fee schedule does not fully address pricing issues, if the rules are unclear or ambiguous, of if the schedule is not understood, there is a risk of increased litigation.

Final Recommendations

In proceedings concurrent with the meetings of the Stakeholder Working Group, participants have engaged in a variety of informal negotiations to try to achieve agreement on proposed medical fee schedule legislation. These have involved representatives of hospitals, physicians, claimants' attorneys, self-insured and other employers and insurers. Prior experience demonstrates that the hardest solutions, and often those which are most successful, come from the parties in interest. While the Virginia Workers' Compensation can conduct further research and propose or adopt a particular fee schedule, this could have arbitrary components which do not fully comprehend or account for the stake of interested parties. Considering this, the

Commission recommends continued negotiation among those in interest to achieve a mutually agreeable, efficient, and effective solution.

[1] Chapter 456, Acts of Assembly, Commonwealth of Virginia (2015)
[2] Commissioner Wesley G. Marshall succeeded Commissioner Williams as Chairman of the Commission effective July 1, 2015.
[3] Virginia Workers' Compensation Commission Report on Specific Medical Issues, Requested by The Honorable Richard L. Saslaw, Senate of Virginia, Commerce and Labor Committee (2010), at 5-7.
[4] See Va. Code §15.2-4207
[5] Perkins v. DBHDS Southside Va. Training Center and Ortho Virginia, JCN VA1705747 (May 1, 2015).
[6] Preliminary Analysis of Virginia House Bill 1820 As Introduced on February 5, 2015, National Council on Compensation Insurance, citing NCCI Financial Call data for Policy Years 2011 and 2012 projected to 1/1/2016.
[7] WCRI is an independent, not-for-profit research organization founded in 1983. It has diverse membership support from employers, insurers, most state governments, medical providers, unions, and others. It acts as a public policy research resource to public officials and stakeholders. It does not make recommendations or take positions. WCRI's research studies must pass independent peer review to be published.
[8] The study states included: Massachusetts, Michigan, Texas, Arkansas, California, Minnesota, Florida, Georgia, Pennsylvania, North Carolina, New Jersey, Iowa, Wisconsin, Louisiana, Illinois, and Virginia.
[9] Source: WCRI, *National Inventory of WC Fee Schedules for Hospitals and Ambulatory Surgical Centers* (2010).
[10] Source: WCRI, *Hospital Outpatient Cost Index for Workers' Compensation, 4th Edition* (2015).
[11] Id.
[12] "Hospital Payments for Outpatient Surgical Cases for Study States Without Material Fee Schedule Changes, 2006 to 2013" WCRI, *Hospital Outpatient Cost Index for Workers' Compensation, 4th Edition* (2015).
[13] Mullins/Highlands Neurosurgery v. Kyn Coal Corp., VWC File No. 236-10-44 (Sept. 2, 2009).
[14] Ceres Marine Terminals v. Armstrong, 59 Va. App. 694, 703-08, 722 S.E.2d 301, 306-08 (2012).
[15] Virginia Workers' Compensation Commission Report on Specific Medical Issues, Requested by The Honorable Richard L. Saslaw, Senate of Virginia, Commerce and Labor Committee (2010), at 1.
[16] Banks v. Plow & Hearth, JCN 2381811 (Aug. 26, 2013), cited in Orthopaedic and Spine Ctr. v. Keystone Auto. Indus., No. 0917-14-1 (Va. Ct. App. Dec. 23, 2014) (unpublished).
[17] WCRI, *A New Benchmark for Workers' Compensation Fee Schedules, Prices Paid By Commercial Insurers* (2013).
[18] Donald and Fredericksburg Orthopaedic Associates v. Fredericksburg Mach. & Steel, LLC, JCN VA00000060232 (Aug. 27, 2012).
[19] Goodyear Tire & Rubber Co. v. Pierce, 9 Va. App. 120, 128, 384 S.E.2d 333, 338, 6 Va. Law Rep. 318 (1989) (citing 2 Arthur Larson, The Law of Workmen's Compensation § 61.12(d) (1987).

Rule 14. Definition of Community.

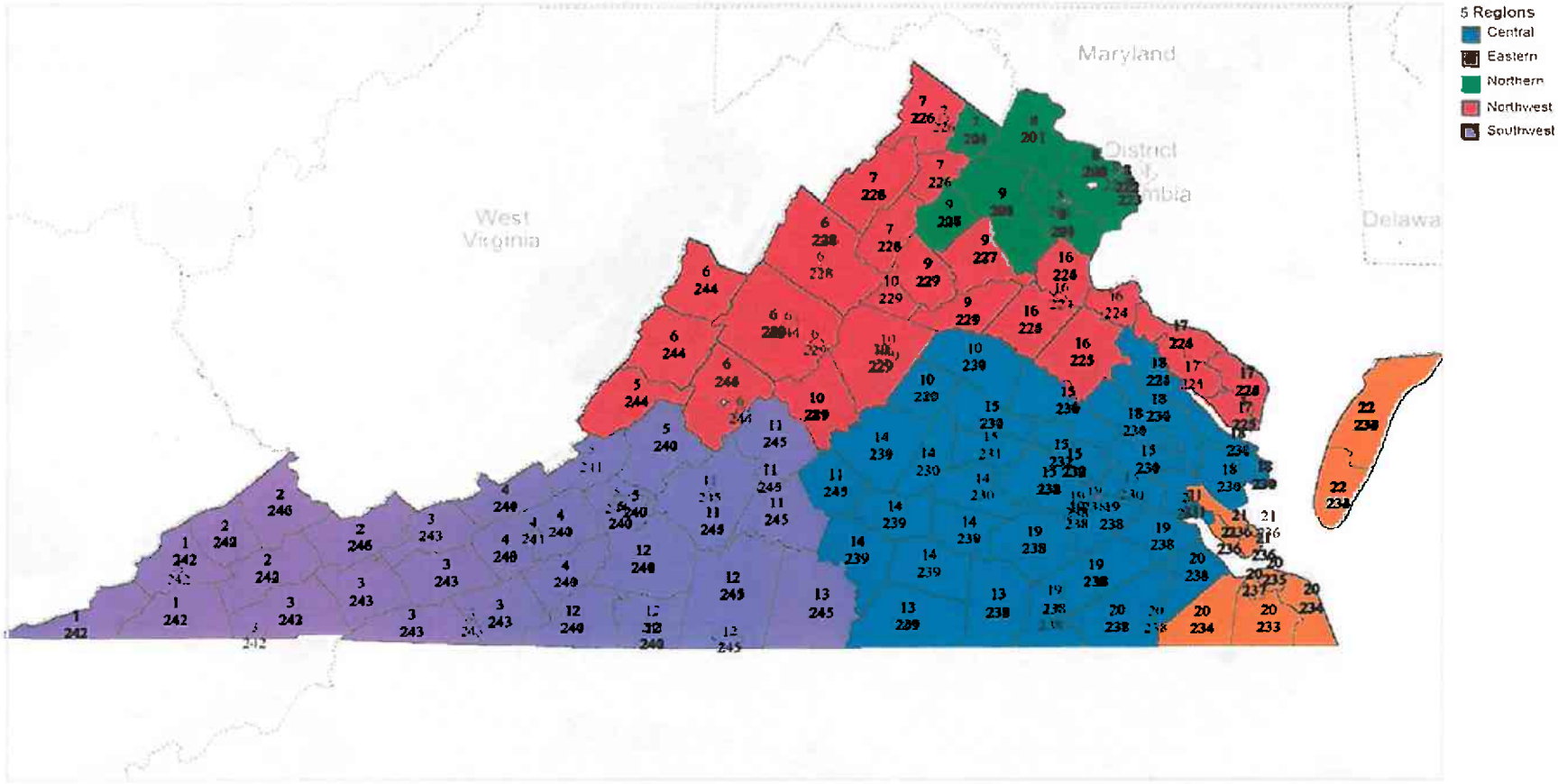
For the purpose of § 65.2-605 of the Code of Virginia, the word "community" shall mean groups of three-digit Virginia zip codes as follows:

COMMUNITY	THREE-DIGIT ZIP CODES
1 – Northern	201, 220, 221, 222, 223
2 – Northwest	224, 225, 226, 227, 228, 229, 244
3 – Central	230, 231, 232, 238, 239
4 – Eastern	233, 234, 235, 236, 237
5 – Southwest	240, 241, 242, 243, 244, 245, 246

Pursuant to subsection G of § 65.2-605.1 of the Code of Virginia, the community applicable to services rendered by a health care provider outside of the Commonwealth of Virginia shall be deemed to be that associated with the principal place of business of the employer if located in the Commonwealth or, if no such location exists, then that associated with the location where the commission hearing regarding a dispute involving those services is conducted.

The commission may consider additional data to determine the prevailing community rate when appropriate.

5 Region Map



Map based on Longitude (generated) and Latitude (generated). Color shows details about 5 Regions. The marks are labeled by sum of PD and sum of 3 Digit Code. Details are shown for Community per WCC, County and Zip code.

RESPONSE TO QUESTIONS REGARDING MEDICAL DATA REPORT FOR THE STATE OF VIRGINIA

NCCI provides an annual Medical Data Report for the state of Virginia. The 2015 Medical Data Report contains summarized information regarding payments for medical services in Virginia using data from Service Year 2014. The Virginia Workers' Compensation Commission has requested that we respond to a series of questions using the information compiled for the 2015 Medical Data Report for the state of Virginia. The responses are as follows.

Request – Please provide the overall percentage of payments for in-network (In) vs. out-of-network (Out) separately for physicians and drugs by paid amount and by transaction count. Include average billed amount per transaction and average paid amount per transaction.

Response – Below are the network distributions for physician and drugs including average charged amounts and paid amounts per transaction. The first chart also shows the percentage of payments, charges, and number of transactions in network and out of network, including the average amount paid and the average amount charged per transaction.

The second chart displays the distribution of drugs in and out of network by percentage of drug payments, percentage of the transactions and average amount paid per transaction. Network indicators are reported at a transaction level; therefore each claim can have a mixture of in and out of network transactions. More than 99% of transactions were reported with a valid network indicator. Note that there are no controls for mix of services between the in-network and out-of-network average paid or charged amounts.

Physician Network Distribution	% of Physician Payments	% of Physician Charges	% of Physician Transactions	Average Paid Per Transaction	Average Charged Per Transaction
In	62.7%	66.2%	69.0%	$113	$181
Out	37.3%	33.8%	31.0%	$150	$206

Drugs Network Distribution	% of Drug Payments	% of Drug Transactions	Average Paid Per Transaction
In	78.0%	80.8%	$148
Out	22.0%	19.2%	$176

Charges are not typically used as a cost containment tool for pharmaceutical fee schedules and were not included in this chart.

Source: NCCI Medical Data Call, Service Year 2014.

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RESPONSE TO QUESTIONS REGARDING
MEDICAL DATA REPORT FOR THE STATE OF VIRGINIA

Request – Provide the percentage of payments for in-network vs. out-of-network for various physician payments by American Medical Association (AMA) service category (chart 5 in the report.)

Response – The chart below shows the AMA service category for physician payments, including the in-network and out-of-network share of total payments, as well as the share of payments within that particular service category.

Distribution of Physician Payments by AMA Service Category and Network Indicator			
	Share of Physician Payments		
AMA Service Category	In-Network	Out - of-Network	Total
Anesthesia	63.7%	36.3%	4.4%
Surgery	58.7%	41.3%	25.6%
Radiology	63.7%	36.3%	11.3%
Pathology	71.1%	28.9%	2.5%
General Medicine	58.0%	42.0%	3.1%
Physical Medicine	63.2%	36.8%	30.8%
Evaluation and Management	68.0%	32.0%	21.0%
Other	24.7%	75.3%	1.3%
Total	62.7%	37.3%	100%

Source: NCCI Medical Data Call, Service Year 2014

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RESPONSE TO QUESTIONS REGARDING
MEDICAL DATA REPORT FOR THE STATE OF VIRGINIA

Request – For top 10 surgery CPT codes ranked by amount paid for Virginia, provide the percentage of payments in-network vs. out-of-network, including the average billed amount per transaction and the average paid amount per transaction

Response – The chart below shows the network distributions for the top 10 surgery CPT codes by amount paid for Virginia, including the percentage paid in network as well as the percentage of the number of transactions in network. The chart also shows the average paid and charged amounts for in-network and out-of-network.

Top 10 Surgery CPT Codes by Paid Amount						
Procedure Code	**% Paid In**	**% Trans In**	**Average Paid In**	**Average Paid Out**	**Average Charged In**	**Average Charged Out**
29827	64.7%	68.2%	$1,936	$2,261	$3,036	$3,504
29826	65.5%	66.9%	$1,266	$1,345	$2,104	$2,105
64483	68.8%	74.0%	$707	$913	$1,082	$1,435
22551	47.5%	49.4%	$4,254	$4,604	$7,537	$6,614
29881	72.7%	75.6%	$1,451	$1,693	$2,439	$2,475
20610	65.4%	72.1%	$130	$178	$199	$233
22851	44.2%	46.2%	$1,580	$1,714	$2,713	$2,632
12001	67.0%	74.0%	$208	$291	$295	$342
63030	49.2%	57.0%	$2,368	$3,243	$4,498	$5,181
63047	48.5%	53.8%	$2,631	$3,247	$5,623	$6,493

Source: NCCI Medical Data Call, Service Year 2014

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RESPONSE TO QUESTIONS REGARDING
MEDICAL DATA REPORT FOR THE STATE OF VIRGINIA

Request – For top 10 surgery CPT codes by transaction for Virginia, provide the percentage of payments in-network vs. out-of-network, including the average billed amount per transaction and the average paid amount per transaction

Response – The chart below shows the network distributions for the top 10 surgery CPT codes by number of transactions for Virginia including the percentage of the amount paid in network and the percentage of the number of transactions in network. The chart also shows the average paid and charged amounts for in-network and out-of-network.

Top 10 Surgery CPT Codes by Number of Transactions						
Procedure Code	**% Paid In**	**% Trans in**	**Average Paid In**	**Average Paid Out**	**Average Charged In**	**Average Charged Out**
20610	65.4%	72.1%	$130	$178	$199	$233
12001	67.0%	74.0%	$208	$291	$295	$342
36415	73.7%	79.4%	$8	$11	$16	$14
64483	68.8%	74.0%	$707	$913	$1,082	$1,435
12002	65.6%	73.0%	$243	$343	$343	$411
64415	59.4%	71.4%	$276	$469	$771	$760
29826	65.5%	66.9%	$1,266	$1,345	$2,104	$2,105
29125	71.9%	75.9%	$118	$145	$164	$216
64450	45.6%	53.9%	$215	$300	$381	$736
62311	55.2%	64.3%	$387	$566	$697	$820

Source: NCCI Medical Data Call, Service Year 2014

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