WORKERS' COMPENSATION FEE SCHEDULES, MAXIMUM ALLOWABLE FEES, AND COMPARATIVE REIMBURSEMENTS

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FOREWORD

This report was written in response to Senate Concurrent Resolution No. 77, H.D. 1, adopted by the Legislature during the Regular Session of 2006. The concurrent resolution requests the Bureau to study reimbursements under the workers' compensation fee schedules. The Bureau wishes to acknowledge the invaluable assistance and cooperation of the medical doctors and osteopathic physicians who responded to the Bureau's reimbursement survey, the Disability Compensation Division of the Department of Labor and Industrial Relations, the First Insurance Company of Hawaii, Ltd., the Hawaii Employers' Mutual Insurance Company, IMS, a Solera Company, the Hawaii Medical Association, and the San Francisco office of the Centers for Medicare and Medicaid Services.

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FACT SHEET

Q. **How many fee schedules are there in Hawaii for workers' compensation?**

A. Two. One is the 110% Medicare fee schedule, which sets maximum charges at 110% of the Medicare payment amounts applicable to Hawaii. The other is the supplemental fee schedule, which by law sets maximum charges at the "prevalent charge for fees for services actually received by providers of health care services to cover charges for that treatment, accommodation, product, or service."

Q. **Do they work in conjunction with each other?**

A. Yes, charges shall not exceed the greater of the prevalent charge set under the supplemental fee schedule or 110% of the charges allowed under Medicare.

Q. **How does that work out in practice?**

A. If maximum allowable fees for a medical service are listed under both the supplemental fee schedule and the Medicare fee schedule, then the maximum allowable fee is determined by the supplemental fee schedule. If maximum allowable fees for a medical service are listed only under the Medicare fee schedule, then the maximum allowable fee is determined by the 110% Medicare fee schedule. If maximum allowable fees for a medical service are not listed under either schedule, then the maximum allowable fee is the provider's lowest fee received for that medical service when rendered to private patients. Medical services are identified by their Current Procedural Terminology, or CPT, codes.

Q. **Which schedule is the primary one?**

A. The supplemental schedule governs the maximum allowable fees of over a majority of the CPT codes that were reported in our survey of most frequently used codes.

Q. **How high are the maximum allowable fees under the supplemental fee schedule?**

A. For the CPT codes reported in the survey, the supplemental schedule sets maximum allowable fees at about 136% of Medicare amounts.

Q. **What are the most frequently used services in workers' compensation?**

A. Based upon our survey, the evaluation and management services were the most frequently reported services. Specifically, the five most frequently reported CPT codes in descending order were 99213 (office visit; established patient; medical decision making is of low to moderate severity), 99214 (office visit; established patient; medical decision making is of moderate to high severity), 99203 (office visit; new patient; medical

decision making is of moderate severity), 99212 (office visit; established patient; medical decision making is self-limited or minor), and 99204 (office visit; new patient; medical decision making is of moderate to high severity).

Q. **How do reimbursement levels in workers' compensation compare to reimbursement levels in employer group health plans?**

A. Based upon our survey, actual reimbursements under the fee schedules are about 99% of the reimbursements received from both carriers and patients under employee group health plans.

Q. **How do Hawaii's maximum allowable fee levels compare to the maximum allowable fee levels of other states?**

A. For the five most frequently reported CPT codes in the survey, Hawaii's maximum allowable fees are about 102% of the average maximum fee levels of the thirty-two states whose fee schedules we reviewed.

Q. **Do all states have fee schedules?**

A. No, some do not, but most do. Some fee schedules are based on charges, expressed as the prevailing charge or the usual and customary charge. Other fee schedules are based on the Medicare fee schedule or upon the Medicare resource-based relative value units. Still others are based upon the relative value units of the Ingenix publication *Relative Values for Physicians*.

Q. **How do states update their fee schedules?**

A. Where specified, the schedules are authorized or required to be adjusted on a periodic basis (although some states do not require adjustment). Specified periods of adjustment are annually, semi-annually, biennially, triennially, quarterly, periodically, from time to time, as necessary, and as needed. Sometimes, the bases for the adjustments are specified. If the basis is specified, the basis is usually the consumer price index, in particular, the consumer price index--urban. Another basis frequently used is the state average weekly wage. Other bases used include the Medicare economic index, the year-over-year inflation rate, changes in levels of reimbursement, and prevalent charges.

Chapter 1

INTRODUCTION

The Request of the Resolution

Senate Concurrent Resolution No. 77, H.D. 1, was adopted by the Legislature during the regular session of 2006. It requests the Legislative Reference Bureau to conduct two separate studies relating to reimbursements to health care providers. (See Appendix A for a copy of the resolution.) The first study relates to reimbursements under Medicaid and QUEST programs and was completed and published as *Medicaid and Quest Provider Payment and Reimbursement Rates*, Report No. 6, 2006. The second study is the present report, and it relates to reimbursements under workers' compensation. The request for the second study mirrors that for the first study, but with word substitutions such as "workers' compensation" for "Medicaid and QUEST."

For this second study, the resolution requests the Bureau to conduct a study of recommended procedures that will ensure that state-funded health care payments adequately reimburse providers who provide services for injured employees under workers' compensation insurance for the actual cost of health care services. Specifically, the resolution requests a study of the following issues:

(1) Processes implemented by other jurisdictions or as recommended by experts that try to ensure that state-funded health care payments to worker compensation providers adequately reimburse them for their actual costs;

(2) A comparison of rates for the ten most frequently used services in worker compensation services, actual costs of those services, and the amount reimbursed to the provider;

(3) A method of updating payments and reimbursements to health care providers every two years to keep pace with inflation; and

(4) A survey of nationwide benchmarks to see how Hawaii compares to other jurisdictions regarding provider payments and reimbursements for at least the ten most frequently used worker compensation health procedures.

The request for the study is evidently prompted by concerns over inadequate levels of reimbursement, given the State's the authority to increase those levels. The Resolution mentions on the one hand that "providers are receiving insufficient payments for health care from government payers, private insurance payers, and patients who do not have insurance." On the other hand, the Resolution asserts: "the State ... controls certain types of payments for health care made to providers," and "it is in the public interest to ensure that health care payments ... controlled by the State are sufficient to cover the actual costs of care."

The Scope of the Study

At the outset, we note that the language of the request for the workers' compensation study is modeled exactly upon the language of the request for the Medicaid study, possibly creating presumptions about workers' compensation that are not valid. Specifically, health care payments to workers' compensation providers, unlike health care payments to Medicaid providers, are generally not state-funded. The State, like any other employer, pays health care providers for services rendered to its own state employees who require medical care upon sustaining a compensable work injury. Similarly, the State, like any other employer, is generally not under any obligation to pay providers for medical services rendered to nonemployees who sustain a compensable work injury.

The Layout of the Report

Our findings are set forth in the following chapters, as follows:

- Chapter two is a brief primer on fee schedule concepts and formulas;

- Chapter three addresses the first issue of the Resolution. This chapter summarizes the reimbursement bases of the fee schedules of the several states. It also discusses the reimbursement methodologies of states without fee schedules;

- Chapter four addresses the third issue of the Resolution. It discusses the updating of those fee schedules among the several states;

- Chapter five addresses the fourth issue of the Resolution. It compares the maximum allowable fees for five different Current Procedural Terminology ("CPT") codes under the fee schedules of Hawaii and other states. The five codes are the codes that were the most frequently reported in the Bureau's survey of medical doctors and osteopathic physicians discussed in chapter six;

- Chapter six discusses the two workers' compensation fee schedules used in Hawaii. One schedule is the Medicare fee schedule raised one hundred and ten per cent. The other schedule is the supplemental fee schedule;

- Chapter seven addresses the second issue of the Resolution. This chapter is based upon the results of our survey to medical doctors and osteopathic physicians regarding reimbursements and covers all the CPT codes that were reported by them. This chapter compares maximum allowable fees and reimbursements under the workers' compensation fee schedules. It also compares reimbursements under the workers' compensation fee schedules with reimbursements from other payment sources, specifically, employee group health plans and uninsured patients;

- Chapter eight concludes the results of the survey to medical doctors and osteopathic physicians. This chapter relates: the comments by the medical doctors and osteopathic physicians on workers' compensation reimbursement and carrier reimbursement practices; the carriers' responses to the comments of the medical doctors and osteopathic physicians; and the responses of the Department of Labor and Industrial Relations to the comments of the medical doctors and osteopathic physicians; and

- Chapter nine presents a summary of salient points and conclusions.

Chapter 2

FEE SCHEDULE PRIMER

The following brief explanation reflects our own understanding of fee schedules, distilled from a reading of the statues, administrative rules, and fee schedules discussed in more detail in the subsequent chapters.

Maximum Allowable Fee = Relative Value Units × Conversion Factor

A workers' compensation medical fee schedule assigns a maximum allowable fee to a specific medical service.

For services performed by individual physicians, the medical service is generally identified by a unique five-digit Current Procedural Terminology code, or CPT code. The CPT is a coding system of diagnostic procedures and services performed by physicians and is developed and copyrighted by the American Medical Association.[1]

The maximum allowable fee assigned to a CPT code is typically the product of two factors, the relative value units and a conversion factor. The basic formula for the maximum allowable fee under a fee schedule for a particular service is as follows:

Maximum allowable fee =

Relative value units × Conversion factor =

RVU × CF.

Expressed verbally:

> The maximum allowable fee is the product of relative value units multiplied by a conversion factor.

Relative value units are expressed in "units" of stand alone numbers, typically up to two decimal places. They are "relative" in the sense that they express the value of a particular physician service in relation to, or relative to, other physician services. Their "value" may pertain to charges (such as in Kentucky, Ohio, and South Carolina) or to the resources involved in performing the particular service (as in the states that use the Medicare Resource-Based Relative Value Scale). Relative value units appear to be an "intra" factor, since they tend to weigh physician services against each other.

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1. Current Procedural Terminology: cpt 2002, Standard Edition, American Medical Association, page iii, Foreword, page x, Introduction.

One important source of ready-made relative value units is the Medicare Resource-Based Relative Value Scale, developed by the federal Centers for Medicare and Medicaid Services. These relative value units are based upon the "resources" expended by a physician in furnishing a service. These resources are comprised of the components of physician work, practice expense, and malpractice expense. The physician work component is "the portion of resources used in furnishing the service that reflects physician time and intensity in furnishing the service." The practice expense component is "the portion of the resources used in furnishing the service that reflects the general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses) comprising practice expenses." The malpractice expense component is "the portion of the resources used in furnishing the service that reflects malpractice expenses in furnishing the service."[2] (Formerly, the national relative value units of Medicare were based upon reasonable charges.[3])

Another source of ready-made relative value units is the Ingenix publication, *Relative Values for Physicians*. These relative value units are reportedly based upon five criteria: time, skill, severity of illness, the risk to the patient, and the risk to the physician.[4] Under their methodology, the authors of the publication take a random sample of physicians across the country and ask the physicians to use the five criteria in evaluating those medical procedures they frequently perform or feel qualified to evaluate. The individual criteria are not weighted, as the authors believe that weighted criteria will distort their survey findings.[5]

The authors of the Ingenix publication state that the most significant difference between the relative values in *Relative Values for Physicians* and that of the Medicare system is that, in *Relative Values for Physicians*, the relative values for one section of the CPT coding system are not set in relation to another section. As an example, they point out that relative values for surgical codes are not determined in relation to office visits. The authors further assert that their system of relative values, unlike those of the Medicare system, is free from federal budgetary influence. They note that critics of the Medicare system believe that financial pressure on the system has resulted in inequitable payments to providers.[6]

There also may be other sources of relative value units besides the Medicare Resource-Based Relative Value Scale or the Ingenix publication, *Relative Values for Physicians*, perhaps among states that do not expressly identify their source of relative value units as being one or the other.

Finally, the conversion factor is expressed in units of dollars. It converts the relative value units into a maximum allowable fee amount. The conversion factor may also serve to

2. 42 United States Code §1395w-4 (c).
3. 71 Federal Register No. 231 (December 1, 2006), p. 69627-69628. Historically, the Medicare national relative value units were once based upon reasonable charges. Beginning in 1992, the relative value units for physician work became resource-based, while the relative value units for practice expense and for malpractice expenses remained based upon average allowable charges. In 2002, the relative value units for practice expense became fully resource-based, following a four-year transition period that was initiated in 1999. Beginning in 2000, the relative value units for malpractice expense became resource-based.
4. *Relative Values for Physicians*, Relative Value Studies, Inc., 2006 edition, Ingenix, at p. 4.
5. *Id.*
6. *Id.* at p. 3.

adjust relative values units for inflation. It appears to be an "inter" factor, since it tends to weigh physician services against the surrounding economy.

The Medicare Resource-Based Relative Value Scale in Workers' Compensation

The Medicare Resource-Based Relative Value Scale is the source of relative value units in the workers' compensation fee schedules of several states. The relative value units for a CPT code is the sum of the Medicare relative value units for physician work, the relative value units for practice expense, and the relative value units for malpractice expense, as follows:

The relative value units =

The relative value units of the Medicare Resource-Based Relative Value Scale =

Medicare relative value units for work + Medicare relative value units for practice expense + Medicare relative value units for malpractice expense =

Work RVU + Practice expense RVU + Malpractice RVU.

The formula for calculating a maximum allowable fee is just the basic formula, where the relative value units are specifically the relative value units of the Medicare Resource-Based Relative Value Scale and the conversion factor is specifically a conversion factor determined by the individual state. In other words:

Maximum allowable fee =

Relative value units × conversion factor =

Relative value units of the Medicare Resource-Based Relative Value Scale × state's conversion factor =

(Medicare relative value units for work + Medicare relative value units for practice expense + Medicare relative value units for malpractice expense) × conversion factor =

(work RVU + practice expense RVU + malpractice RVU) × CF.

Expressed verbally:

> The maximum allowable fee is the product of the sum of the Medicare relative value units for physician work, the relative value units for practice expense, and the relative value units for malpractice expense multiplied by a conversion factor.

The relative value units used by these states for workers' compensation are referred to in the federal Medicare program as the "national" or the "non-adjusted national" relative value units of the Medicare Resource-Based Relative Value Scale. Under the federal Medicare program,

these national, non-adjusted relative value units of the Medicare Resource-Based Relative Value Scale are the relative value units that would theoretically be used everywhere in the nation and its territories, if the nation and its territories were a single Medicare locality.

The Medicare Resource-Based Relative Value Scale, Geographically Adjusted

In contrast to the "national" or "non-adjusted national" relative value units of the Medicare Resource-Based Relative Value Scale are the "geographically adjusted" relative value units of the Medicare Resource-Based Relative Value Scale.

At least one state (specifically, Michigan) adopts the geographically adjusted relative value units of the Medicare Resource-Based Relative Value Scale as the source of its relative value units for workers' compensation.

Under the Medicare program, the nation and its territories are not comprised of a single Medicare locality. They are instead divided into 89 different Medicare localities. Accordingly, the national, non-adjusted relative value units of the Medicare Resource Based Relative Value Scale are geographically adjusted for each of the 89 different Medicare localities, through the application of the Geographic Practice Cost Indices.

The Geographic Practice Cost Indices are made up of three components that correspond to the three components of the relative value units of the Medicare Resource-Based Relative Value Scale. The three geographic practice cost indices reflect the relative costs respectively of physician work, practice expenses, and malpractice insurance in the physician's geographic area of practice compared to the national average costs for each of the relative value units.[7] There is one set of Geographic Practice Cost Indices for each of the 89 different Medicare localities.

For each Medicare locality, the relative value units of the Medicare Resource-Based Relative Value Scale for physician work, practice expense, and malpractice are each multiplied by the corresponding component of the Geographic Practice Cost Indices. The geographically adjusted relative value units of the Medicare Resource-Based Relative Value Scale may be expressed as follows:

> Geographically adjusted relative value units of the Medicare Resource-Based Relative Value Scale =
>
> [(Medicare relative value units for physician work × geographic practice cost index for physician work) + (Medicare relative value units for practice expense × geographic practice cost index for practice expense) + (Medicare relative value units for malpractice expense × geographic practice cost index for malpractice expense)] =

7. 71 Federal Register No. 231 (December 1, 2006), p. 69628.

[(work RVU × work GPCI) + (practice expense RVU × practice expense GPCI) + (malpractice RVU × malpractice GPCI)]

Expressed verbally:

> The geographically adjusted relative value units of the Medicare Resource-Based Relative Value Scale are equal to the sum of the products of the national, non-adjusted relative value units of the Medicare Resource-Based Relative Value Scale multiplied by the corresponding Geographic Practice Cost Indices.

A numeric relationship exists between the geographically adjusted relative value units of the Medicare Resource-Based Relative Value Scale and the "national" or "non-adjusted national" relative value units of the Medicare Resource-Based Relative Value Scale. Specifically, the geographically adjusted relative value units of the Medicare Resource-Based Relative Value Scale will equal the "national" or "non-adjusted national" relative value units of the Medicare Resource-Based Relative Value Scale if each of the three Geographic Practice Cost Indices is set equal to 1. In other words, by setting each of the three Geographic Practice Cost Indices equal to 1:

The geographically adjusted relative value units of the Medicare Resource-Based Relative Value Scale =

[(work RVU × work GPCI) + (practice expense RVU × practice expense GPCI) + (malpractice RVU × malpractice GPCI)] =

[(work RVU × 1) + (practice expense RVU × 1) + (malpractice RVU × 1)] =

[(work RVU) + (practice expense RVU) + (malpractice RVU)] =

[work RVU + practice expense RVU + malpractice RVU] =

The national, non-adjusted relative values units of the Medicare Resource-Based Relative Value Scale.

This numeric relationship exists because the national, non-adjusted relative value units of the Medicare Resource-Based Relative Value Scale do not need to be geographically adjusted for the nation and its territories as a whole. They need to be geographically adjusted only for localities that are smaller than the nation and its territories as a whole, specifically, for the 89 different Medicare localities that comprise the nation and its territories.

In any case, the formula for calculating a maximum allowable fee is yet again the basic formula, where the relative value units are specifically the geographically adjusted relative value units of the Medicare Resource-Based Relative Value Scale and the conversion factor is specifically a conversion factor determined by the individual state. In other words:

Maximum allowable fee =

Relative value units × conversion factor =

Geographically adjusted relative value units of the Medicare Resource-Based Relative Value Scale × conversion factor =

[(Medicare relative value units for physician work × geographic practice cost index for physician work) + (Medicare relative value units for practice expense × geographic practice cost index for practice expense) + (Medicare relative value units for malpractice expense × geographic practice cost index for malpractice expense)] × conversion factor =

[(work RVU × work GPCI) + (practice expense RVU × practice expense GPCI) + (malpractice RVU × malpractice GPCI) × CF.

Expressed verbally:

> The maximum allowable fee is the product of the sum of the geographically adjusted relative value units of the Medicare Resource-Based Relative Value Scale multiplied by a conversion factor.[8]

The Medicare Payment Formula in Workers' Compensation

The General Medicare Payment Formula

Finally, other states adopt more than just the relative value units of the Medicare Resource-Based Relative Value Scale, whether geographically adjusted or nationally non-adjusted, for use in their workers' compensation fee schedules. They adopt, instead, the entire Medicare payment formula, which is made up of the geographically adjusted relative value units of the Medicare Resource-Based Relative Value Scale, the Medicare conversion factor, and for this year, the budget neutrality adjuster. Stated otherwise, the workers' compensation fee schedules of these states are based directly upon the Medicare fee schedules.

For the Medicare program, the *general* payment formula for services performed in a Medicare locality is the product of the geographically adjusted relative value units of the Medicare Resource-Based Relative Value Scale for that Medicare locality multiplied by the Medicare conversion factor. The conversion factor is determined by the Centers for Medicare and Medicaid Services,[9] and is updated annually for inflation,[10] based upon increases or

8. For Michigan, there is a wrinkle. Two Medicare localities comprise the state of Michigan under the federal Medicare program. Each locality has its own set of Geographic Practice Cost Indices. For workers' compensation, Michigan blends both sets of Geographic Practice Cost Indices into a single set of Geographic Practice Cost Indices and applies that single set of Geographic Practice Cost Indices to the entire state.
9. 42 CFR section 414.28.
10. 71 Federal Register No. 231 (December 1, 2006), p. 69628.

decreases in the Medicare Economic Index.[11] The conversion factor for 2007 is equal to $37.8975.[12]

In other words, the *general* payment formula is also just the basic formula, where the relative value units are specifically the geographically adjusted relative value units of the Medicare Resource-Based Relative Value Scale and the conversion factor is specifically the Medicare conversion factor determined by the Centers for Medicare and Medicaid Services. The *general* payment formula for services performed in a Medicare locality under the Medicare program is as follows:

> Medicare payment =
>
> The geographically adjusted relative value units of the Medicare Resource-Based Relative Value Scale × conversion factor =
>
> [(Medicare relative value units for physician work × geographic practice cost index for physician work) + (Medicare relative value units for practice expense × geographic practice cost index for practice expense) + (Medicare relative value units for malpractice expense × geographic practice cost index for malpractice expense)] × conversion factor =
>
> [(work RVU × work GPCI) + (practice expense RVU × practice expense GPCI) + (malpractice RVU × malpractice GPCI)] × CF.[13]

Expressed verbally:

> The Medicare payment is the product of the geographically adjusted relative value units of the Medicare Resource-Based Relative Value Scale multiplied by the Medicare conversion factor.

The Actual Medicare Payment Formula

This year, the *general* formula is not being used. It has been modified. A budget neutrality factor is being used in the payment formula this year due to a need to meet the budget neutrality provisions of the Social Security Act.[14] Federal budgetary concerns have resulted in an adjustment to the relative value units for physician work. Specifically, the relative value units for physician work are being multiplied by a budget neutrality factor, as follows: Medicare relative value units for physician work × budget neutrality factor.

11. 42 CFR section 414.30(a).
12. From the overview of the physician fee schedule on the website of the Centers for Medicare & Medicaid Services, at http://www.cms.hhs.gov/PhysicianFeeSched/
13. 71 Federal Register No. 231 (December 1, 2006), p. 69628.
14. 71 Federal Register No. 231 (December 1, 2006), p. 69628, 69735-69736.

The budget neutrality factor equals 0.8994.[15] It is less than 1. Accordingly, the relative value units for physician work are being adjusted downward this year from what it would have normally have been under the *general* Medicare payment formula. Specifically, the relative value units for physician work are being reduced 10.06% (since 1 - 0.8994 = 0.1006). Furthermore, "when applying the 0.8994 work adjustor to the work RVU you must round the product to two decimal places."[16]

The *actual* Medicare payment formula is elaborate, but is nonetheless just the basic formula, where the relative value units are specifically the budget neutrality adjusted and geographically adjusted relative value units of the Medicare Resource-Based Relative Value Scale and where the conversion factor is specifically the Medicare conversion factor determined by the Centers for Medicare and Medicaid Services. The *actual* formula for services performed in a Medicare locality under the Medicare program for the year 2007 is as follows:

> Medicare payment =
>
> The geographically adjusted relative value units, where the relative value units for physician work are multiplied first by a budget neutrality factor, of the Medicare Resource-Based Relative Value Scale × conversion factor =
>
> [(Medicare relative value units for physician work × budget neutrality factor × geographic practice cost index for physician work) + (Medicare relative value units for practice expense × geographic practice cost index for practice expense) + (Medicare relative value units for malpractice expense × geographic practice cost index for malpractice expense)] × conversion factor =
>
> [(work RVU × BN × work GPCI) + (practice expense RVU × practice expense GPCI) + (malpractice RVU × malpractice GPCI)] × CF.[17]

Expressed verbally:

> The Medicare payment is the product of the geographically adjusted relative value units of the Medicare Resource-Based Relative Value Scale, where the relative value units for physician work are first multiplied by a budget neutrality factor before being multiplied by the Geographic Practice Cost Index for physician work, multiplied by the Medicare conversion factor.

15. The website of the Centers for Medicare and Medicaid Services, at http://www.cms.hhs.gov/PhysicianFeeSched/01_overview.asp.
16. *Id.*
17. 71 Federal Register No. 231 (December 1, 2006), p. 69629.

The Actual Medicare Payment Formula, for Use in Workers' Compensation

Finally, states that adopt the Medicare payment formula for use in workers' compensation apply a percentage over 100 to the Medicare payment formula. They multiply the Medicare payment amount by a factor greater than 1 but less than 2.

The formula for calculating maximum allowable fees in workers' compensation, like all the other formulas, is ultimately just the basic formula, where the relative value units are specifically the budget neutrality adjusted and geographically adjusted relative value units of the Medicare Resource-Based Relative Value Scale and where the conversion factor is specifically the Medicare conversion factor multiplied by a percentage over 100 determined by the individual state. The maximum allowable fee for states that apply a percentage to the Medicare payment formula is as follows:

> Workers' compensation maximum allowable fee =
>
> Medicare payment × percentage over 100 =
>
> [(Medicare relative value units for work × budget neutrality factor × geographic practice cost index for work) + (Medicare relative value units for practice expense × geographic practice cost index for practice expense) + (Medicare relative value units for malpractice expense × geographic practice cost index for malpractice expense)] × conversion factor × percentage over 100 =
>
> [(work RVU × work GPCI) + (practice expense RVU × practice expense GPCI) + (malpractice RVU × malpractice GPCI)] × CF × %.

Expressed verbally:

> The maximum allowable fee in workers' compensation is the product of the sum of the geographically adjusted relative value units of the Medicare Resource-Based Relative Value Scale, where the relative value units for physician work are first multiplied by a budget neutrality factor before being multiplied by the Geographic Practice Cost Index for physician work, multiplied by a percentage of the Medicare conversion factor.

This then constitutes the basics of fee schedule concepts. The rest of the chapter involves further complexities of the Medicare payment formula.

The Relative Value Units for Practice Expense Under the Medicare Resource-Based Relative Value Scale

Under the Medicare Resource-Based Relative Value Scale (RBRVS), a CPT code is assigned one figure representing the relative value units for physician work and one figure representing the relative value units for malpractice expense. However, each code is assigned four different figures representing relative value units for practice expense: one for the fully implemented non-facility relative values units for practice expense, a second for the fully implemented facility relative value units for practice expense, a third for the year 2007 (or transitional) non-facility relative value units for practice expense, and a fourth for the year 2007 (or transitional) facility relative value units for practice expense.

The reason for this is that relative value units for practice expense are divided into two levels: a facility practice expense and a non-facility practice expense. The facility practice expense relative value units apply to services furnished to patients in a hospital or like setting.[18] The non-facility practice expense relative value units apply to services performed in a physician's office or like setting.[19]

The discussion of maximum allowable fees in this report is limited to non-facility fees because of the need to control variables, including the difference between non-facility fees and facility fees.

Furthermore, the relative value units for practice expense are divided into two sub-levels: the fully implemented practice expense and the transitional practice expense. This year, the transitional practice expense is also called the year 2007 practice expense. "Fully implemented" and "transitional" refer to the Centers for Medicare and Medicaid Services having recently revised the methodology for determining the relative value units for practice expense. The new methodology is currently being "transitioned" into use. It is scheduled to be "fully implemented" for Medicare in the year 2010. The sub-level that applies this year for Medicare is the transitional practice expense, or the year 2007 transitional practice expense.[20]

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18. 42 CFR section 414.22 (b)(5)(i)(A) on facility practice expense RVUs provides that: "The lower facility practice expense RVUs apply to services furnished to patients in the hospital, skilled nursing facility, community mental health center, or in an ambulatory surgical center [ASC] when the physician performs procedures on the ASC approved procedures list. (The facility practice expense RVUs for a particular code may not be greater than the non-facility RVUs for the code.)"
19. 42 CFR section 414.22 (b)(5)(i)(B) on non-facility practice expense RVUs provides that: "The higher non-facility practice expense RVUs apply to services performed in a physician's office, a patient's home, an ASC if the physician is performing a procedure not on the ASC approved procedures list, a nursing facility, or a facility or institution other than a hospital or skilled nursing facility, community mental health center, or ASC performing an ambulatory surgical center approved procedure."
20. August 29, 2007, phone interview with the Centers for Medicaid and Medicare Services, Region IX, Consortium for Financial Management and Fee For Service Operations, based in San Francisco. In a September 10, email follow up, the San Francisco-based office further explained that the four-year transitional period regarding the new methodology for calculating practice expense relative value units is discussed by the Centers for Medicare and Medicaid Services in their final rule with regard to Medicare Part B payment policy, in 71 Federal Register No. 231 (December 1, 2006), at pp. 69629, 69641.

For states that have adopted the Medicare Resource-Based Relative Value Scale for use in workers' compensation, some expressly specify which of the two sublevels of practice expense is adopted. One state, Arkansas, specifies the use of the fully implemented values. Two others, Oregon and Utah, specify the use of the transitional values. The others do not specify the use of one or the other type of practice expense.

In performing some calculations in this report, we decided we would use the transitional practice expense, if the state did not specify which practice expense to use, since it is the transitional practice expense that applies this year for Medicare.

The Participating Physician's Rate of Payment Under Medicare

Finally, the term "participating," as in "participating physician" evidently refers to a physician's participation in the federal Medicare program, in which the fee schedule amount for a "nonparticipating physician" is ninety-five percent of the fee schedule amount for a "participating physician."[21] Stated otherwise, the fee schedule amount for a "participating physician" is the full fee schedule amount. Two states, Hawaii and Texas, also use the term for workers' compensation and specify the use of the "participating" rate.

21. 42 USC section 1395w-4(a)(3); 42 CFR section 414.20(b).

Chapter 3

FEE SCHEDULES AND REIMBURSEMENT METHODS OF THE SEVERAL STATES

This chapter addresses the first issue of the Resolution, which states as follows:

> *Processes implemented by other jurisdictions or as recommended by experts that try to ensure that state-funded health care payments to worker compensation providers adequately reimburse them for their actual costs;*

In this chapter, we discuss the reimbursement bases of the fee schedules of the several states. We also discuss the reimbursement methodologies of the states without fee schedules. (See Appendix B for the sources of materials reviewed in this chapter.)

Based upon the statutes, administrative rules, fee schedules, and the workers' compensation administrators' websites of the several states, we have organized the several states into the following categories in order to facilitate our discussion of reimbursement methodologies:

- States without fee schedules;
- States with fee schedules whose bases are not expressly specified;
- States with fee schedules based upon charges;
- States with fee schedules whose source of relative values is the Ingenix publication, *Relative Values for Physicians*;
- States with fee schedules whose source of relative values is the Medicare Resource-Based Relative Value Scale; and
- States with fee schedules whose payment formula is a percentage of the Medicare payment formula.

In determining how to classify the states with fee schedules, we were primarily influenced by the language, whether in a statute, administrative rule, or the fee schedule itself, that appeared to provide the most specific information about the bases actually adopted for use in the fee schedules.

We note that most of the states that use a fee schedule use only one fee schedule, and are accordingly placed in only one category. However, two of the states, Hawaii and Florida, both use two different types of fee schedules, and are accordingly placed into two different categories. Hawaii is placed with the states with fee schedules based upon charges and the states with fee schedules whose payment formula is a percentage of the Medicare payment formula. Florida is placed with the states with fee schedules whose bases are not specified and the states with fee schedules whose payment formula is a percentage of the Medicare payment formula.

States Without Fee Schedules

First, we find that a minority of states do not have fee schedules. States that apparently do not have them are Delaware, Indiana, Iowa, Missouri, New Hampshire, New Jersey, Virginia, and Wisconsin. These eight states generally have statutes that require that charges basically be reasonable, and they define reasonableness as "prevailing charges," "usual and customary fees," or "actual charges."

Delaware has no fee schedule. Benefits that are not disputed are payable at the rate billed by the provider, according to the website of the Delaware Department of Labor, Division of Industrial Affairs. However, the Delaware statutes authorize the establishment of a fee schedule and its publication on the Internet when completed. The schedule as envisioned in the statutes sets maximum allowable payments at ninety per cent of the seventy-fifth percentile of actual charges within the geozip where the service is rendered, utilizing information in the employers' and carriers' national databases.

Indiana limits the employer's pecuniary liability to such charges that prevail in the same community for a like service to injured persons.

Iowa prohibits excessive charges.

Missouri prohibits a health care provider from charging a fee greater than the usual and customary fee the provider receives for the same treatment or service when the payor is a private individual or a private health insurance carrier.

New Hampshire requires the employer to pay the full amount of the health care provider's bill, unless the employer can show just cause as to why the total amount should not be paid. In other words, the *full* amount of the bill must be paid, unless it is *unreasonable*.

New Jersey requires that fees be reasonable and based upon the usual fees and charges which prevail in the same community for similar services.

Virginia limits the employer's pecuniary liability to such charges as prevail in the same community for similar treatment when such treatment is paid for by the injured person. The website of the Virginia Workers' Compensation Commission confirms that there is no fee schedule in Virginia. Rather, charge schedules agreed to by the carrier and the provider are to be enforced.

Wisconsin establishes a formula to determine whether a fee charged by a health care provider is reasonable, according to the website of the Wisconsin Department of Workforce Development. Specifically, Wisconsin statutes require a determination that a fee is reasonable if the fee is at or below the mean fee for such a procedure plus 1.4 standard deviations from the mean, as shown by data from, evidently, the carrier's database. Concomitantly, a fee is determined to be unreasonable if the fee is above the mean fee for such a procedure, plus 1.4

standard deviations from that mean, as shown by data in the carrier's database. In other words, it appears that Wisconsin deems a fee to be reasonable if the carrier can show that it falls within a limited range of fees on either side of the mean of fees in their database.

States with Fee Schedules Whose Bases are Not Expressly Specified

Second, we find that the majority of states have fee schedules. These forty-two states can be divided into states with fee schedules whose bases are specified and states with fee schedules whose bases are not expressly specified. The states with fee schedules whose bases are not expressly specified are Arizona, Florida, Minnesota, Nebraska, North Carolina, North Dakota, and Vermont. Specifically, we were not able to find express language in their statutes, administrative rules, or fee schedules from which we could determine their bases.

Arizona requires the industrial commission to fix a schedule of fees to be charged by physicians attending injured employees.

Florida specifies that one of its two fee schedules is set at the medical reimbursement level adopted by its three-member panel as of January 1, 2003.

Minnesota requires the implementation of a relative value fee schedule. Specifically, it authorizes the adoption by reference of the relative value fee schedule adopted for the federal Medicare program or a relative value fee schedule adopted by other federal or state agencies. However, the fee schedule established under the administrative rules does not identify the source of the relative value units that were adopted, and the Medicare Resource-Based Relative Value Scale is not listed among the documents that were expressly incorporated by reference into the rules.

Nebraska authorizes the compensation court to establish schedules of maximum fees. The administrative rules specify that the fee schedule, when used in conjunction with the instruction, ground rules, unit values, and conversion factors set out in the fee schedule, is the fee schedule in workers' compensation cases. The fee schedule specifies that the fee for a particular service is determined by multiplying the listed unit value by the dollar conversion factor.

North Carolina requires the adoption of a schedule of maximum fees for medical compensation. The statutes authorize the consideration of any and all reimbursement systems and plans in establishing the fee schedule. It also authorizes the consideration of any and all reimbursement methodologies, including Resource-Based Relative Value Scale payments. However, neither the administrative rules nor the fee schedule identifies which reimbursement methodology was chosen.

North Dakota requires that fees must be in accordance with the fee schedules. The administrative rules state that maximum fees are determined in accordance with the most current edition of the fee schedules. The fee schedules set out the fee amounts.

Vermont requires that the reimbursement rate in the fee schedule shall include considerations of medical necessity, clinical efficacy, cost-effectiveness, and safety.

States with Fee Schedules Based on Charges

Third, we find that among the states with fee schedules whose bases are expressly specified are states whose fee schedules are based expressly upon charges. These states with fee schedules based expressly upon charges are Alabama, Alaska, Connecticut, Georgia, Hawaii, Illinois, Kentucky, Louisiana, Mississippi, New Mexico, New York, Ohio, Rhode Island, and South Carolina. Conceptually, their fees schedules are typically based upon the same statutory principles that are followed in the states that do not have fee schedules. Typically, their fee schedules are based upon the principles of the "prevailing charges in the same community" or the "usual and customary charges."

Several of the states, specifically, Alabama, Alaska, Connecticut, Illinois, Louisiana, Mexico, and Rhode Island, also use mathematical formulations in defining the precise level of the "prevailing charge" or the "usual and customary charge" that will govern their fee schedules. Specifically, they set their maximum allowable fees at a mean or percentile of current or historical charges. Percentiles of current charges range from a low of the sixtieth to eightieth percentile in New Mexico to a high of the ninetieth percentile in Alaska and Rhode Island.

We note that some of the states, specifically, Kentucky, Ohio, South Carolina, have administrative rules or fee schedules that also specify the use of relative value units in computing a maximum allowable fee. The sources of these relative value units are not identified. However, since the statutes of these states establish fee schedules that are based upon charges, we infer that these relative value units are also based upon charges.

Alabama sets maximum fees exactly equal to the amounts derived by multiplying the preferred provider reimbursements customarily paid on May 19, 1992, by the largest health care service plan by a factor of 1.075.

Alaska statutes indicate that its fee schedule is based on the usual, customary, and reasonable fees for the treatment or service in the community in which it is rendered. The administrative rules further indicate that the usual, customary, and reasonable fees are based on the 90th percentile of the range of charges for similar services reported to an organization, to be identified administratively. The organization's schedule of providers' charge data is used in determining the usual, customary, and reasonable fees.

Connecticut limits fees to the charges that prevail in the same community or similar communities for similar treatment of injured persons of a like standard of living when the similar treatment is paid for by the injured person. The administrative rules establish the fee schedule as the seventy-fourth percentile level of the data base of statewide charges.

Georgia requires the state to publish a list by geographical location of usual, customary, and reasonable charges.

Hawaii authorizes the administrative establishment of a supplemental fee schedule not exceeding the prevalent charges for fees for services actually received by providers of health care services to cover charges for that treatment, accommodation, product, or service, when it is determined that the allowance under the Medicare program is not reasonable, or if the medical treatment, accommodation, product, or service existing as of June 29, 1995, is not covered under the medicare program.

Illinois sets the maximum allowable payment at ninety per cent of the eightieth percentile of historical charges and fees, specifically, provider billed amounts, as of August 1, 2004 but not earlier than August 1, 2002.

Kentucky limits fees to such charges as are fair, current, and reasonable for similar treatment of injured persons in the same community for like services, where treatment is paid for by general health insurers. The administrative rules specify that the appropriate fee for a procedure shall be obtained by multiplying a relative value unit for the medical procedure by the applicable conversion factor.

Louisiana requires that its reimbursement schedule be limited to the mean of the usual and customary charges.

Mississippi requires that fees be limited to such charges as prevail in the same community for similar treatment.

New Mexico specifies that rates in their schedules of maximum charges shall not fall below the sixtieth percentile or above the eightieth percentile of current rates for health care providers.

New York requires that fees shall be limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living.

Ohio requires the establishment of guidelines for payment policies that recognize usual, customary, and reasonable methods of payment for covered services. The Ohio fee schedule contains a footnote that explains that, in the calculation of the maximum allowable rate, the total relative value unit adjustor for each CPT code in the payment system is carried out to five decimal places.

Rhode Island sets the maximum rate of reimbursement at the ninetieth percentile of the usual and customary fees charged by health care providers in the state and immediate surrounding area.

South Carolina limits fees to such charges as prevail in the community for similar treatment of injured persons of a like standard of living when such treatment is paid for by the injured person. The administrative rules require the establishment of maximum allowable payments for medical services provided by medical practitioners based on a relative value scale and a conversion factor set by the commission.

States with Fee Schedules Whose Source of Relative Values is the Ingenix Publication, *Relative Values for Physicians*

Fourth, we find that among the states with fee schedules whose bases are expressly specified are states whose fee schedules are based expressly upon the relative values of the Ingenix publication, *Relative Values for Physicians.* These states with fee schedules whose source of relative values is specified as the *Relative Values for Physicians* are Colorado, Montana, Nevada, South Dakota, and Wyoming.

Colorado requires the establishment of a fee schedule. The administrative rules adopt and incorporate by reference as modified the 2006 edition of the *Relative Values for Physicians*, published by Ingenix. The rules further specify that the incorporation is limited to the 2006 edition and does not include later revisions or additions.

Montana requires that charges submitted by providers must be the usual and customary charges for non-workers' compensation patients. However, the administrative rules specify that the fee schedule is comprised of the relative values scales given in the most current edition of the *Relative Values for Physicians*, published by Ingenix, Inc.

Nevada requires the establishment of a fee schedule. The administrative rules require health care providers to comply with the most recently published edition of or update to the *Relative Values for Physicians*, which Nevada adopts by reference.

South Dakota requires the establishment of standards and procedures for determining if charges for health services are excessive. The administrative rules specify that the definitions and procedures for determining reimbursement for medical services or treatment are those set forth in *Relative Values for Physicians.*

Wyoming requires the establishment of fee schedules. The administrative rules adopt the current edition as of the first day of each calendar year, the *Relative Values for Physicians,* as published by Ingenix. The rules specify that fees in all cases must conform to the applicable edition of the *Relative Values for Physicians.*

States with Fee Schedules Whose Source of Relative Values is the Medicare Resource-Based Relative Value Scale

Fifth, we find that among the states with fee schedules whose bases are expressly specified are states whose fee schedules are based upon the relative values of the Medicare Resource-Based Relative Value Scale. Among this group of states is a subgroup of states that adopt only the relative values of the Medicare Resource-Based Relative Value Scale, and not the entire Medicare payment formula. These states are Arkansas, Idaho, Kansas, Maine, Michigan, Oregon, Tennessee, Utah, Washington, and West Virginia.

We have included into this category those states that refer to their relative values as "RBRVS" or "Resource Based Relative Value System [sic]," because we presume these designations refer to the Medicare Resource-Based Relative Value Scale.

We note that a few of these states, specifically, Arkansas, Oregon, and Utah, further specify the particular type of relative value units to be used for practice expense. They differentiate between facility and non-facility practice expense values and between transitional and fully-implemented practice expense values.

Arkansas authorizes the establishment of a fee schedule. The fee schedule specifies that the fee schedule is based on the Medicare Resource-Based Relative Value Scale, utilizing the national relative value units and specific conversion factors adopted by Arkansas. Furthermore, the schedule specifies that calculations for any specific CPT code can be done by multiplying the national "fully implemented non-facility total relative value units" by the conversion factor.

Idaho requires that fees for physician services shall be set using relative value units from the current year Medicare Resource-Based Relative Value System as it is modified from time to time, multiplied by conversion factors adopted by Idaho.

Kansas requires the establishment of a fee schedule that is reasonable. The fee schedule specifies that the incorporation of the Medicare Resource-Based Relative Value Scale concept for improvement in the statistical validity is used for the unit values employed to determine maximum allowable fees. Specifically, the maximum fee schedule amount for a procedure is determined by multiplying the unit value of the procedure by the dollar conversion factor applicable to the particular section in effect on the date the service was provided.

Maine requires the establishment of a fee schedule based upon consideration of the maximum charges paid by private third party payors for similar services provided by health care providers. The fee schedule indicates the schedule incorporates the Medicare RBRVS REPORT: The Physician's Guide 2005.

Michigan administrative rules specify that the formula and methodology for determining the relative value units shall be adopted from the Medicare RBRVS fee schedule using the Geographical Practice Cost Indices for Michigan. The rules specify a melded average of the Geographic Practice Cost Indices, based on 60% of the figures published for Detroit added to 40% of the figures published for the rest of the state.

Oregon requires that the fee schedules represent the reimbursement generally received for the services provided. The administrative rule adopts, among other things, the "Year 2007 Transitional Non-Facility Total" in the Centers for Medicare and Medicaid Services 2007 Medicare Resource-Based Relative Value Scale Addendum B, 71 Federal Register No. 231, December 1, 2006, as the basis for the fee schedule for payment of medical service providers.

Tennessee administrative rules indicate that the fee schedule is based upon the Centers for Medicare and Medicaid Services Medicare Resource-Based Relative Value Scale system, utilizing the national relative value units and specific conversion factors adopted by Tennessee.

Specifically, the maximum reimbursement amount is calculated for any specific CPT code by multiplying the national total relative value units, unadjusted for the Geographic Practice Cost Indexes, by the appropriate conversion factor.

Utah administrative rules adopt and incorporate by reference the Centers for Medicare and Medicaid Services Resource-Based Relative Value System [sic], 2007 edition, as the method for calculating reimbursement. Specifically, the rules adopt the non-facility total unit value for calculating reimbursement. The fee schedule further specifies that the transitional relative value is selected as the method for calculating reimbursement. The fee schedule also indicates that Utah has chosen not to use the Center for Medicare and Medicaid Service's designated Utah Geographic Practice Cost Indexes adjustment, but rather to use the non-adjusted national Medicare Resource-Based Relative Value System to calculate reimbursement values.

Washington administrative rules indicate that conversion factors are used to calculate payment levels for services reimbursed under the Washington resource based relative value scale (RBRVS). (We infer that "RBRVS" refers to the Medicare RBRVS.)

West Virginia statutes require the establishment of a schedule of maximum reasonable amounts to be paid to health care providers. The fee schedules are organized around RBRVS-based procedure codes and fees and non-RBRVS-based procedure codes and fees. (Again, we infer that "RBRVS" refers to the Medicare RBRVS.)

States with Fee Schedules Whose Payment Formula is a Percentage of the Medicare Payment Formula

Sixth, we find that among the group of states that adopt the relative values of the Medicare Resource-Based Relative Value Scale is a subgroup of states that also adopt the entire Medicare payment formula as well. Specifically, they adopt the Medicare payment formula, or the Medicare fee schedule amounts, and apply a percentage to it. These states are California, Florida, Hawaii, Maryland, Massachusetts, Oklahoma, Pennsylvania, and Texas. Percentages of the Medicare payment amounts range from a low of 109% in Maryland to a high of 125% in Texas. The percentages are usually applied to the Medicare fee schedule amounts of the current year. However, a couple of states use fee schedules of prior years as their base. Specifically, Maryland uses the 2004 Medicare fee schedule, while Pennsylvania uses the 1994 Medicare fee schedule.

California authorizes the administrative adoption and revision of an official medical fee schedule for physician services, commencing January 1, 2006. If the administrative director fails to adopt an official medical fee schedule for physicians by January 1, 2006, the existing official medical fee schedule rates for physician services remains in effect until a new schedule is adopted or the existing schedule is revised. The administrative rules further specify that for physician services rendered on or after July 1, 2004, the maximum allowable reimbursement amounts set forth in the official medical fee schedule 2003 for each procedure code are reduced by five per cent or by specified percentages of the Medicare rate. Specifically, procedures that are reimbursed at a rate between 100% and 105% of the Medicare rate are reduced between zero

and 5% so that the official medical fee schedule reimbursement does not fall below the Medicare rate. Reimbursement for procedures that are reimbursed under the official medical fee schedule 2003 at a rate below the Medicare rate are not further reduced.

Florida sets one of its two fee schedules at 110% of the reimbursement allowed by Medicare.

Hawaii prohibits charges from exceeding 110% of the fees prescribed in the Medicare Resource Based Relative Value Scale system applicable to Hawaii. The administrative rules specify use of the participating fees.

Maryland limits fees to the amount that prevails in the same community for similar treatment of an injured individual with a standard of living that is comparable to that of the covered employee. However, the fee schedule indicates that the schedule uses the 2004 reimbursement methodologies, model, and values or weights used the Centers for Medicare and Medicaid Services. The schedule further indicates that the conversion factor to be used for determining reimbursement is the effective conversion factor adopted by the Centers for Medicare and Medicaid Services for 2004 multiplied by 109%.

Massachusetts requires that rates of payment shall be established by the division of health care finance and policy under the provisions of the health care finance and policy chapter. The division is required to produce rates of payment that conform to Title XIX. Under the federal Social Security Act, Title XIX is the Medicaid program. In contrast, the Medicare program is Title XVIII. We assume that the Title XIX Medicaid rates of payment are based upon percentages of the Title XVIII Medicare rates of payment and that, accordingly, the workers' compensation rates of payment are also based upon percentages of the Medicare rates of payment.

Oklahoma specifies that fees shall be based on the most current relative value units produced by the Centers for Medicare and Medicaid Services for the Medicare physician fee schedule as of January 1 of the prior year. However, in no event shall the reimbursement rate for any single procedure be less than 115% of the current Medicare reimbursement rate for that procedure.

Pennsylvania administrative rules specify that, generally, medical fees for services rendered under the statutes shall be capped at 113% of the Medicare reimbursement rate applicable in the Commonwealth under the Medicare Program for comparable services rendered. The fee schedule specifies that the schedule uses, as its base fees, the 1994 Medicare Fee Schedule.

Texas administrative rules specify that the maximum allowable reimbursements shall apply the Medicare payment policies. Furthermore, the conversion factor to be used for determining reimbursement for the service categories of evaluation and management, general medicine, physical medicine and rehabilitation, surgery, radiology, and pathology is the effective conversion factor adopted by the Centers for Medicare and Medicaid Services multiplied by 125%. The website of the Texas Department of Insurance, Division of Workers' Compensation

further specifies that reimbursement is 125% of the Medicare participating physician reimbursement amount as listed in the Medicare fee schedule.

The Table of Reimbursement Methodology and Fee Schedule Adjustments

Table 4-1 at the end of next chapter provides a breakdown by state of the reimbursement methodologies and fee schedule adjustments discussed in the present and next chapters.

Chapter 4

ADJUSTING FEE SCHEDULES AMONG THE SEVERAL STATES

This chapter addresses the third issue of the Resolution, which states as follows:

A method of updating payments and reimbursements to health care providers every two years to keep pace with inflation;

In this chapter, we discuss the fee schedule adjustments of the several states that have fee schedules. States that do not have fee schedules are not covered in this chapter. (See Appendix B for the sources of materials reviewed in this chapter.)

Most of the states that have fee schedules also tend to have statutes or administrative rules that require or authorize adjustments to those fee schedules. Some states do not have such statutes or administrative rules. But for states that do have such statutes r administrative rules, the schedules are generally authorized or required to be adjusted on a periodic basis. Specified periods of adjustment are annually, semi-annually, biennially, triennially, quarterly, periodically, from time to time, as necessary, and as needed. Sometimes, the bases for the adjustments are specified. If the basis is specified, the basis is usually the consumer price index, in particular, the consumer price index--urban. Another basis used is the state average weekly wage. Other bases include the Medicare economic index, the year-over-year inflation rate, reimbursement levels by private third-party payors, and prevalent charges.

Based upon the statutes and administrative rules of the several states, we have organized the several states into the following categories in order to facilitate our discussion of fee schedule adjustments:

- States that lack statutes or administrative rules regarding the adjusting of their fee schedules;
- States with fee schedules subject to discretionary adjusting;
- States with fee schedules subject to mandatory adjusting, but without a specified basis for adjusting; and
- States with fee schedules subject to mandatory adjusting, with a specified basis for adjusting.

Although Hawaii has two fee schedules, both are subject to mandatory adjusting, and both have a specified basis for adjusting. Thus, Hawaii is placed in a single category: states with fee schedules subject to mandatory adjusting with a specified basis for adjusting.

States that Lack Statutes or Administrative Rules Regarding the Adjusting of Their Fee Schedules

First, we note that among the states with fee schedules, some lack statutes or administrative rules on adjusting those schedules. We were unable to find statutory or administrative language regarding the updating of fee schedules for Arkansas, Florida, Mississippi, New York, North Dakota, Ohio, South Dakota, Utah, and Vermont.

States with Fee Schedules Subject to Discretionary Adjusting

Second, we find that among the states with fee schedules, some have statutes or administrative rules that authorize, but do not mandate, the adjusting of those schedules. The operative language in these statutory or administrative provisions tend to be the words or phrases "may," "in his or her discretion," or "shall have the authority to." These states are California, Louisiana, South Carolina, Washington, and Wyoming.

California specifies that the administrative director, commencing January 1, 2006, shall have the authority to adopt and revise, no less frequently than biennially, an official medical fee schedule for physician services.

Louisiana specifies that any necessary adjustments to the reimbursement schedule may be made annually.

South Carolina administrative rules specify that the commission may review and update the relative values and/or the conversion factor as needed.

Washington specifies that the director, in his or her discretion, shall periodically change, as may be necessary, a fee schedule of the maximum charges. The administrative rules further provide that adjustments to the conversion factors may occur annually. Adjustments must be made on estimated increases or decreases in the state's average wage for the current year and on other factors as determined by department policy.

Wyoming indicates that changes in any rule or regulation shall be considered only at quarterly intervals.

States with Fee Schedules Subject to Mandatory Adjusting, but Without a Specified Basis for Adjusting

Third, we find that among the states with fee schedules, some have statutes or administrative rules that require the fee schedules to be adjusted or at least reviewed. The operative language in these statutory or administrative provisions tends to be the word "shall." Furthermore, some of these states also specify the basis for adjusting their schedules. Others do not. States that require their schedules to be adjusted but do not specify the basis for adjusting their schedules are Alaska, Arizona, Colorado, Georgia, Kansas, Kentucky, Maryland,

Massachusetts, Michigan, Nebraska, New Mexico, North Carolina, Rhode Island, Texas, and West Virginia.

Alaska administrative rules indicate that the board will annually identify in its bulletin the name of the organization whose annual or semi-annual publication of the schedule of usual, customary, and reasonable fees must be used.

Arizona provides that the commission shall annually review the schedule of fees.

Colorado provides that the fee schedules shall be reviewed on or before July 1 of each year by the director.

Georgia provides that the board shall annually publish a list by geographical location of usual, customary, and reasonable charges.

Kansas specifies that the schedule of maximum fees shall be revised as necessary at least every two years to ensure that the schedule is current, reasonable, and fair.

Kentucky provides that on or before November 1, 1994, and on July 1 every two years thereafter, the schedule of fees shall be reviewed and updated, if appropriate.

Maryland provides that at least once every two years, the commission shall review its guide of medical and surgical fees for completeness and reasonableness and make appropriate revisions to the guide.

Massachusetts provides that the executive office shall determine, at least annually, and certify to the division of industrial accidents of the department of labor and industries, rates of payment for general health supplies, care, or rehabilitative services and accommodations, which rates shall be paid under the workers' compensation chapter.

Michigan provides that the schedules of maximum charges shall be annually revised.

Nebraska provides that the compensation court shall review the schedules of maximum fees at least biennially and adopt appropriate changes when necessary.

New Mexico provides that the fee schedule shall be revised annually by the director.

North Carolina provides that the commission shall periodically review the schedule of maximum fees for medical compensation, and make revisions.

Rhode Island provides that the director shall update and revise the schedule of rates of reimbursement as necessary.

Texas specifies that the fee guidelines shall be reviewed and revised at least every two years to reflect fair and reasonable fees.

West Virginia provides that the insurance commissioner shall establish and alter from time to time, as it determines appropriate, a schedule of the maximum reasonable amounts to be paid to health care providers.

States with Fee Schedules Subject to Mandatory Adjusting, with a Specified Basis for Adjusting

Fourth, we find that among the states with fee schedules that are required to be adjusted, some also specify the basis for adjusting their schedules. As noted previously, the most common basis for adjustments is the consumer price index, followed by the statewide average weekly wage. States that require their schedules to be adjusted and also specify the basis for adjusting their schedules are Alabama, Connecticut, Hawaii, Idaho, Illinois, Maine, Minnesota, Montana, Nevada, Oklahoma, Oregon, Pennsylvania, and Tennessee.

Alabama specifies that the board shall annually adjust the schedule of fees by increases that shall be no more than the annual increases in the cost of living as reflected by the United Stated Department of Labor consumer price index.

Connecticut administrative rules specify that the practitioner fee schedule shall be adjusted and published annually. It shall be subject to the annual increase limit. The "annual increase" is defined as the annual percentage increase in the consumer price index for all urban workers which shall be applied to the practitioner fee schedule as a limit on the annual growth in total medical fees.

Hawaii specifies that the director shall update the fee schedules every three years or annually, as required. The updates shall be based upon one of two events. One is future charges or additions to the Medicare Resource Based Relative Value Scale system applicable to Hawaii. This event applies to the Medicare fee schedule, raised to one hundred and ten per cent. The other event that triggers an update is a statistically valid survey, conducted by the director, of prevalent charges for fees for services actually received by providers of health care services or information provided to the director by the appropriate state agency having access to prevalent charges for medical fee information. This event presumably applies to the supplemental fee schedule, which is based upon prevalent charges.

Idaho specifies that fees for physician services shall be adjusted each year. Each fiscal year adjustment shall be determined by the director and shall equal the year over year inflation rate forecasted as of the midpoint of the fiscal year by the all item, goods and services index in the pacific northwest as published by Data Resources Incorporated. Such forecast index shall be the last published forecast prior to the start of the fiscal year. The adjustment may exceed the index rate at the discretion of the legislature.

Illinois specifies that not later than September 30 in 2006 and each year thereafter, the commission shall automatically increase or decrease the maximum allowable payment established and in effect on January 1 of that year by the percentage change in the Consumer Price Index-U for the twelve month period ending August 31 of that year. The increase or

decrease shall become effective on January 1 of the following year. However, if the commission finds that there is a significant limitation on access to quality health care in either a specific field of health care services or a specific geographic limitation on access to health care, it may change the Consumer Price Index-U increase or decrease for that specific field of health care services or a specific geographic limitation on access to health care to address that limitation.

Maine indicates that standards of maximum charges must be adjusted annually based upon any appropriate changes in levels of reimbursement made by private third-party payors for similar services.

Minnesota specifies that the conversion factors must be adjusted annually on October 1 by no more than the percentage change in the statewide average weekly wage for December 31 of the year two years previous to the adjustment over the statewide average weekly wage for December 31 of the year previous to the adjustment. Furthermore, the statutes provide that the relative value units may be statistically adjusted in the same manner as for the original workers' compensation relative value fee schedule.

Montana administrative rules specify that the conversion factors shall be established annually by the department by increasing the conversion factors from the preceding year by the percentage increase in the state's average weekly wage. If for any year the state's average weekly wage does not increase, the rates will be held at the existing level until there is a net increase in the state's average weekly wage.

Nevada specifies that the administrator shall review and revise the schedule of reasonable fees and charges on or before February 1 of each year. In the revision, the administrator shall adjust the schedule by the corresponding annual change in the Consumer Price Index, Medical Care Component.

Oklahoma specifies that the conversion factors shall be adjusted by the Consumer Price Index and shall be adequate to reflect the usual and customary rates for treatment of workers' compensation patients, taking into consideration all relevant factors including, but not limited to, the additional time required to provide disability management. Furthermore, the statutes specify that the fee and treatment schedule shall be reviewed biennially by the administrator, who shall be empowered to amend or alter the fee and treatment schedule to ensure its adequacy.

Oregon specifies that the director shall update the fee schedule annually. As appropriate and applicable, the update shall be based upon a statistically valid survey of medical service fees or markups, medical service fee information, information provided by providers of health insurance that is reasonably necessary and available to develop the fee schedules, or the annual percentage increase or decrease in the physician's services component of the national Consumer Price Index.

Pennsylvania specifies that the maximum allowance for a health care service shall be updated as of the first day of January of each year. The update, which shall be applied to all services performed after January 1 of each year, shall be equal to the percentage change in the Statewide average weekly wage. Such updates shall be cumulative.

Tennessee specifies that the commissioner shall review the fee schedules on an annual basis and, when appropriate, shall revise the fee schedules as necessary. It is the intent of the general assembly that this annual review consider, among other factors, the medical consumer price index. The administrative rules further provide that the base Medicare amount may be adjusted upward annually based upon the annual Medicare Economic Index adjustment, but the maximum allowable amount of reimbursement shall not fall below the effective 2005 Medicare amount for at least two years from 2005.

The Table of Reimbursement Methodology and Fee Schedule Adjustments

Table 4-1 below provides a breakdown by state of the reimbursement methodologies and fee schedule adjustments discussed in the previous and present chapters.

Table 4-1
Reimbursement Methodology and Fee Schedule Adjustments

State	FS	Fee Basis	Updates	Update Period	Update Basis
Alabama	Yes	Charges	Mandatory	Annual	CPI
Alaska	Yes	Charges	Mandatory	Semi or annual	
Arizona	Yes	Unspecified	Mandatory	Annual	
Arkansas	Yes	RBRVS	Unspecified		
California	Yes	% Medicare	Discretionary	Biennial	
Colorado	Yes	RVP	Mandatory	Annual	
Connecticut	Yes	Charges	Mandatory	Annual	CPI
Delaware	No	Charges			
Florida	Yes	1) % Medicare; 2) Unspecified	Unspecified		
Georgia	Yes	Charges	Mandatory	Annual	
Hawaii	Yes	1) % Medicare; 2) Charges	Mandatory	1) Annual; 2) Triennial	1) RBRVS; 2) Survey of charges
Idaho	Yes	RBRVS	Mandatory	Annual	Inflation rate
Illinois	Yes	Charges	Mandatory	Annual	CPI
Indiana	No	Charges			
Iowa	No	Charges			
Kansas	Yes	RBRVS	Mandatory	Biennial	
Kentucky	Yes	Charges	Mandatory	Biennial	
Louisiana	Yes	Charges	Discretionary	Annual	
Maine	Yes	RBRVS	Mandatory	Annual	3rd party payors
Maryland	Yes	% Medicare	Mandatory	Biennial	
Massachusetts	Yes	% Medicare	Mandatory	Annual	
Michigan	Yes	RBRVS, w/GPCI	Mandatory	Annual	
Minnesota	Yes	Unspecified	Mandatory	Annual	SAWW
Mississippi	Yes	Charges	Unspecified		
Missouri	No	Charges			
Montana	Yes	RVP	Mandatory	Annual	SAWW

State	FS	Fee Basis	Updates	Update Period	Update Basis
Nebraska	Yes	Unspecified	Mandatory	Biennial	
Nevada	Yes	RVP	Mandatory	Annual	CPI
New Hampshire	No	Charges			
New Jersey	No	Charges			
New Mexico	Yes	Charges	Mandatory	Annual	
New York	Yes	Charges	Unspecified		
North Carolina	Yes	Unspecified	Mandatory	Periodic	
North Dakota	Yes	Unspecified	Unspecified		
Oklahoma	Yes	% Medicare	Mandatory	Biennial	CPI
Oregon	Yes	RBRVS	Mandatory	Annual	Survey of fees; CPI; other
Pennsylvania	Yes	% Medicare	Mandatory	Annual	SAWW
Rhode Island	Yes	Charges	Mandatory	As necessary	
South Carolina	Yes	Charges	Discretionary	As needed	
South Dakota	Yes	RVP	Unspecified		
Tennessee	Yes	RBRVS	Mandatory	Annual	MEI
Texas	Yes	% Medicare	Mandatory	Biennial	
Utah	Yes	RBRVS	Unspecified		
Vermont	Yes	Unspecified	Unspecified		
Virginia	No	Charges			
Washington	Yes	RBRVS	Discretionary	Annual	
West Virginia	Yes	RBRVS	Mandatory	Time to time	
Wisconsin	No	Charges			
Wyoming	Yes	RVP	Discretionary	Quarterly	

Abbreviations

CPI	Consumer Price Index
FS	Fee schedule
GPCI	Geographic Practice Cost Indices
MEI	Medicare Economic Index
RBRVS	Medicare Resource-Based Relative Value Scale
RVP	The Ingenix publication, *Relative Values for Physicians*
SAWW	Statewide Average Weekly Wage

Chapter 5

MAXIMUM ALLOWABLE FEES AMONG THE SEVERAL STATES FOR SERVICES RENDERED IN A NON-FACILITY SETTING

This chapter addresses the fourth issue of the Resolution, which states as follows:

> *A survey of nationwide benchmarks to see how Hawaii compares to other jurisdictions regarding provider payments and reimbursements for at least the ten most frequently used worker compensation health procedures;*

In this chapter, we compare maximum allowable fees among the several states. Specifically, we compare the non-facility maximum allowable fees of five Current Procedural Terminology (CPT) codes that relate to evaluation and management services and represent the most frequently reported codes from the Bureau's provider reimbursement survey, to be discussed in chapter seven. "Non-facility" refers to services rendered in a provider's office or like setting. Since our provider reimbursement survey was limited to reimbursements for services rendered in a non-facility setting, our comparison of nationwide maximum allowable fees is likewise limited to maximum allowable fees for services rendered in a non-facility setting.

We were able to obtain or calculate the non-facility maximum allowable fees for thirty-two states, including Hawaii, applicable to the year 2007. Ten other states apparently use fee schedules, but we were not able to obtain or calculate maximum allowable fees for them. For seven of these states, the fee schedules are apparently not available except through purchase. The purchase prices for printed versions of their fee schedules range from $24 to $315. These states are Alaska, Arizona, Connecticut, Georgia, Kentucky, New York, and South Carolina. For the three other states, we were not able to calculate their maximum allowable fees, because we were not able to locate or obtain the most current edition of their source of relative value units. These states are Montana, Nevada, and Wyoming. Their source of relative value units is the Ingenix publication, *Relative Values for Physicians*.

The Five CPT Codes for Comparison

The five most frequently reported codes from the Bureau's provider reimbursement survey are CPT codes 99203, 99204, 99212, 99213, and 99214.

The descriptions of these five CPT codes[1] and their maximum allowable fees under Hawaii's fee schedules are as follows:

1. Current Procedural Terminology: cpt 2002: Standard Edition, American Medical Association.

Table 5-1
Maximum Allowable Fees of Five Most Frequently Reported Codes

CPT Code	Description	Max. Allow. Fee in Hawaii
99203	Office visit; new patient; moderate severity; 30 minutes	$137.51
99204	Office visit; new patient; moderate to high severity; 45 minutes	$164.35
99212	Office visit; established patient; self limited or minor; 10 minutes	$ 50.31
99213	Office visit; established patient; low to moderate severity; 15 minutes	$ 73.79
99214	Office visit; established patient; moderate to high severity; 25 minutes	$103.98

Main Findings

We find that Hawaii's non-facility maximum allowable fees for the five CPT codes tend to fall in the middle band of these thirty-two states. Some of the fees are below the average, some are above the average, but all are within one standard deviation of the average. Hawaii's non-facility maximum allowable fees range for each of these five codes from about 94% to 115% of the corresponding average non-facility maximum allowable fees for all thirty-two states. On average, Hawaii's non-facility maximum allowable fees are about 102% of the non-facility maximum allowable fees for those thirty-two states, including Hawaii.

In particular, out of the thirty-two states, Hawaii has the eighth highest non-facility maximum allowable fee for CPT code 99203, the eighteenth highest non-facility maximum allowable fee for CPT code 99204, the eleventh highest non-facility maximum allowable fee for CPT code 99212, the thirteenth highest non-facility maximum allowable fee for CPT code 99213, and the eighteenth highest non-facility maximum allowable fee for CPT code 99214.

Among other observations, Hawaii's non-facility maximum allowable fees for the five codes are all consistently higher than the respective fees of eleven states: Alabama, California, Maryland, Massachusetts, Ohio, Oklahoma, North Carolina, North Dakota, Pennsylvania, Vermont, and West Virginia. The lowest non-facility maximum allowable fees are generally from Vermont. Hawaii's non-facility maximum allowable fees for the five CPT codes range from 120% to 139% of the average non-facility maximum allowable fees for those same codes among these eleven states. On average, Hawaii's non-facility maximum allowable fees are about 125% of the non-facility maximum allowable fees for these eleven states.

Likewise, Hawaii's non-facility maximum allowable fees for the five codes are all consistently lower than the respective fees of the seven states of Idaho, Illinois, Maine, Minnesota, Oregon, Tennessee, and Washington. The highest non-facility maximum allowable fees are from either Idaho or Illinois. Hawaii's non-facility maximum allowable fees for the five CPT codes range from 72% to 90% of the average non-facility maximum allowable fees for those same codes among these seven states. On average, Hawaii's non-facility maximum allowable fees are about 79% of the non-facility maximum allowable fees for these seven states.

Accordingly, Hawaii's non-facility maximum allowable fees for the five codes are in some instances higher, and in others lower, than the respective fees of each of the thirteen remaining states, specifically, Arkansas, Colorado, Florida, Kansas, Louisiana, Michigan, Mississippi, Nebraska, New Mexico, Rhode Island, South Dakota, Texas, and Utah. Hawaii's non-facility maximum allowable fees for the five CPT codes range from 95% to 118% of the average non-facility maximum allowable fees for those same codes among these thirteen states. On average, Hawaii's non-facility maximum allowable fees are about 103% of the non-facility maximum allowable fees for these thirteen states.

Patterns or Trends Between Fee Schedules and Fee Levels

In chapters three and four, we discussed respectively the bases of states' fee schedules and the adjustment methods of those fee schedules. For this chapter, we attempted to apply those findings to the non-facility maximum allowable fee levels of the states. We attempted to look for patterns or tendencies between the types of fee schedule bases and fee schedule adjustment methods on the one hand, and non-facility maximum allowable fee levels on the other hand.[2]

First, we looked at the seven states with consistently higher fees than Hawaii for the five evaluation and management CPT codes. These states are Idaho, Illinois, Maine, Minnesota, Oregon, Tennessee, and Washington.

A possible pattern emerges with regard to the bases of the fee schedules. We find that at least five of these seven states base their fee schedules on the national relative values of the Medicare Resource-Based Relative Value Scale. These states do not adopt the entire Medicare payment formula itself. Instead, they generally apply their own conversion factors to the Medicare relative values. These states are Idaho, Maine, Oregon, Tennessee, and Washington.[3] Minnesota is a possible sixth state; however, its statutes merely authorize and do not mandate the use of the Medicare Resource-Based Relative Value Scale, and the ultimate source of its relative values is not specified in its fee schedules.

A possible pattern also emerges with regard to fee schedule adjustment methods and periods of adjustment. We find that all seven of these states adjust their schedules annually, apparently for inflation, using the consumer price index, the consumer price index-urban, the statewide average weekly wage, the year-over-year inflation rate, changes in levels of reimbursement, or the Medicare Economic Index. Adjustments in the six of the states are mandatory. Adjustments in Washington are discretionary.

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2. We attempt to make no claims with regard to *causation*. In other words, just because certain types of fee schedules or methods of adjustment may be associated with high maximum allowable fee levels does not mean that those types of fee schedules or methods of adjustment will cause, or always produce, high maximum allowable fee levels.

3. A further significance of these five states is that they comprise half of the ten states that base their fee schedules on the national relative values of the Medicare Resource-Based Relative Value Scale and do not adopt the entire Medicare payment formula. (The other five are Arkansas, Kansas, Michigan, Utah, and West Virginia.)

Second, we looked at the eleven states with consistently lower fees than Hawaii for those five evaluation and management CPT codes. These states are Alabama, California, Maryland, Massachusetts, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Vermont, and West Virginia.

No obvious pattern emerges with regard to the bases of the fee schedules. One possible pattern is that five of these eleven states base their schedules on a percentage of the Medicare fee schedule applicable to their state (or Medicare locality). However, the specified year of the Medicare fee schedule is not necessarily the current year. These five states are California, Maryland, Massachusetts, Oklahoma, and Pennsylvania. California appears to set its "Official Medical Fee Schedule 2003" such that it will not exceed 100% of the Medicare rates. Maryland sets its fee schedule at 109% of the 2004 Medicare fee schedule. Massachusetts bases its rates of payment upon Medicaid rates of payment, which we assume are, in turn, based upon Medicare rates of payment. Oklahoma sets its fee schedule at no less than 115% of the "current" Medicare reimbursement rates. (Oklahoma updates its fee schedule biennially. Its current fee schedule became effective January 1, 2006. This schedule is evidently based upon the Medicare fee schedule that became effective January 1, 2005.) Pennsylvania caps its fees at 113% of the 1994 Medicare fee schedule.

A possible pattern emerges with regard to the periods of adjustment: annual adjustments are not the norm. Only eight of these eleven states have any provision for adjusting their schedules. Five of the eight have biennial or flexible adjustment periods. Maryland and Oklahoma require biennial adjustments. California authorizes, but does not require, biennial adjustments. North Carolina requires periodic adjustments. West Virginia requires adjustments, from time to time. Only the remaining three of the eight, specifically Alabama, Massachusetts, and Pennsylvania, require annual adjustments.

Finally, we looked at the thirteen states whose fees are neither consistently lower nor consistently higher than Hawaii's fees for those five evaluation and management CPT codes. These states are Arkansas, Colorado, Florida, Kansas, Louisiana, Michigan, Mississippi, Nebraska, New Mexico, Rhode Island, South Dakota, Texas, and Utah.

A possible pattern, albeit not very strong, emerges with regard to the bases of the fee schedules. Four of the thirteen states have fee schedules based on charges: usual and customary charges, prevailing charges, or current rates. These states are Louisiana, Mississippi, New Mexico, and Rhode Island.[4]

No pattern emerges with regard to fee schedule adjustment methods or periods of adjustment.

In summary, then, the higher fee levels nationwide for the five evaluation and management CPT codes are associated with states whose fee schedules are based upon the national relative values of the Medicare Resource-Based Relative Value Scale. Their schedules

4. A further significance of these four states is that they constitute the majority of the seven states other than Hawaii whose fee schedules are based upon charges and whose fee schedule amounts we were able to obtain. (The other three are Alabama, Illinois, and Ohio.)

are required to be adjusted annually, using a specified mechanism such as the consumer price index or the statewide average weekly wage. In contrast, the lower fee levels nationwide for the five evaluation and management CPT codes are associated with states whose schedules are not necessarily required to be adjusted annually.

The Table

Table 5-2 sets forth the non-facility maximum allowable fees for CPT codes 99203, 99204, 99212, 99213, and 99214 for thirty-two states, including Hawaii, applicable to the year 2007. The table was assembled by the Bureau. The non-facility maximum allowable fees for some states were obtained directly from those states' fee schedules. The non-facility maximum allowable fees for other states had to be calculated by the Bureau. In the annotations, we try to account for each figure or the lack of a figure placed into each cell of the table. The endnotes specify the source documents of a state's non-facility maximum allowable fees and offer explanations of the calculations we made in determining a state's non-facility maximum allowable fees. Additionally, the endnotes indicate the reasons why non-facility maximum allowable fees were not obtained either for a particular state or for an entire state.

States whose non-facility maximum allowable fee amounts were taken directly from a state's fee schedules are: Alabama, California, Florida, Illinois, Louisiana, Maine, Massachusetts, Michigan, Mississippi, Nebraska, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Vermont, Washington, and West Virginia. However, the non-facility maximum allowable fee amounts were available not statewide, but only for localities (or some other limited context) for: Alabama, Florida, Illinois, and Pennsylvania.

States whose non-facility maximum allowable fees were calculated by the Bureau based upon instructions in that state's statutes, administrative rules, or fee schedules are: Arkansas, Colorado, Hawaii, Idaho, Kansas, Maryland, Minnesota, Oregon, Tennessee, Texas, and Utah. The non-facility maximum allowable fee amounts listed for these states are applicable statewide, except for Texas, for which the figures are applicable only to Dallas County. Normally, calculations consisted merely of multiplying relative value units by a conversion factor or multiplying a fee amount by a specified percentage over 100%. For a few states, specifically, Idaho and Tennessee, we had to make a judgment call regarding whether the fully implemented or transitional (year 2007) relative value units should be used in the calculations, since neither the statutes nor the administrative rules specified which relative value units to use. We decided to use the transitional (year 2007) relative value units, as discussed in endnotes 38 and 99, respectively.

Further explanations and details are given in the endnotes to the table.

Table 5-2
Nationwide Non-Facility Maximum Allowable Fees (in Dollars) in 2007 for CPT Codes 99203, 99204, 99212, 99213, and 99214

State↓ CPT code[1]→	99203[2]	99204[3]	99212[4]	99213[5]	99214[6]
Alabama[7]	99.36[8]	145.04[9]	50.02[10]	58.11[11]	75.85[12]
Alaska[13]					
Arizona[14]					
Arkansas[15]	112.47[16]	173.58[17]	45.61[18]	75.72[19]	114.24[20]
California[21]	103.86	146.12	42.02	56.93	89.57
Colorado[22]	115.08[23]	164.40[24]	49.32[25]	73.98[26]	110.97[27]
Connecticut[28]					
Delaware[29]					
Florida[30]	108.00	163.00	43.00	68.00	104.00
Georgia[31]					
Hawaii[32]	**137.51[33]**	**164.35[34]**	**50.31[35]**	**73.79[36]**	**103.98[37]**
Idaho[38]	161.28[39]	246.96[40]	64.26[41]	104.58[42]	158.76[43]
Illinois[44]	165.71	236.31	72.56	95.11	141.20
Indiana[45]					
Iowa[46]					
Kansas[47]	118.60[48]	167.71[49]	47.26[50]	64.40[51]	101.00[52]
Kentucky[53]					
Louisiana[54]	122.00	182.00	48.00	68.00	105.00
Maine[55]	153.60	217.20	61.20	83.40	130.80
Maryland[56]	107.20[57]	151.44[58]	42.27[59]	58.93[60]	91.96[61]
Massachusetts[62]	101.16	142.67	40.33	55.97	87.24
Michigan[63]	135.54	191.76	53.71	72.29	113.95
Minnesota[64]	139.90[65]	208.32[66]	56.11[67]	79.94[68]	120.69[69]
Mississippi[70]	122.72	186.35	48.99	79.29	120.19
Missouri[71]					
Montana[72]					
Nebraska[73]	128.15	182.22	50.83	69.75	109.22
Nevada[74]					
New Hampshire[75]					
New Jersey[76]					
New Mexico[77]	107.33	181.22	48.12	67.07	93.15
New York[78]					
North Carolina[79]	91.97	137.97	36.21	51.16	79.33
North Dakota[80]	88.90	127.00	38.10	57.15	85.73
Ohio[81]	110.52	156.54	43.94	60.69	94.12
Oklahoma[82]	102.50	145.71	40.47	55.71	87.61
Oregon[83]	153.06[84]	234.38[85]	60.99[86]	99.25[87]	150.67[88]
Pennsylvania[89]	94.85	158.22	42.13	60.15	92.81
Rhode Island[90]	105.16	152.74	53.83	71.37	92.63
South Carolina[91]					
South Dakota[92]	109.20	156.00	46.80	70.20	105.30
Tennessee[93]	155.24[94]	237.71[95]	61.85[96]	100.66[97]	152.81[98]

State↓ CPT code[99]→	**99203[100]**	**99204[101]**	**99212[102]**	**99213[103]**	**99214[104]**
Texas[105]	119.24[106]	180.49[107]	47.83[108]	76.94[109]	116.58[110]
Utah[111]	115.20[112]	176.40[113]	45.90[114]	74.70[115]	113.40[116]
Vermont[117]	84.11	124.51	36.09	50.54	79.94
Virginia[118]					
Washington[119]	145.46	222.14	58.07	94.72	143.21
West Virginia[120]	102.37	145.51	40.19	54.99	86.29
Wisconsin[121]					
Wyoming[122]					
Average (n=32)	119.2891	175.1866	48.9475	71.35906	107.8813
Std dev	21.82659	33.20261	8.550673	14.65266	22.2171
Max	165.71	246.96	72.56	104.58	158.76
Min	84.11	124.51	36.09	50.54	75.85
Hawaii/average × 100	115.27	93.81	102.78	103.41	96.38

1. The CPT code descriptions are from the Current Procedural Terminology: cpt 2002: Standard Edition, American Medical Association.
2. CPT code 99203 identifies an office visit by a new patient. Medical decision making is of moderate severity. The session typically lasts 30 minutes.
3. CPT code 99204 identifies an office visit by a new patient. Medical decision making is of moderate to high severity. The session typically lasts 45 minutes.
4. CPT code 99212 identifies an office visit by an established patient. Medical decision making is self-limited or minor. The session typically lasts 10 minutes.
5. CPT code 99213 identifies an office visit by an established patient. Medical decision making is of low to moderate severity. The session typically lasts 15 minutes.
6. CPT code 99214 identifies an office visit by an established patient. Medical decision making is of moderate to high severity. The session typically lasts 25 minutes.
7. The amounts listed are from the 2007 doctor fee schedule. Under this fee schedule, each of the five CPT codes are listed five times, modified by the same set of five modifiers (-6, -A, -C, -N, and -Q). We do not know what the modifiers represent. We have listed the fee amounts yielded by modifier -C, because this modifier yields the highest fee amounts among the five modifiers for the same CPT code.
8. This amount of $99.36 applies when the code is followed by modifier -C, and is higher than the amount of $93.61, which applies when the code is followed by any of the other four modifiers: -6, -A, -N, or -Q.
9. This amount of $145.04 applies when the code is followed by modifier -C, and is higher than the amount of $134.27, which applies when the code is followed by any of the other four modifiers: -6, -A, -N, or -Q.
10. This amount applies regardless of the modifier.
11. This amount applies regardless of the modifier.
12. This amount applies regardless of modifier.
13. The 2004 Official Alaska Workers' Compensation Medical Fee Schedule is available for purchase from Ingenix in loose leaf binder format for $315.
14. The October 1, 2006 Physicians Fee Schedule changes are available for purchase from the Industrial Commission of Arizona at $27.00 each for schedules with binder, $24.00 each for schedules without binder, and $22.50 each for a CD Rom.
15. The fee schedule effective May 15, 2000, specifies in its instructions for use that fees are calculated by multiplying the national "fully implemented non-facility total relative value units" by the specific conversion factor adopted by Arkansas. The fee schedule specifies that the conversion factor for medicine (including

evaluation and management services) is $44.28. We used the relative value units from the Fully Implemented Non-Facility Total column in Addendum B, from 71 Federal Register 231 (December 1, 2006).

16. 2.54 × $44.28.
17. 3.92 × $44.28.
18. 1.03 × $44.28.
19. 1.71 × $44.28.
20. 2.58 × $44.28.
21. Amounts listed are from Table A, February, 2007 Addendum, 8 California Code of Regulations section 9789.11(f). The table lists maximum fees for physician services rendered on or after February 15, 2007.
22. According to the administrative rules, at 7 Colo. Code Regs. § 1101-3 (Rule 18), the fee schedule for the year 2007 is based on the 2006 edition of the *Relative Values for Physicians*. The conversion factor for the evaluation and management codes is $8.22/RVU.
23. 14.0 × $8.22.
24. 20.0 × $8.22.
25. 6.0 × $8.22.
26. 9.0 × $8.22.
27. 13.5 × $8.22.
28. The 2007 update of the Connecticut 2002 fee schedule, effective April 1, 2007, is available for purchase from Ingenix at a price of $50.00 in softbound format.
29. "There is no fee schedule in Delaware for medical treatment. Benefits that are not disputed are payable at the rate billed by the provider," according to the website of the Delaware Department of Labor.
30. Amounts listed are from the 2/27/07 draft of the 2007 fee schedule. We chose list the maximum allowable fees for services rendered in a non-facility in Medicare locality 04 (Dade and Monroe counties). Florida, like Hawaii, uses two fee schedules in conjunction with each other. One is the 110% Medicare fee schedule. The other is the fee schedule adopted by the three-member panel as of January 1, 2003. The maximum allowable fee for a CPT code is the higher of the two fee amounts from the two schedules. For the five CPT codes reviewed here, the maximum allowable fees all turn out to be from the 110% Medicare fee schedule.
31. The website of the Georgia State Board of Workers' Compensation indicates that the Georgia Workers' Compensation Medical Fee Schedule, effective April 1, 2007, is available for purchase from Ingenix at $165.00 in loose leaf binder format, and at $350.00 in CD-ROM format.
32. Unless otherwise specified, the governing fee schedule is the supplemental fee schedule. Under the 2007 supplemental fee schedule, the fee for a procedure is calculated by multiplying the unit value of the procedure by the conversion factor of $33.54. This conversion factor applies to all service categories.
33. 4.1 × $33.54.
34. 4.9 × $33.54.
35. 1.5 × $33.54.
36. 2.2 × $33.54.
37. The governing fee schedule for this code is the Medicare fee schedule raised to one hundred and ten percent. The fee is 94.53 × 1.10 = 103.98. The participating physician amount of $94.53 was obtained from the Medicare Part B, Hawaii, 2007 Provider Disclosure Report, on the Noridian website.
38. The statutes, at IS 72-803, specify that fees are calculated by multiplying relative value units from the current year RBRVS by conversion factors adopted by Idaho. The administrative rules, at IAC, rule 17.02.08.031, specify that the conversion factor for CPT codes 99000 - 99499, miscellaneous services, is $63.00. Neither the statutes nor the administrative rules specify whether it is the fully implemented or transitional (year 2007) relative value units that should be used. Accordingly, for our calculations, we decided to use the transitional relative value units, specifically, the relative value units found in the Year 2007 Transitional Non-Facility Total column in Addendum B, from 71 Federal Register 231 (December 1, 2006). We also infer that in expressly adopting the RBRVS, Idaho did not adopt Medicare's geographic practice cost indices.

39. 2.56 × $63.00.
40. 3.92 × $63.00.
41. 1.02 × $63.00.
42. 1.66 × $63.00.
43. 2.52 × $63.00.
44. Amounts listed are from the 2007 fee schedule. We chose to download, from the website of the Illinois Workers' Compensation Commission, the figures that pertain specifically to geozip 606 (Chicago).
45. We are unaware of whether Indiana has a fee schedule.
46. Iowa laws do not appear to establish a fee schedule.
47. The December 1, 2005, fee schedule specifies in its introduction that fees are calculated by multiplying the unit value of the procedure by the dollar conversion factor applicable to the particular section in effect on the date the service was provided. The introduction specifies that the conversion factor for evaluation and management services is $46.33.
48. 2.56 × $46.33.
49. 3.62 × $46.33.
50. 1.02 × $46.33.
51. 1.39 × $46.33.
52. 2.18 × $46.33.
53. The website of the Kentucky Office of Workers' Claims indicates that the Kentucky 2005 Workers' Compensation Medical Fee Schedule for Physicians, effective February 15, 2006, is available for purchase from the Kentucky State Treasurer, at $45.00 for a book, and at $25.00 for a CD.
54. The amounts listed are from August 1994 edition of the fee schedule, as published in the March 2006 edition of the Louisiana Administrative Code.
55. Amounts listed are from the fee schedule effective 11/05/06.
56. The medical fee guide, effective June 5, 2006, indicates that Maryland uses the 2004 reimbursement methodologies, models, and values or weights used by the Centers for Medicare and Medicaid Services. The conversion factor generally to be used in determining reimbursement is the conversion factor adopted by the Centers for Medicare and Medicaid Services for 2004 multiplied by 109%. The website of the Maryland Workers' Compensation Commission contains the 2004 Medicare Fee Schedule, dated June 10, 2004, applicable to locality 01 (Baltimore and surrounding counties). We infer that the schedule is applicable statewide. The fee amounts are listed in columns. For our calculations, we used the fee amounts applicable when participating physicians perform services in a non-facility. We multiplied those fee amounts by 1.09.
57. $98.35 × 1.09.
58. $138.94 × 1.09.
59. $38.78 × 1.09.
60. $54.06 × 1.09.
61. $84.37 × 1.09.
62. The fees are listed in the fee schedule effective 9/01/04, under the column for global fees.
63. The amounts listed are from the Michigan Workers' Compensation Fee Schedule 2007, effective April 2, 2007. Specifically, the amounts are from the column for maximum allowable payment (MAP) in a non-facility site of service.
64. The administrative rules, at MR 5221.4020, specify that the maximum fee for a service is the product of a relative value unit and a conversion factor. Both are listed in the rules. For CPT codes 99203 to 99214, the relative value units are listed in part 5221.4030, which covers medical/surgical procedure codes. Column 5 in part 5221.4030 lists the total relative value units for the service when the service is provided by a health care provider in the provider's office. For medical/surgical services in part 5221.4030, for dates of service from October 1, 2006 to September 30, 2007, the conversion factor is $76.87.
65. 1.82 × $76.87.

66. 2.71 × $76.87.
67. 0.73 × $76.87.
68. 1.04 × $76.87.
69. 1.57 × $76.87.
70. The amounts listed are from the fee schedule effective 7/01/07.
71. Missouri laws do not appear to establish a fee schedule.
72. The fee schedule is based on the *Relative Values for Physicians*. The administrative rules, at Mont. Admin. R. 24.29.1531, specify the use of the most current edition of the *Relative Values for Physicians*. The most current edition for the year 2007 appears to be the 2007 edition of the publication, which was evidently published on December 30, 2006. We were not able to locate and borrow a copy of the 2007 edition, which sells for $329.95 a copy.
73. The amounts listed are from the fee schedule effective 7/01/06.
74. The fee schedule is based on the *Relative Values for Physicians*. The administrative rules, at Nev. Admin. Code §616C.145, specify the use of the most recently published edition of the publication. No conversion factors are given in the rules. Apparently, the rules appear to authorize individual physicians to develop their own conversion factors, following the guidelines on conversion factor development given in the *Relative Values for Physicians*.
75. New Hampshire laws do not appear to establish a fee schedule. Carriers are required to pay the full amount of the health care provider's bill.
76. New Jersey laws do not appear to establish a fee schedule.
77. The amounts listed are from the New Mexico Workers' Compensation Medical Fee Schedule, effective December 31, 2005. The fee schedule is incorporated as section 3 of the New Mexico Workers' Compensation Administration's Compilation of Medical Rules and Fee Schedule, January 2007. Section 2 of the compilation, pertaining to the director's amended fee schedule order issued on December 26, 2006, verifies that the 2005 Schedule of Maximum Allowable Payments remains in effect until a replacement is issued. Evidently, a 2006 Schedule of Maximum Allowable Payments had been issued on December 21, 2006, but was withdrawn on December 26, 2006, as part of the amended fee schedule order.
78. The website of the New York State Workers' Compensation Board indicates that copies of the fee schedule may be purchased from Medicode, Inc. The purchase price is not given.
79. The amounts listed are from the fee schedule effective 5/01/07.
80. The amounts listed are from the 1/01/07 fee schedule.
81. The amounts listed are from the 2007 fee schedule, from the column for non-facility fees.
82. The amounts listed are from the fee schedule effective 1/01/06.
83. The administrative rules, at OAR 436-009-0004 and 436-009-0040, specify that payment according to the fee schedule is determined by multiplying the assigned relative value unit by the applicable conversion factor. It further specifies that where the procedure is performed inside the medical service provider's office, the relative value unit is found in the Year 2007 non-facility total column, from the 2007 Medicare Resource-Based Relative Value Scale Addendum B, 71 Federal Register No. 231, December 1, 2006. The rules further specify that the conversion factor for evaluation/management is $59.79.
84. 2.56 × $59.79.
85. 3.92 × $59.79.
86. 1.02 × $59.79.
87. 1.66 × $59.79.
88. 2.52 × $59.79.
89. The amounts listed are from the fee schedule amount column in the 2007 WC Part B Fee Schedule. We chose to use the amounts that apply specifically to Medicare Location 1, because Medicare Location 1 has the highest fee amounts of the four Medicare locations.
90. The amounts listed are from the fee schedule effective 10/25/06.

91. The website of the South Carolina Workers' Compensation Commission indicates that the fee schedule is available for purchase at $60.00 each.
92. The amounts listed are from the fee schedule effective 6/27/07. The administrative rules, at SDAR 47:03:05:02, indicate that the fee schedule is based on the *Relative Values for Physicians*.
93. The administrative rules, at TCRR 0800-2-18-.01 and 0800-2-18-.02, indicate that the fee for a CPT code is calculated by multiplying the national total relative value units, unadjusted for the Geographic Practice Cost Indices, found in the most current versions of the Medicare RBRVS, by the specific conversion factor adopted by Tennessee. The rules specify that the Tennessee conversion factors are based on the Center for Medicare and Medicaid Services' 2006 unit amount of $37.8975. In particular, the rules further indicate that the conversion factor for CPT codes related to office visits and evaluation and management is $60.64, or 160% of the Center for Medicare and Medicaid Services' 2006 unit amount of $37.8975. Neither the statutes nor the administrative rules specify whether it is the fully implemented or the transitional (year 2007) relative value units that should be used. Accordingly, for our calculations, we decided to use the transitional relative value units, specifically, the relative value units found in the Year 2007 Transitional Non-Facility Total column, from Addendum B, 71 Federal Register No. 231 (December 1, 2006).
94. 2.56 × $60.64.
95. 3.92 × $60.64.
96. 1.02 × $60.64.
97. 1.66 × $60.64.
98. 2.52 × $60.64.
99. The CPT code descriptions are from the Current Procedural Terminology: cpt 2002: Standard Edition, American Medical Association.
100. CPT code 99203 identifies an office visit by a new patient. Medical decision making is of moderate severity. The session typically lasts 30 minutes.
101. CPT code 99204 identifies an office visit by a new patient. Medical decision making is of moderate to high severity. The session typically lasts 45 minutes.
102. CPT code 99212 identifies an office visit by an established patient. Medical decision making is self-limited or minor. The session typically lasts 10 minutes.
103. CPT code 99213 identifies an office visit by an established patient. Medical decision making is of low to moderate severity. The session typically lasts 15 minutes.
104. CPT code 99214 identifies an office visit by an established patient. Medical decision making is of moderate to high severity. The session typically lasts 25 minutes.
105. The website of the Texas Department of Insurance, Division of Workers' Compensation, references a Medicare fee schedule calculator on the website of Trailblazer Health Enterprises, LLC at http://www.trailblazerhealth.com, for calculating fees under the Texas fee schedule. The department further specifies the use of the participating physician reimbursement amount, in its section on Frequently Asked Questions about the Workers' Compensation 2002 Medical Fee Guideline. Over on the Trailblazer site, we used the fee schedule calculator, specifying 2007 as the year, Texas as the state, and Dallas county as the locality. We looked for the dollar amount given as the participating amount for non-facility fees. We then multiplied that amount by 125%.
106. $95.39 × 1.25.
107. $144.39 × 1.25.
108. $38.26 × 1.25.
109. $61.55 × 1.25.
110. $93.26 × 1.25.
111. The administrative rules, at UAC R612-2-5, indicate that the non-facility total unit value from the 2007 edition of the Medicare RBRVS is to be applied to calculate reimbursements. The medical fee guidelines effective July 1, 2007, further specify that the non-adjusted national RBRVS is to be used to calculate reimbursement values. The guidelines also specify that Utah does not use the Center for Medicare and Medicaid Service's

designated Geographic Practice Cost Indices applicable to Utah. Furthermore, the guidelines indicate that the Centers for Medicare and Medicaid Services transitional relative value, as published by INGENIX, is selected as the method for calculating reimbursements. Finally, the guideline specifies that the total reimbursement value is calculated by multiplying the relative value unit assigned to each CPT code by each specialty's unique 2007 conversion factor adopted by Utah. The rules further specify that the conversion rate effective July 1, 2007, for evaluation and management codes 99201-99204 and 99211-99214 is $45.00. We did not obtain the INGENIX publication. We instead chose to use the transitional relative values from the Year 2007 Transitional Non-Facility Total column in Addendum B, 71 Federal Register 231 (December 1, 2006).

112. 2.56 × $45.00.
113. 3.92 × $45.00.
114. 1.02 ×$45.00.
115. 1.66 × $45.00.
116. 2.52 × $45.00.
117. The amounts listed are from the fee schedule effective 5/15/06, from the column for the fees effective 1/01/07.
118. "There is no fee schedule in Virginia," according to the website of the Virginia Workers' Compensation Commission. "Charge schedules agreed to by the carrier and the provider will be enforced."
119. The amounts listed are from the fee schedule effective 7/01/07, from the column for the dollar value applicable to a non-facility setting.
120. The amounts listed are from the fee schedule effective 1/01/06, from the column for non-facility fees.
121. Wisconsin laws do not appear to establish a fee schedule.
122. The fee schedule is based on the Ingenix publication, *Relative Values for Physicians*. The administrative rules, at Rules, Regulations and Fee Schedules of the Wyoming Workers' Safety and Compensation Division, chapter 9, section 1, specify the use of the current edition of the *Relative Values for Physicians*. The current edition for the year 2007 appears to be the 2007 edition of the publication, which was evidently published on December 30, 2006. We were not able to locate and borrow a copy of the 2007 edition, which sells for $329.95 a copy.

Chapter 6

HAWAII'S TWO WORKERS' COMPENSATION FEE SCHEDULES

Hawaii uses two fee schedules for workers' compensation. One is the Medicare fee schedule applicable to Hawaii, raised to one hundred and ten percent. The other is the supplemental fee schedule, based on prevalent charges. This chapter discusses the legislation that established the two fee schedules and the administrative rules that govern their use. Since the Medicare Resource-Based Relative Value Scale and Medicare payment formula were discussed in an earlier chapter, this chapter focuses more on the supplemental fee schedule.

The Two Fee Schedules Under Hawaii's Workers' Compensation Law

Act 234, Session Laws of Hawaii 1995, relating to workers' compensation reform, took effect on June 29, 1995. One of the many reforms accomplished by the Act was the repeal of an administratively established fee schedule that had been adjusted annually to reflect increases or decreases in the Consumer Price Index for the Honolulu region. On its effective date, the Act immediately replaced that schedule with one that was one hundred and ten per cent of the Medicare fee schedule. The Act also required the Director of Labor and Industrial Relations to administratively establish a supplemental (literally, "additional") fee schedule not exceeding the prevalent charges for services that either are not covered under Medicare or are covered, but for which the Medicare allowances are not reasonable. The Act required that fees be adequate.

The Act also required the schedules to be updated annually. In particular, the Act required that the updates be based upon: future changes to the Medicare Resource Based Relative Value Scale system applicable to Hawaii; or a statistically valid survey of prevalent charges or information on prevalent charges provided by the state agency having access to such information.

Act 234 was subsequently amended the next year to authorize rather than require the establishment of the supplemental fee schedule and to provide for triennial or annual updates, as required, rather than require annual updates, to the schedules. Finally, it replaced fiscal years with calendar years for the commencement periods of the 110% Medicare fee schedule.[1]

The portion of Act 234, as amended, that pertains to the fee schedules is codified as section 386-21(c), Hawaii Revised Statutes, which presently reads as follows:

> *(c) The liability of the employer for medical care, services, and supplies shall be limited to the charges computed as set forth in this section. The director shall make determinations of the charges and adopt fee schedules based upon those determinations. Effective January 1, 1997, and for each succeeding calendar year thereafter, the charges shall not exceed one hundred ten per cent of*

1. Act 260, Session Laws of Hawaii 1996.

fees prescribed in the Medicare Resource Based Relative Value Scale system applicable to Hawaii as prepared by the United States Department of Health and Human Services, except as provided in this subsection. The rates or fees provided for in this section shall be adequate to ensure at all times the standard of services and care intended by this chapter to injured employees.

If the director determines that an allowance under the medicare program is not reasonable, or if a medical treatment, accommodation, product, or service existing as of June 29, 1995, is not covered under the medicare program, the director, at any time, may establish an additional fee schedule or schedules not exceeding the prevalent charge for fees for services actually received by providers of health care services to cover charges for that treatment, accommodation, product, or service. If no prevalent charge for a fee for service has been established for a given service or procedure, the director shall adopt a reasonable rate that shall be the same for all providers of health care services to be paid for that service or procedure.

The director shall update the schedules required by this section every three years or annually, as required. The updates shall be based upon:

(1) Future charges or additions prescribed in the Medicare Resource Based Relative Value Scale system applicable to Hawaii as prepared by the United States Department of Health and Human Services; or

(2) A statistically valid survey by the director of prevalent charges for fees for services actually received by providers of health care services or based upon the information provided to the director by the appropriate state agency having access to prevalent charges for medical fee information.

When a dispute exists between an insurer or self-insured employer and a medical services provider regarding the amount of a fee for medical services, the director may resolve the dispute in a summary manner as the director may prescribe; provided that a provider shall not charge more than the provider's private patient charge for the service rendered.

The Legislative Intent of Act 234 with Regards to the Fee Schedules

Based upon our review of the legislative history of Act 234, Session Laws of Hawaii 1995, as evidenced in the drafts of the legislation, the committee reports, floor debates, and task force report, we find that, although it is not expressly stated, the legislative intent of Act 234, Session Laws of Hawaii 1995, with regard to medical fees, was to adjust the level of workers' compensation medical fees downward so that the fees would be on par with the level of medical fees of prepaid health care plans.

The problem facing the legislature in 1995 was reportedly the marked gap that had existed between workers' compensation medical fees and prepaid health care plan medical fees

prior to 1995. The legislature intended to close that gap. Workers' compensation medical fees for some procedures were as much as 400% of private sector charges, and Hawaii's workers' compensation medical fee schedule was the highest in the country.[2] The fee schedule was 142 per cent of the national average and over 200 per cent of Medicare charges.[3] A reason cited for the disparity was the existing statutes, which required the fee schedule at the time to be automatically increased each year by the consumer price index.[4]

A key legislative committee report with respect to the bill that became Act 234 stated that conformity between work-related and non-work-related medical fees can be best achieved by repealing the use of the consumer price index and, instead, using the non-industrial fees charged by private prepaid health care contractors as the primary guideline or benchmark for the workers' compensation fee schedule and the reimbursement allowances under the Medicare program as a basis for calculating allowances for medical treatments, accommodations, products, and services.[5] Furthermore, legislative floor discussion indicated that the bill would address the out-of-control medical fee schedule by resetting it at a starting point of 120 per cent of Medicare and by allowing the Department of Labor and Industrial Relations to adjust accordingly when the Medicare fee schedule was out of line.[6]

Determining the Governing Fee Schedule for a Procedure or Service

With two co-existing fee schedules, it is possible that both fee schedules may concurrently list different maximum allowable fees for a CPT code. Administrative rules have been established to assist users in ascertaining which fee schedule determines the maximum allowable fee for a CPT code in any particular instance. The rules may be summarized as follows:

(1) If maximum allowable fees for a CPT code are listed under the supplemental fee schedule, the supplemental fee schedule determines the maximum allowable fee for that CPT code, regardless of whether the Medicare fee schedule also lists a maximum allowable fee for that CPT code;[7]

(2) If maximum allowable fees for a CPT code are listed only under the Medicare fee schedule, the 110% Medicare fee schedule determines the maximum allowable fee for that CPT code;[8] and

2. Governor's Task Force on Workers Compensation: Report and Recommendations, November 28, 1994, item no. 6, as discussed in Senate Standing Committee Report No. 899.
3. Senate Standing Committee Report No. 829, Senate Journal 1995.
4. Senate Standing Committee Report No. 829, Senate Standing Committee Report No. 899, Senate Journal 1995.
5. Senate Standing Committee Report No. 899, Committee on Ways and Means, Senate Journal 1995.
6. Senate Journal 1995, p. 400.
7. Hawaii Administrative Rules section 12-15-90(b).
8. Hawaii Administrative Rules section 12-15-90(a).

(3) If no maximum allowable fees for a CPT code are listed under either of the two fee schedules, then the maximum allowable fee is set as the lowest fee received by the health care provider for the same procedure or service when rendered to private patients. The provider should be prepared to itemize the lowest fee received for the same health care, services, and supplies furnished to any private patient during the one-year period preceding the date of the workers' compensation charge.[9]

The Charge-Based Supplemental Fee Schedule

The supplemental fee schedule is charge-based. Specifically, it is based upon "the prevalent charge for fees for services actually received by providers of health care services to cover charges for that treatment, accommodation, product, or service."[10]

The supplemental fee schedule for calendar year 2007 is set out as Exhibit A of chapter 12-15, Hawaii Administrative Rules. It is entitled the "Workers' Compensation Supplemental Medical Fee Schedule," effective January 1, 2007. Prior editions of the supplemental fee schedule, reflecting prior adjustments to the schedule, were issued in calendar years 1996, 1997, 2002, and 2005. The supplemental fee schedule is required under section 386-21(c), Hawaii Revised Statutes, to be updated "every three years or annually, as required."

In context, it appears that the three year requirement applies to the supplemental fee schedule, while the annual requirement applies to the 110% Medicare fee schedule. Hawaii's 110% Medicare fee schedule piggybacks the federal Medicare fee schedule. Updates to the 110% Medicare fee schedule are made automatically when updates are made to the Medicare fee schedule. Under federal law, specifically, 42 U.S.C. section 1395w-4(b), the Secretary of Health and Human Services is required to make those updates to the Medicare fee schedule on an annual basis. That would seem to leave the three-year requirement to apply to the supplemental fee schedule.

The supplemental fee schedule lists CPT codes, accompanied by their unit values. These unit values are developed from statistically valid surveys of prevalent charges conducted by the Department of Labor and Industrial Relations.[11] These statistical surveys of prevalent charges are in turn usually based upon the schedules of maximum allowable medical fees used by health care plan contractors for their prepaid health care plans. In some cases, surveys are sent to health care providers.[12]

Pursuant to section 386-21.5, Hawaii Revised Statutes, health care plan contractors are required to provide their schedules of maximum allowable fees to the department upon the

9. Hawaii Administrative Rules section 12-15-90(c).

10. Hawaii Revised Statutes section 386-21(c).

11. E-mail correspondence from the Administrator, Department of Labor and Industrial Relations, Disability Compensation Division, May 22, and August 14, 2007.

12. E-mail correspondence from the Administrator, Department of Labor and Industrial Relations, Disability Compensation Division, October 4, 2007.

department's request, and the department is required in turn to use those schedules of fees to the extent possible as the primary guideline in establishing those prevalent charges. According to the department, the health care plan contractors have been providing information to the department with the assurance that their responses will be treated as proprietary information, not subject to public disclosure. The survey responses are weighted by the number of health care plan contractor subscribers and their dependents and may be adjusted for outliers.[13]

Procedurally, the Department of Labor and Industrial Relations updates the supplemental fee schedule through the administrative rulemaking process, which includes the holding of a public hearing and the approval by the Governor, and is preceded by the statistical surveys. According to the department, the total time required under a "best case scenario" to promulgate adjustments to the supplemental fee schedule, from the building of a survey to approval by the Governor, is eight to nine months. The survey phase, from building the survey to analyzing the survey responses, takes about two and a half months. The administrative rule making phase, from the drafting of adjustments to the supplemental fee schedule to preparations for a public hearing, including the Governor's approval for the proposed rule changes to proceed to a public hearing, takes about two and a half months. Finally, the administrative rule making phase, from notice of a public hearing to approval of the proposed rule changes by the Governor, takes about three months.[14]

The statistical survey phase is initiated by one of three events: a petition for review of fees, legislative testimony indicating areas for fee review, or by the statutory requirement for a triennial review of fees.[15] Usually, a petition for a review of fees occurs when a health care provider or the medical association requests the department for a review of the allowable fees for specific codes, which fees the physicians or medical associations believe are inadequate.[16]

If the survey results indicate to the department that prevalent charges are higher than the allowable fees under the 110% Medicare schedule, the department begins preparation for a public hearing. Ultimately, the proposed adjustments are made unless there are valid arguments not to make the adjustments.[17]

The preparation for a public hearing also involves the participation of other departments and agencies. In particular, the Insurance Division of the Department of Commerce and Consumer Affairs conducts an actuarial study of the survey results and the impacts that fee schedule changes may have on small business, specifically, on their workers' compensation

13. Email correspondence from the Administrator, Department of Labor and Industrial Relations, Disability Compensation Division, to the Bureau, October 4, 2007.
14. Email correspondence from the Administrator, Department of Labor and Industrial Relations, Disability Compensation Division, to the Bureau, December 3, 2007.
15. Email correspondence from the Administrator, Department of Labor and Industrial Relations, Disability Compensation Division, to the Bureau, October 4, 2007.
16. E-mail correspondence from the Administrator, Department of Labor and Industrial Relations, Disability Compensation Division, May 22, August 14, and October 4, 2007.
17. E-mail correspondence from the Administrator, Department of Labor and Industrial Relations, Disability Compensation Division, May 22, August 14, and October 4, 2007.

insurance premiums.[18] The actuarial study takes about one month.[19] Once the actuarial study is completed, other state agencies subsequently involved in preparing their review and recommendations to the Governor regarding the request for a public hearing include the Department of Budget and Finance and the Department of Business, Economic Development, and Tourism.[20] Their review takes about one month.[21]

The current January 1, 2007, supplemental fee schedule is reportedly an "atypical" example of the amount of time required to make changes to the supplemental fee schedule.[22] The current supplemental fee schedule apparently required a little over three years to be finalized. One reason for the atypical length of time appears to be that the original survey done in 2004 was redone the following year in 2005, but with a wider scope the second time around. Another reason appears to be that the administrative rule making process following completion of the second survey spanned over a one year period.

First, with regard to the statistical survey phase, the 2007 supplemental fee schedule is based upon a comprehensive survey conducted in 2005, which both assimilates and supersedes a smaller survey of selected CPT codes conducted earlier in October 2004. The 2004 survey was limited to a review of the approximately 100 CPT codes requested by the Hawaii Medical Association in August 2003. In contrast, the 2005 survey covered the 100 most frequently used codes according to a RAND workers' compensation study, all the codes included in the supplemental fee schedule prior to 2005, as well as the 100 CPT codes that were requested by the Hawaii Medical Association in 2003. The comprehensive 2005 survey was conducted in May 2005 at the request of the Director of Labor and Industrial Relations in April 2005, following receipt of the results of the smaller 2004 survey in January 2005.[23]

Second, with regard to the administrative rulemaking phase, a draft of the supplemental fee schedule based upon the 2005 comprehensive survey results was ready by November 2005. Apparently, the preparation for a public hearing, including the request for a hearing, the actuarial study, and approvals for a hearing, took about one year to complete. The public hearing was held in September 2006. The Governor granted final approval to the proposed amendments to the supplemental fee schedule in October 2006. The current supplemental fee schedule took effect in January 2007.[24]

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18. E-mail correspondence from the Administrator, Department of Labor and Industrial Relations, Disability Compensation Division, October 4, and December 3, 2007.
19. E-mail correspondence from the Administrator, Department of Labor and Industrial Relations, Disability Compensation Division, to the Bureau, December 3, 2007.
20. E-mail correspondence from the Administrator, Department of Labor and Industrial Relations, Disability Compensation Division, October 4, and December 3, 2007.
21. E-mail correspondence from the Administrator, Department of Labor and Industrial Relations, Disability Compensation Division, December 3, 2007.
22. E-mail correspondence from the Administrator, Department of Labor and Industrial Relations, Disability Compensation Division, to the Bureau, October 4, 2007.
23. E-mail correspondence from the Administrator, Department of Labor and Industrial Relations, Disability Compensation Division, to the Bureau, May 22, August 14, October 4, December 3, and December 4, 2007.
24. E-mail correspondence from the Administrator, Department of Labor and Industrial Relations, Disability Compensation Division, to the Bureau, October 4, 2007.

The resulting 2007 supplemental fee schedule produced increases in fees of twenty-nine per cent for surgical procedures, four and two-tenths per cent for medicine codes, and twenty and seven-tenths per cent for evaluation and management codes, and decreases in fees of eight and six-tenths per cent for radiology codes.[25]

Calculating the Maximum Allowable Fee for a Procedure or Service Under the Supplemental Fee Schedule

Where the maximum allowable fee for a procedure or service is governed by the supplemental fee schedule, the calculation of the maximum allowable fee for calendar year 2007 under the workers compensation laws follows a basic formula developed by the Department of Labor and Industrial Relations as follows:

> *The calculated "value of one unit" is $33.54. The fee for each procedure should be computed by multiplying its "unit value" by $33.54.*[26]

Under the supplemental fee schedule, a procedure is identified by its CPT code. Each CPT code is assigned a specific number of unit values by the department. Furthermore, the "value of one unit" is determined by the department to be worth $33.54. The "value of one unit" has always been equal to $33.54 since the initial, January 1, 1996 edition of the supplemental fee schedule. Thus, changes in the maximum allowable fee are attributable to changes in the "number of unit values" assigned to the CPT code.

For example, CPT code 99213 represents an office visit for the evaluation and management of an established patient. It is governed by the supplemental fee schedule. The code is assigned 2.2 unit values by the department. As stated above, each unit value is worth $33.54. Accordingly, the maximum allowable fee for CPT code 99213 under the supplemental fee schedule is as follows:

Maximum allowable fee =
Number of unit values × the specific value of one unit =
2.2 × $33.54 =
$73.79.

The Resource-Based Medicare Fee Schedule

As discussed in chapter two, the Medicare fee schedule is resource-based. Specifically, it is based upon the time, intensity, and expenses expended by a physician in furnishing a service. Under federal statutes, the schedule is required to be updated annually, by the Secretary of

25. E-mail correspondence from the Administrator, Department of Labor and Industrial Relations, Disability Compensation Division, to the Bureau, May 22, 2007.

26. Hawaii Administrative Rules chapter 12-15, January 1, 2007 preface.

Health and Human Services.[27] The actual payment formula being used in Medicare for the year 2007 is as follows:

> Medicare maximum allowable fee =
> [(Medicare relative value units for physician work × budget neutrality factor × geographic practice cost index for physician work) + (Medicare relative value units for practice expense × geographic practice cost index for practice expense) + (Medicare relative value units for malpractice expense × geographic practice cost index for malpractice expense)] × conversion factor =
> [(work RVU × BN × work GPCI) + (practice expense RVU × practice expense GPCI) + (malpractice RVU × malpractice GPCI)] × CF.[28]

Calculating the Maximum Allowable Fee for a Procedure or Service Under the 110% Medicare Fee Schedule

As used in Hawaii's workers' compensation laws, the Medicare fee schedule applicable to Hawaii is raised to one hundred and ten per cent.

Section 12-15-90(a), Hawaii Administrative Rules, indicates that the calculation of the maximum allowable fee for a procedure or service governed by the 110% Medicare fee schedule is as follows:

> The workers' compensation maximum allowable fee =
> 1.10 × the Medicare maximum allowable fee,
> where the Medicare maximum allowable fee is the Medicare payment amount "applicable to Hawaii" for a "participating" physician.

The term "applicable to Hawaii" refers to the relative values of the Medicare Resource-Based Relative Value Scale being geographically adjusted for Hawaii through the Geographic Practice Cost Indices applicable to Hawaii. For Hawaii in 2007, the specific geographic practice cost indices are as follows:

> The work geographic practice cost index = 1.005.
> The practice expense geographic practice cost index = 1.113.
> The malpractice geographic practice cost index = 0.787.[29]

The term "participating" means that the full Medicare payment amount applicable to a "participating physician" under the Medicare program is applicable to all providers under the State's workers' compensation laws.

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27. 42 U.S.C. section 1395w-4(b).
28. 71 Federal Register No. 231 (December 1, 2006), p. 69629. See also note 18 in chapter two and accompanying text.
29. Federal Register, Vol. 71, No. 231, December 1, 2006, Final rule, addendum D, page 70016.

As an example, CPT code 99213 is also listed in the Medicare Resource-Based Relative Value Scale, which assigns the following figures to the relative value units of this code:

The relative value units for physician work = 0.92.
The relative value units for practice expense in a transitioned non-facility = 0.71.
The relative value units for malpractice expense = 0.03.[30]

The maximum allowable fee under the Medicare fee schedule, not raised to any percentage, for this type of established patient office visit would be as follows:

The Medicare maximum allowable fee =
[(work RVU × BN × work GPCI) + (practice expense RVU × practice expense GPCI) + (malpractice RVU × malpractice GPCI)] × CF =
[((0.92 × 0.8994) × 1.005) + (0.71 × 1.113) + (0.03 × 0.787)] × $37.8975 =
$62.45.

Finally, this Medicare maximum allowable fee raised to one hundred and ten per cent under Hawaii's workers' compensation laws gives the workers' compensation maximum allowable fee. Stated otherwise, the maximum allowable fee under the workers' compensation law is 1.10 × the Medicare maximum allowable fee. Accordingly, the maximum allowable fee for CPT code 99213, were the code governed by the 110% Medicare fee schedule, is as follows:

Workers' compensation maximum allowable fee =
1.10 × Medicare maximum allowable fee =
1.10 × $62.45 =
$68.70.

Note that the supplemental fee schedule produced a higher maximum allowable fee than did the Medicare fee schedule raised to one hundred and ten per cent.

The Next Chapter: A Preview

In the next chapter, most of the CPT codes reported by the medical doctors and osteopathic physicians as those most frequently used were found to be governed by the supplemental fee schedule rather than by the Medicare fee schedule raised to one hundred and ten per cent. In other words, as a practical matter, the primary schedule evidently appears to be the supplemental fee schedule, while the secondary schedule is the Medicare fee schedule raised to one hundred and ten per cent. Furthermore, the supplemental fee schedule reimburses medical doctors and osteopathic physicians at levels that generally exceed one hundred and ten per cent of the Medicare fee schedule.

30. Federal Register, Vol. 71, No. 231, December 1, 2006, Final rule, addendum B, page 70002.

Chapter 7

MAXIMUM ALLOWABLE FEES AND COMPARATIVE REIMBURSEMENTS IN HAWAII FOR SERVICES RENDERED IN A NON-FACILITY SETTING

This chapter addresses the second issue of the Resolution, which states as follows:

> *A comparison of rates for the ten most frequently used services in worker compensation services, actual costs of those services, and the amount reimbursed to the provider;*

In this chapter, we discuss the results of a survey conducted by the Bureau on typical CPT codes used for workers' compensation in Hawaii, the governing fee schedule for those CPT codes, the maximum allowable fees for those CPT codes, the reimbursements received for those CPT codes under the workers' compensation fee schedules, and the reimbursements received for those same CPT codes from two different sources of payment, specifically, uninsured patients and employee group health plans.[1]

The goal of the survey was to be able to compare actual workers' compensation reimbursements with the maximum allowable fees under the fee schedules and with reimbursements from different types of payers, in particular, employee group health plans and uninsured patients.

We limited the scope of the survey with regard to the types of providers, the setting, and the time frame. Specifically, we limited to survey to medical doctors (M.D.s) and osteopathic physicians (D.O.s) for services they rendered in a non facility setting (office setting) in the current year 2007.

We did not gather information on actual costs. With regard to actual costs, the Bureau's prior study on Medicaid reimbursements noted that obtaining cost information from individual providers "would probably be too labor-intensive and provide too many variables, since individual health care providers probably do not have the time or the ability to break down their cost of doing business by each treatment they provide."[2]

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1. We later learned that the term used by the Insurance Division on their website is "employer group health plan," not "employee group health plan."
2. Medicaid and Quest Provider Payment and Reimbursement Rates, Shawn K. Nakama, Report No. 6, 2006, Legislative Reference Bureau, at page 36.

The Survey

At the outset, we make the disclaimer that the surveys were not intended to be random samples or statistically valid surveys. Our methodology was informal. Nevertheless, we hope that the findings are reasonable.

During June and July of 2007, we were able to obtain, from two representative workers' compensation carriers in Hawaii, lists of medical doctors and osteopathic physicians, with business addresses in the State, who had submitted charges to them for services rendered to workers' compensation patients since January 1, 2007. The lists contained the names and business addresses of both individual practitioners and business entities, such as clinics and hospitals.

We decided to send surveys only to the individual practitioners on the lists provided by the carriers, and not to the business entities that were on those lists. We wanted to be able to control the potential variables in the responses, especially since the survey would be anonymous and follow up would likely be difficult to do. In retrospect, we regard this decision as a possible flaw in the execution of the survey, as it accounts for the rather small number of practitioners to whom the surveys were sent and the even smaller number of responses.

On July 16, 2007, the Bureau sent out surveys to 306 medical doctors (M.D.s) and osteopathic physicians (D.O.s) with business addresses in the State.

In the surveys, the medical doctors and osteopathic physicians were asked to list up to ten CPT codes that reflected their type of medical practice and were utilized in billing for services provided since January 1, 2007, to workers' compensation patients in a non-facility setting (the doctor's or physician's office). For each of the CPT codes, the doctors and physicians were asked to provide figures that reflected the reimbursements made to them under the workers' compensation fee schedules. We note that in workers' compensation, reimbursements are made by only the carrier (or the employer). The patient does not make co-payments.[3]

The doctors and physicians were also asked to provide figures that reflected the average amounts of reimbursement from the carrier, and the average amounts of co-payment made by the patient, for those same codes under employee group health plans, specifically, the employee group health plans of HMSA, HMAA, and UHA. We note that, in contrast to workers' compensation, reimbursements under employee group health plans are made by both the carrier and the patient.

The doctors and physicians were also asked to provide the amounts reimbursed for those same codes when made by uninsured patients. (See Appendix C for a copy of the survey.)

3. Section 386-21(a), Hawaii Revised Statutes.

The Survey Respondents

Responses were received from a total of fifty medical doctors and osteopathic physicians. Nine respondents reported that they did not perform any workers' compensation or office procedures for workers' compensation in the past year. Forty-one respondents reported that they provided medical services to workers' compensation patients during the past year. Medical doctors specializing in internal medicine made up the largest group of respondents. The table below provides a break out of the respondents by licensure and specialty area.

Table 7-1
Survey Respondents

	WC	No WC	Total
Medical Doctors (M.D.s):			
Anesthesiology	3		3
Cardiology	2		2
Infectious diseases and internal medicine	2		2
Internal medicine	10	1	11
Ophthalmology	2		2
Orthopaedic surgery	3		3
Physical medicine and rehabilitation	2		2
Psychiatry	3		3
Other specialties (one respondent each)	6	2	8
Unspecified specialty	5	2	7
Osteopathic Physicians (D.O.s):	3	3	6
Licensure unspecified:		1	1
Totals	41	9	50

The CPT Codes Reported, Including the Five Most Frequently Reported

Most of the responses were CPT codes. A few were not and thus could not be incorporated into the report.[4] A total of seventy-nine different CPT codes were reported. Most of the CPT codes were reported only once or twice, by one or two respondents. The codes covered six of the seven sections of the American Medical Association's Current Procedural Terminology, specifically, Evaluation and Management, Anesthesiology, Surgery, Radiology, and Medicine (except Anesthesiology). None covered Pathology and Laboratory.

4. The other coding systems were the Healthcare Common Procedure Coding System level II codes, which cover products, supplies, and services not included in the CPT codes, and the International Classification of Diseases-9 diagnostic codes.

The table below groups, by CPT section, the number of CPT codes reported for that section and the number of times any CPT code in that section was reported by a respondent:

Table 7-2
Grouping of Codes and Report Frequency

AMA CPT Section	# of CPT Codes	# of Reports
Eval and mgmt	18	95
Anesthesia	16	20
Surgery	12	15
Radiology	7	9
Pathology and lab	0	0
Medicine	26	46
Totals	**79**	**185**

As indicated above, the most frequently reported codes were from the evaluation and management section. The forty-one respondents who provided services to workers' compensation patients reported a total of eighteen different evaluation and management CPT codes. In the aggregate, these eighteen codes were reported a total of ninety-five times by the forty-one respondents.

The five most frequently reported codes in the survey were also all from the evaluation and management section. In descending order, based upon the number of times each code was reported by any respondent, these codes are as follows:

Table 7-3
The Five Most Frequently Reported Codes

CPT Code	Description	No. of Respondents Reporting this Code
99213	Office visit; established patient; low to moderate severity; 15 minutes	26
99214	Office visit; established patient; moderate to high severity; 25 minutes	16
99203	Office visit; new patient; moderate severity; 30 minutes	10
99212	Office visit; established patient; self limited or minor; 10 minutes	9
99204	Office visit; new patient; moderate to high severity; 45 minutes	7

In other words, twenty-six of the forty-one respondents reported CPT code 99213, sixteen of the forty-one reported CPT code 99214, ten of the forty-one reported CPT code 99203, nine reported CPT code 99212, and seven reported CPT code 99204. In the aggregate, these five most frequently reported codes were reported a total of sixty-eight different times from the forty-one respondents.

Given the small number of respondents to the survey, we find that setting forth only the five most frequently reported CPT codes is enough, since it might stretch the meaning of "most frequently reported" too far if the next five codes were listed. However, we see no reason to doubt the validity of these results, since these same CPT codes have turned up as the most common CPT codes in other surveys. Specifically, CPT codes 99213 and 99214 were listed among the ten most used CPT codes in Hawaii's workers' compensation medical fee schedule in a 2002 report by the Auditor, based upon data from HMSA.[5] Furthermore, CPT codes 99213, 99214, 99203, and 99212 were listed among the top 23 CPT codes in the volume of medical billings for Hawaii's workers' compensation in 2006 in a print out prepared for the Bureau by one of the carriers.[6] Additionally, the American Medical Association states that the evaluation and management codes are used by most physicians in reporting a significant portion of their services.[7]

The rest of this chapter will focus on the sixty-three non-anesthesia CPT codes. The anesthesia CPT codes, unlike the other CPT codes, are more difficult to manage because they are not assigned a flat maximum allowable fee. The maximum allowable fee fluctuates with the length of time. Generally, the more time spent performing the service, the higher the maximum allowable fee. Moreover, it appears that the services are generally rendered in a facility setting, specifically, during surgery in a hospital. They are accordingly outside the scope of the survey.

The survey data for these sixty-three non-anesthesia codes are found in table 7-5 at the end of the chapter.

The Supplemental Fee Schedule as the Primary Fee Schedule

We find that it is the supplemental fee schedule, rather than the 110% Medicare fee schedule, that determines the maximum allowable fees for the majority of the sixty-three non-anesthesia CPT codes reported in the survey. As indicated in chapter six, when the maximum allowable fees for a CPT code are listed in the supplemental fee schedule, the maximum allowable fee under the supplemental fee schedule supersedes the maximum allowable fee for that code under the 110% Medicare fee schedule.

Of the sixty-three non-anesthesia CPT codes reported, the maximum allowable fees for forty-five of them, constituting a 71 per cent majority of the reported codes, are governed under the supplemental fee schedule. In contrast, only eighteen codes, constituting a 29 per cent minority of the reported codes, are governed under the 110% Medicare fee schedule.

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5. Management Audit of the Disability Compensation Division and A Study of the Correlation Between Medical Access and Reimbursement Rates Under the Medical Fee Schedule, Report No. 02-07, March 2002, The Auditor, State of Hawaii, p. 39, including Exhibit 3.3. The source for the data was attributed to WorkComp Hawaii, A Subsidiary of HMSA.
6. These two other surveys were apparently based on the CPT codes used by or billed from all health care providers, not just medical doctors and osteopathic physicians. Accordingly, other common codes included services for physical therapy, massage therapy, chiropractic, and acupuncture.
7. Current Procedural Terminology: cpt 2007, Standard Edition, American Medical Association, p. xiii.

Functionally, it is as if the supplemental fee schedule is misnamed and should really be labeled the primary schedule, and the 110% Medicare fee schedule should be labeled as the true supplemental schedule.

The Shift from 110 Per Cent Medicare Fee Schedule to the Supplemental Fee Schedule as the Primary Fee Schedule

The fee schedule that determines the maximum allowable fees for the sixty-three non-anesthesia CPT codes reported in our survey shifted from the 110% Medicare fee schedule to the supplemental fee schedule with the 2002 and 2007 editions of the supplemental fee schedule. Whereas the 110% Medicare fee schedule was established on June 29, 1995,[8] the supplemental fee schedule was first issued by administrative rule on January 1, 1996,[9] with subsequent editions issued on January 1 of 1997, 2002, 2005, and 2007.

During the first two years of the two fee schedules, specifically 1996 and 1997, the maximum allowable fees for fifty-eight of the sixty-three codes reported in our survey, or 92% of the codes, were determined by the 110% Medicare fee schedule. No maximum allowable fees for any of these codes, or 0%, were listed in the supplemental fee schedule. The maximum allowable fees for five codes were not covered by either schedule.

However, in 2002, the maximum allowable fees for only thirty-five of the sixty-three codes, or 56%, were determined by the 110% Medicare fee schedule. In contrast, the maximum allowable fees for twenty-seven of the sixty-three codes, or 43%, were listed in the supplemental fee schedule. The maximum allowable fees for one code was not covered by either schedule.

Nothing changed in 2005 regarding the sixty-three reported codes. The same alignment of codes from 2002 was maintained.

However, in 2007, the maximum allowable fees for only eighteen, or 29%, of the sixty-three codes are determined by the 110% Medicare fee schedule. In contrast, the maximum allowable fees for forty-five of the sixty-three codes, or 71%, are now listed in the supplemental fee schedule. The maximum allowable fees for every code are covered by either one or the other schedule.

8. The effective date of Act 234 (1995) is June 29, 1995.
9. The effective date of the repeal of Hawaii Administrative Rules title 12, chapter 13, and its replacement by title 12, chapter 15 is January 1, 1996.

The table below summarizes the foregoing discussion:

Table 7-4
The Primary Fee Schedule Over the Years with Regard to the Maximum Allowable Fees for the CPT Codes Reported in Our Survey

Governing Fee Schedule	1996	1997	2002	2005	2007
110% MC FS sets fees	58	58	35	35	18
Supp FS sets fees	0	0	27	27	45
Neither FS sets fees	5	5	1	1	0
Total CPT codes	**63**	**63**	**63**	**63**	**63**

The Department of Labor and Industrial Relations explains that the supplemental fee schedule now appears to be the primary fee schedule because the Medicare physician fee schedule may not be keeping up with the cost of services rendered. The department relayed reports that the Centers for Medicare and Medicaid Services deflated the work relative value units by 10.1 per cent for payment calculations in the 2007 fee schedule in order to maintain budget neutrality. The Centers is proposing to further deflate the work relative value units to 11.8 per cent for payment calculations under the 2008 fee schedule, again to maintain budget neutrality. Furthermore, the Centers is also proposing to decrease the 2008 conversion factor by 9.9 per cent.[10] Accordingly, when the department conducts its surveys, and the surveys indicate that the prevailing charge for that code is greater than 110 per cent of the corresponding Medicare payment amount, a CPT code is added to the supplemental fee schedule or, if the code is already in the schedule, the maximum allowable fee is increased. Conversely, if the department's surveys indicate that the prevailing charge is less than or equal to 110 per cent of the corresponding Medicare payment amount, a CPT code is deleted from the supplemental fee schedule.[11]

Maximum Allowable Fees Under the Fee Schedules

We find that the two fee schedules together set maximum allowable fees for the sixty-three codes at a level that is about 130 per cent higher than the Medicare payment amounts for those same codes. For the eighteen codes governed by the 110% Medicare fee schedule, the 110% Medicare fee schedule sets maximum allowable fees at a level that is about 110 per cent higher than the Medicare payment amounts for those eighteen codes. For the forty-five codes governed by the supplemental fee schedule, the supplemental schedule sets maximum allowable fees at level that is about 136 per cent higher than the Medicare payment amounts for those forty-five codes.

10. Email correspondence from the Administrator, Department of Labor and Industrial Relations, Disability Compensation Division, to the Bureau, Oct. 4, 2007.

11. *Id.*

Average Actual Reimbursements Under the Fee Schedules

It should be noted that actual reimbursements are not equivalent to the maximum allowable fees. We find that the average actual reimbursements for the sixty-three codes as reported by the respondents are slightly less than the maximum allowable fees for those sixty-three codes under the two fee schedules. Under the two fee schedules together, average actual reimbursements for the sixty-three codes amount to about 89 per cent of the maximum allowable fees for those sixty-three codes. For the eighteen codes governed by the 110% Medicare fee schedule, the average actual reimbursements amount to about 93 per cent of the maximum allowable fees for those eighteen codes. For the forty-five codes governed by the supplemental fee schedule, the average actual reimbursements amount to about 88 per cent of the maximum allowable fees for those forty-five codes.

We note that the first of the respondents to offer comments in the survey commented that "[workers' compensation carriers] never pay the allowed amount."

One of the two representative carriers explained that differences between the maximum allowable reimbursements under the fee schedules and actual reimbursements received by the providers are attributable to factors such as: preferred provider organization or network contracts are discounted below the fee schedule; the provider is not using an appropriate or current fee schedule; the provider did not use the appropriate code for the service rendered; the provider "unbundled" services that should have been bundled;[12] or the documentation provided did not support the level of service billed.

The other representative carrier noted that the providers are required to bill for services in accordance with the fee schedule and administrative rules. Billed charges may be audited for compliance with the fee schedules and reduced to the maximum allowable amounts.

Comparisons of Reimbursements from Workers' Compensation with Reimbursements Under Employee Group Health Plans

We find that average actual reimbursements under the workers' compensation fee schedules are on par with average actual reimbursements from the carrier and the patient under employee group health plans. Average actual reimbursements for the sixty-three codes under the two workers' compensation fee schedules together are equivalent in amount to about 99 per cent of the average actual reimbursements from the carrier and the patient for those same codes under employee group health plans. For the eighteen codes governed by the 110% Medicare fee

12. With regard to "bundling," fees listed in the Medicare fee schedule are subject to Medicare rules on bundling. Section 12-15-90(d), Hawaii Administrative Rules. As an example, certain codes, such as telephone calls, are considered by the Centers on Medicare and Medicaid Services to be "bundled" services. Bundled services are not payable and should not be billed when performed incident to or in conjunction with another service. Note to Exhibit A, Chapters 12-15, Hawaii Administrative Rules, Workers' Compensation Supplemental Medical Fee Schedule.

schedule, the average actual workers' compensation reimbursements are coincidentally equivalent in amount to about 110 per cent of the average actual reimbursements from the carrier and the patient for those same eighteen codes under employee group health plans. For the forty-five codes governed by the supplemental fee schedule, the average actual workers' compensation reimbursements are equivalent in amount to about 96 per cent of the average actual reimbursements from the carrier and the patient for those same forty-five codes under employee group health plans.

Comparisons of Reimbursements from Workers' Compensation with Reimbursements from the Uninsured Patients

Based upon the survey responses, we believe that some of the figures provided to us as reimbursement amounts from uninsured patients might be more accurately interpreted as the provider's usual and customary charges.

With this shortcoming then, we find that average actual reimbursements under the two fee schedules for the sixty-three codes are equivalent in amount to about 82 per cent of the average actual reimbursements for those same codes from uninsured patients. For the forty-five codes governed by the supplemental fee schedule, the average actual workers' compensation reimbursements are equivalent in amount to about 83 per cent of the average actual reimbursements from uninsured patients for those same forty-five codes. For the eighteen codes governed by the 110% Medicare fee schedule, average actual workers' compensation reimbursements are equivalent in amount to about 80 per cent of the average actual reimbursements from uninsured patients for those same eighteen codes.

The Legislative Intent of Act 234 with Regard to the Governing Fee Schedule and Actual Reimbursement Figures from Workers' Compensation and Employee Group Health Care Plans

We noted earlier in the chapter that the 110% Medicare fee schedule appears to have been superseded by the supplemental fee schedule, at least for the sixty-three CPT codes reported in our survey.

We reviewed this turn of events against the legislative intent of Act 234, Session Laws of Hawaii 1995, which was discussed earlier in chapter six. The intent of the Act, as noted earlier, was to adjust the level of workers' compensation medical fees downward so that the fees would be on par with the level of medical fees of prepaid health care plans. We find that the legislative intent of the Act with regard to medical fees has been fulfilled.

Today, based upon the results of our rather informal survey, we find that the legislative intent of Act 234 appears to have been fulfilled with regard to maximum allowable fees and actual reimbursements for workers' compensation. As reported earlier in chapter six, worker's compensation fees for some procedures were as much as 400 per cent of private sector charges,

and Hawaii's fee schedule was the highest in the country. The fee schedule was 142 per cent of the national average and over 200 per cent of Medicare charges.

Although we do not have data to compare maximum allowable fee levels as between worker's compensation and employee group health plans, we have data to compare reimbursement amounts as between workers' compensation and employee group health plans. We find that reimbursements for workers' compensation are on par with employee group health plan reimbursements for the sixty-three codes reported in our survey. Actual reimbursements today under workers' compensation are about 99 per cent, not 400 per cent, of the *reimbursements* under employee group health plans.

Furthermore, maximum allowable fees under the two workers' compensation fee schedules for the sixty-three codes reported in the survey are about 130 per cent, not 200 per cent, of Medicare charges. Specifically, maximum allowable fees under the 110 % Medicare fee schedule are 110 per cent of Medicare charges, while maximum allowable fees under the supplemental fee schedule are about 136 per cent of Medicare charges. Finally, as discussed earlier in chapter five, we find that Hawaii's maximum allowable fees are about 102 per cent, not 142 per cent, of the national average, for the five most frequently reported CPT codes in our survey.

Back to S.C.R. No. 77, H.D. 1 (2007)

Based upon the results of our survey, then, workers' compensation actual reimbursements appear to be on par with employee group health plan reimbursements. Specifically, reimbursements under the two workers' compensation fee schedules are equal to about 99 per cent of the reimbursements from both carriers and patients under employee group plans for the sixty-three non-anesthesia CPT codes reported in the survey. For the eighteen CPT codes whose maximum allowable fees are governed by the 110 per cent Medicare fee schedule, the average actual workers' compensation reimbursements are equal to about 110 per cent of the average actual reimbursements from the carrier and the patient for those same eighteen codes under employee group health plans. For the forty-five codes whose maximum allowable fees are governed by the supplemental fee schedule, the average actual workers' compensation reimbursements are equal to about 96 per cent of the average actual reimbursements from the carrier and the patient for those same forty-five codes under employee group health plans.

However, the larger question unanswered is whether reimbursements from employee group health care plans are adequate. If they are not, then workers' compensation reimbursements are not adequate either. We note that S.C.R. No. 77, H.D. 1 was evidently prompted by concerns over inadequate levels of reimbursement from various sources of reimbursement, among them private insurance payers. These larger concerns are beyond the scope of this study. In this regard, however, we note that reimbursements from workers' compensation are just a small fraction of reimbursements from all sources of reimbursement. Specifically, the Department of Labor and Industrial Relations estimates that medical fees for

workers' compensation and no-fault automobile insurance account for approximately only 10 per cent of all medical fees.[13]

The Table of Data Relating to the Provider Reimbursement Survey

Table 7-5 at the end of this chapter provides a breakdown of reimbursement figures and related data for each of the sixty-three non-anesthesia CPT codes reported in the provider reimbursement survey. The table is basically a summary worksheet of the figures and data that we used in calculating percentages and in drafting the text of this chapter. The columns are described below, reflecting the order in which they appear in the table from left to right.

The column "CPT code" lists each of the sixty-three non-anesthesia CPT codes reported to us by the survey respondents.

The column "Respondents" lists the number of respondents who reported a particular CPT code. Reporting a particular code means that the code reflects the respondent's type of medical practice and was used in billing for services provided since January 1, 2007, to workers' compensation patients in a non-facility setting.

The column "MC" lists the Medicare payment amount applicable to Hawaii in 2007 for each of the reported CPT codes. The figures were obtained from the "Medicare Part B Hawaii 2007 Provider Disclosure Report" on the Noridian website, at https://www.noridianmedicare.com. The figures reflect the Medicare payment amounts for participating providers when services are rendered in a non-facility setting.

The column "MC*1.1" lists the maximum allowable fee for each of the reported CPT codes under the 110% Medicare fee schedule used in Hawaii's workers' compensation laws, under the assumption that the 110% Medicare fee schedule governs those codes. We calculated the figures by multiplying the Medicare payment amounts by 1.1.

The column "gov FS" indicates which of Hawaii's two workers' compensation fee schedules governs or determines the maximum allowable fees for each of the reported CPT codes. As indicated in chapter six, if the maximum allowable fee schedule for a CPT code is listed in both the supplemental fee schedule and the Medicare fee schedule, the supplemental fee schedule determines the maximum allowable fee for that CPT code. If the maximum allowable fee schedule for a CPT code is not listed in the supplemental fee schedule but is listed in the

13. Meeting with the Department of Labor and Industrial Relations, Disability Compensation Division, May 16, 2007; Email correspondence from the Department of Labor and Industrial Relations, Disability Compensation Division, to the Bureau, May 22, 2007.

    Technically, the motor vehicle insurance laws incorporate the workers' compensation supplemental medical fee schedule for the portion of required coverage referred to as "personal injury protection benefits." Also, charges for services covered under personal injury protection benefits but for which no fee has been set under the workers' compensation supplemental fee schedule are limited to eighty per cent of the providers' usual and customary charges for those services, sections 431:10C-308.5 (a), (b), (c), and 431:10C-103.5(a), Hawaii Revised Statutes.

Medicare fee schedule, the 110% Medicare fee schedule determines the maximum allowable fee for that CPT code. If the maximum allowable fee schedule for the CPT code is not listed under either fee schedule, then the maximum allowable fee for that CPT code is equal to the lowest fee received by the health care provider for the same procedure or service when rendered to private patients. We made the determination ourselves as to which fee schedule determines the maximum allowable fee for each of the sixty-three non-anesthesia CPT codes.

The column "WC max" lists the maximum allowable fee for each of the reported CPT codes under the applicable workers' compensation fee schedule. For codes whose maximum allowable fees are governed by the supplemental fee schedule, we calculated the maximum allowable fee for each code ourselves by multiplying the unit values for that code by $33.54 (the calculated "value of one unit"). For codes whose maximum allowable fees are governed by the 110% Medicare fee schedule, the calculations were done previously under the column "MC*1.1."

The column "WC actual" lists the average reimbursement amount made to the respondents for each of the reported CPT codes under the workers' compensation fee schedules. In other words, the column lists the average reimbursement amount made, when the payors are workers' compensation carriers. We averaged the amounts that were reported to us.

The column "UI" lists the average reimbursement amount made to the respondents for each of the reported CPT codes, when the payors are uninsured patients. We averaged the amounts that were reported to us.

The column "Group carrier" lists the average of the average reimbursement amount made to the respondents for each of the reported CPT codes, when the payors are carriers under an employee group health plan. We asked the providers to provide us with the average amounts reimbursed to them by the carriers under the employee group health plans of HMSA, HMAA, and UHA. We then averaged the average amounts that were reported to us.

The column "Group copay" lists the average of the average reimbursement amount made to the respondents for each of the reported CPT codes, when the payors are patients making co-payments under an employee group health plan. We asked the providers to provide us with the average amounts reimbursed to them by patients under the employee group health plans of HMSA, HMAA, and UHA. We then averaged the average amounts that were reported to us.

The column "Group total" lists the sum of the carriers' reimbursement and the patient's co-payment for each of the reported CPT codes under an employee group health plan. For each of the reported codes, we added the figure in the column "Group carrier" to the corresponding figure in the column "Group copay."

Table 7-5
Data Relating to the Provider Reimbursement Survey

CPT Code	Resp.	MC	MC*1.1	Gov FS	WC Max	WC Actual	UI	Group Carrier	Group Copay	Group Total
11040	1	42.55	46.81	110% MC	46.81	46.81	--	--	--	--
12001	2	144.49	158.94	Supp	204.59	204.59	240	--	--	--
12002	1	152.95	168.25	Supp	218.01	--	295	--	--	--
20550	1	57.31	63.04	Supp	80.5	80.5	120	56.1	14	70.1
20605	1	57.68	63.45	Supp	80.5	69.48	--	48.92	12	60.92
20610	3	71.66	78.83	Supp	97.27	88.84	104.64	72.72	15.53	88.25
29075	1	82.88	91.17	110% MC	91.17	87.54	82.88	79.32	20.66	99.98
29125	1	64.88	71.37	110%MC	71.37	67.05	64.88	52.77	15	67.77
29515	1	65.36	71.9	110%MC	71.9	68.96	65.36	61.88	16.11	77.99
29848	1	472.57	519.83	Supp	768.07	537.98	--	567.16	14	581.16
65222	1	69.88	76.87	Supp	93.91	76.44	100	85.7	15	100.7
66984	1	671.99	739.19	110% MC	739.19	739	1,571.00	852	145	997
73030	2	33.31	36.64	Supp	50.31	42.75	51.66	44.14	8.9	53.04
73070-26	1	7.36	8.1	Supp	15.26	17.12	--	27	0	27
73100	1	29.43	32.37	Supp	43.6	43.6	63	40.5	13.5	54
73110	1	33.18	36.5	Supp	46.96	46.73	--	43.5	0	43.5
73510	1	36.99	40.69	Supp	53.66	53.66	62	50.96	13.5	64.46
73564	2	39.9	43.89	Supp	57.02	49.58	59.95	46.27	11.65	57.92
73610	1	32.34	35.57	Supp	46.96	46.95	66	49.98	13.5	63.48
90801	4	150.49	165.54	Supp	201.24	187.21	236.61	165.88	11	176.88
90802	1	159.29	175.22	Supp	211.3	191	--	210	15	225
90805	3	70.1	77.11	Supp	90.56	65	102.62	61.7	55.5	117.2
90807	6	100.34	110.37	Supp	130.81	130.76	194.39	116.03	51.25	167.28
90846	1	90.19	99.21	Supp	140.87		174.72			
90847	3	111.03	122.13	Supp	171.05	130	191.53	135	15	150
90862	3	52.37	57.61	Supp	77.14	42.74	75.76	--	--	--
92002	2	71.6	78.76	Supp	90.56	78.16	94.5	72.15	12.5	84.65
92004	1	128.76	141.64	Supp	164.35	140.82	150	133.55	15	148.55
92012	1	66.05	72.66	Supp	83.85	73	84	62	10	72
93000	1	26.43	29.07	Supp	53.66	--	--	45.48	6.56	52.04
93015	2	111.94	123.13	Supp	197.89	195.23	216.5	139.55	22.37	161.92
93307	2	--	--	Supp	--	--	--	--	--	--
93320	2	414.28	455.71	Supp	717.75	658.9	721	440.95	126.6	567.51
93325	2	--	--	Supp	--	--	--	--	--	--
94010	1	35.71	39.28	Supp	60.37	181.69	--	54.41	10.44	64.85
94060	1	60.42	66.46	Supp	114.04	--	--	94.5	10.98	105.48
95860	1	92.21	101.43	Supp	144.22	144.22	145	105.06	18.54	123.6
95900	1	65.44	71.98	Supp	93.91	93.91	100	64.98	11.47	76.45
95904	1	56.45	62.1	Supp	80.5	80.5	90	54.98	9.7	64.68
97110	1	27.64	30.4	Supp	36.89	36.89	50	25.03	1.32	26.35
97140	2	26.12	28.73	110% MC	28.73	28.73	50	21.29	3.76	25.05

CPT Code	Resp.	MC	MC*1.1	Gov FS	WC Max	WC Actual	UI	Group Carrier	Group Copay	Group Total
97535	1	29.87	32.86	110% MC	32.86	--	--	24.73	4.37	29.1
97760	1	31.31	34.44	110% MC	34.44	34.44	50	26.69	1.41	28.1
98925	1	28.91	31.8	110% MC	31.8	32.55	30	23.27	5.27	28.54
98926	1	39.86	43.85	110% MC	43.85	43.85	40	31.91	7.25	39.16
99201	2	37.64	41.4	Supp	67.08	44.32	71.17	45	15	60
99202	5	65.32	71.85	110% MC	71.85	68.1	95.99	61.86	11.51	73.37
99203	10	96.43	106.07	Supp	137.51	106.19	110.34	96.54	13.38	109.92
99204	7	145.69	160.26	Supp	164.35	142.2	144.07	119.25	17.2	136.45
99205	2	182.39	200.63	Supp	234.78	180.53	172.79	165.29	21.48	186.77
99211	2	21.62	23.78	Supp	40.25	30.67	30	35.1	9.97	45.07
99212	9	38.91	42.8	Supp	50.31	46.07	55.6	34.1	9.67	43.77
99213	26	62.45	68.7	Supp	73.79	65.56	78.94	56.09	11	67.09
99214	16	94.53	103.98	110% MC	103.98	89.71	113.92	67.84	10.28	78.12
99215	4	127.46	140.21	Supp	160.99	110.96	132.13	131.81	18.15	149.96
99223	1	177.66	195.43	110%MC	195.43	204.64	--	164.1	7.26	171.36
99232	1	65.25	71.78	110%MC	71.78	75.18	--	60.35	9.86	70.21
99238	1	67.65	74.42	110%MC	74.42	75.16	--	76.27	0	76.27
99242	1	93.36	102.7	110% MC	102.7	102.7	172.02	69.71	7.74	77.45
99243	3	127.72	140.49	Supp	160.99	151.15	214.31	131.34	16.22	147.56
99244	2	186.82	205.5	110% MC	205.5	196.52	201.5	129.05	15.5	144.55
99245	2	231.55	254.71	Supp	275.03	111.9	--	224.37	19.69	244.06
99361	1	--	--	110% MC	--	110	--	--	--	--

Abbreviations:

Resp. = Number of respondents who reported this CPT code

MC = Medicare non-facility maximum allowable fee

MC* 1.1 = Medicare non-facility maximum allowable fee × 1.1

Gov FS = Governing workers' compensation fee schedule for that particular CPT code

WC Max = Workers' compensation non-facility maximum allowable fee

WC Actual = Average actual workers' compensation reimbursements

UI = Average actual reimbursements from uninsured patients

Group Carrier = Average actual reimbursements from the group carrier under an employee group health plan

Group Copay = Average actual co-payments from the patient under an employee group health plan

Group Total = Total average actual reimbursements from the group carrier and the patient under an employee group health plan

Supp = The supplemental workers' compensation fee schedule

110%MC = The Medicare fee schedule raised to one hundred and ten per cent

Chapter 8

COMMENTS FROM THE DOCTORS AND PHYSICIANS

In this chapter, we relay the comments on fee schedule reimbursements from the medical doctors and osteopathic physicians who participated in the survey. We also relay the responses of the carriers and the Department of Labor and Industrial Relations to the comments made by the doctors and physicians.

We note at the outset that we made some grammatical or stylistic changes to those comments and responses, which are otherwise presented verbatim.

Comments from the Doctors and Physicians

For our survey, we asked the doctors and physicians to provide comments or explanations on the differences, if any, in the reimbursement levels associated with workers' compensation, employee group health plans, and uninsured patients. Comments were received from twenty-two of the fifty respondents.

Comments on the Fee Schedule and Workers' Compensation

A few of the comments, received by more than one respondent, involved the fee schedules and the workers' compensation system. Table 8-1 below summarizes these comments and the responses to those comments by the Department of Labor and Industrial Relations:

Table 8-1
The Fee Schedule and Workers' Compensation

Doctor and Physician Comments	DLIR Response[1]
The fees are inadequate.	*Health care providers can notify the department if they believe that fees for certain codes are inadequate. The department will then survey health care plan contractors concerning the fees for those codes and allow for more than 110% of Medicare if the survey indicates that the prevalent charges for those codes are greater than 110% of Medicare. Alternatively, providers may lobby the Legislature to increase the percentage of Medicare at which fees are reimbursed.*

1. Email correspondence from the Administrator, Department of Labor and Industrial Relations, Disability Compensation Division, to the Bureau, October 9, 2007.

Doctor and Physician Comments	DLIR Response[1]
Workers' compensation cases involve uncompensated time. They involve comparatively more administrative work than what is involved under other insurance.	*The department is considering adding CPT code 99455 to the supplemental fee schedule. This code covers such items as developing a treatment plan, calculating impairment, assessing capabilities and stability, and determining causation (work relatedness). However, some of the items covered by the code are also covered under other evaluation and management CPT codes. Therefore, an attempt must be made to avoid double billing for the same work.*

A Note on CPT Code 99455

We support the position of the department in considering the addition of CPT code 99455 to the supplemental fee schedule. The code is the counterpart to CPT code 99456, which is presently listed in the supplemental fee schedule.

The two codes are described by the American Medical Association in substantially identical language. Both codes cover work-related or medical disability examinations, which include 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 a future medical treatment plan; and completion of necessary documentation/certificates and report.

The difference between the two codes involves the role of the physician. CPT code 99455 covers examinations by "the treating physician," while CPT code 99456 covers examinations by "other than the treating physician."[2]

Comments on Payments by Carriers

Other comments, received by more than one respondent, involved reimbursements by the carriers. The following table 8-2 summarizes the providers' comments and the individual responses of the carriers to those responses:

Table 8-2
Payments from Carriers

Provider Comments	Responses of Carrier 1	Responses of Carrier 2
Payments are delayed, from six months to a year.	*Hawaii Administrative Rules section 12-15-94 requires the employer to pay an undisputed bill within 60 calendar days of receipt. Turn around time from receipt of bill to payment for this carrier has averaged 3-7 days over the past 3 years.*	*I don't think any carrier would intentionally delay payments. However, there may be issues in the claims process that cause the payments to be delayed. Insurers are required to comply with many complex aspects of the workers'*

2. Current Procedural Terminology: cpt 2007: Standard Edition, American Medical Association, p. 31.

Provider Comments	Responses of Carrier 1	Responses of Carrier 2
	We are currently averaging 14 days for undisputed bills. Payment is delayed when the provider fails to include clinical notes to substantiate a charge or the notes provided do not match the codes used for billing. (Only the portion that has a discrepancy is not paid.) Payments delayed longer than 60 days are due to controverted claims or controverted treatment. An administrative hearing on the matter may take 3-6 months. The appeals process may take an additional 12-18 months.	*compensation law and its administrative rules as well. As insurers navigate through their respective claim administration requirements, payments can be delayed if such requirements must first be met.*
Payments are denied or not made at all.	*(See response above.)*	*The workers' compensation system is full of "red tape" for providers and insurers. Interestingly, some providers do not bill for their services for a very long time. Instead, they provide many service units over a long period of time (generally in excess of what would have gotten approved had the approval been requested prior to the service being provided), then bill all services within a very short period of time. Sometimes the bills come in a year or two after the service. In addition, providers take months and sometimes years to respond to simple information requests that would expedite their payment. We just received seven such resubmissions that are over 19 months old. If the provider failed to obtain the necessary authorization, or the claim is denied, payment would be justifiably denied by any type payor: group health, Medicare, or workers' compensation.*
Payments are downcoded.	*Carriers have a fiduciary duty to the business entities we insure, and pay what we are legally obligated to pay. In order for insurers to fulfill this duty, we review provider fees and corresponding documentation and verify that the appropriate code and fee are used. Although there are explicit descriptions and guidelines in the appropriate use of billing codes, in many instances, the documentation does not support the level of service billed.*	*"Downcoding" allows the insurer to pay for the level of service evidenced by the provider's documentation rather than paying $0 because the billed charge is not substantiated in full. Providers frequently upcode their bills by billing for a higher level of service than what was actually provided as evidenced by their documentation. Using a "plate lunch coding example," it is like billing for a "full-size plate" while delivering a "mini plate." Another common billing practice is "unbundling" whereby components of an individual service are billed separately at higher rates than if they were billed using a code that combines them. This is where the provider bills separately for the rice, chicken and mac*

Provider Comments	Responses of Carrier 1	Responses of Carrier 2
		salad, with the total exceeding that of the actual plate lunch which they were part of. These billing practices are not unique to workers' compensation in Hawaii but plague the entire healthcare industry. Many providers nationally and in Hawaii have paid multi-million dollar settlements to payors when sued for healthcare billing fraud over such billing practices.
The paperwork is inordinate.	*Nothing in HRS section 386-96 on reports of physicians requires a provider to furnish more than one copy of the report of the injury and treatment. If the provider of service completed the required form appropriately, notes would not be necessary. Clinical notes are necessary in order to verify the level of service being charged.* *The Department of Labor and Industrial Relations solicited input from various sectors of workers' compensation regarding standardization of forms in an effort to address this issue. Adoption of utilization guidelines supported in past legislative sessions by both providers and insurers would also streamline the process and minimize "paperwork."*	*As a government mandated entitlement program, workers' compensation can be expected to be more bureaucratic than a market-driven health plan, so many of these issues are systemic in nature. The workers' compensation system could use some modernization to take advantage of technologies that were not available when the system was reformed in 1995. There are many opportunities to modernize and streamline the work, money, and data flows that connect providers, insurers, and state administrators.*

Carrier 2 also offered additional comments relating to the utilization of codes and services and to provider complaints that workers' compensation involves uncompensated time:

> *Furthermore, utilization of codes in addition to just the reimbursement amount needs to be evaluated. For example, the dominant group health insurer in Hawaii only has 3 levels of evaluation and management codes (99211-99215 and 99201-99205), vs. the 5 levels defined under AMA-CPT and used by Medicare, workers' compensation, and other group health plans. With 3 levels of reimbursement vs. five, providers [under workers' compensation] will get reimbursed the same whether the service is a level 3 or a 4. If you factor that in, the reimbursement under workers' compensation is even higher than the difference[between] fee schedule[s].*
>
> *Another key issue to bear in mind when comparing the different fee schedules (workers' compensation vs. group health vs. Medicare) is the actual utilization of services under each fee schedule. How much and how much of what type of service will be allowed? Workers' compensation allows more utilization than any other health coverage. With few and very generous utilization guidelines, workers' compensation is obligated to look at each service billed closely for upcoding and unbundling. For example, under group health and Medicare, a patient may automatically receive 10 physical therapy treatments for a low back*

injury, and no other alternative treatments such as massage. Any additional physical therapy treatments in excess of the 10 would be very difficult to get approved and thus, reimbursed for. Under workers' compensation, on the other hand, for the same injury there may be in excess of 50 chiropractic treatments + 50 physical therapy treatments + 50 massage treatments + 50 acupuncture treatments, each averaging about $130/treatment.

With regard to workers' compensation involving uncompensated time... in general I think you would find this to be true for any type of medical coverage not just workers' compensation.

The Individual Comments of the Doctors and Physicians

As stated earlier, comments were received from twenty-two of the fifty respondents to the survey. The twenty-two individual comments are presented below in the order in which they were received, one bullet per respondent:

- *Workers' compensation denies more claims than they pay. They never pay the allowed amount. They never pay on time. They demand excessive paperwork. I refuse to see any new workers' compensation cases.*

- *The compensation is not the problem once the workers' compensation company accepts liability. Accepting liability until the case is heard by a hearing officer would solve this problem. If found not liable the medical treatment expenses incurred by the workers' compensation company could be turned over to the private carrier to pay as it is no longer a workers' compensation liability. The problem is mainly getting the workers' compensation carrier to accept liability. Injured patients unable to work cannot afford to pay the medical doctor; and private insurance refuses to pay, stating it is a workers' compensation issue. Once a medical doctor takes the patient and does the evaluation suggesting workers' compensation liability, if the workers' compensation company rejects liability the patient is left to pay the bill for treatment. If the patient cannot pay, the medical doctor either must abandon the patient or work pro bono. Many medical doctors just refuse workers' compensation cases, to avoid this.*

- *The patient needs authorization to come here, if we don't get authorization, we don't get paid. If we make a mistake, and not make an authorization for another physician, the other physician won't get paid. When you file a claim with workers' compensation you need to attach notes, work comp II form, and work comp II form in 5 copies. For the amount of work and headache you could file 100 claims of the other insurance. When a doctor gives recommendation, workers' compensation denies and your patient cannot get services. Workers' compensation is so bad, lots of physicians are not participating.*

- *Biggest problems are workers' compensation insurance companies are always delinquent in payments and often create a variety of "red tape" hurdles to not pay physicians. These companies treat physicians and their office staff very badly by not returning phone calls, not paying on claims, creating lots of extra paperwork to do which often gets them nowhere.*

- *I do not treat workers' compensation patients -- haven't for about 10 years. No plans to either.*

- *(no more because rates of reimbursement are only about 70% of my charge).*

- *I have not done workers' compensation for years and so do not know the "amounts reimbursed by them." I quit doing workers' compensation because of the interminable paperwork and uncompensated time, recurring letters, etc. Also I have no time for hearings, court, depositions. I also became tired of dealing with <u>rude</u> patients, attorneys and insurance adjustors. Money was not the major issue.*

- *Different reimbursements with different companies and/or situations, I guess.*

- *Seeing workers' compensation patients requires a lot more administrative work: getting authorizations, documentation, filing claims compared to other patients. Although the fees are similar, it is not worth the extra work involved.*

- *Workers' compensation fees are not only too low, but carriers make a standard practice of delaying payments, sometimes for a year, and then not paying at all on the grounds bill invoice is "more than a year".*

- *Workers' compensation requires too much paperwork, and reimbursement is not reflect [sic] the amount of time we have to spend. Also, workers' compensation insurance frequently downcode. We don't have the time to keep up with their requirement [sic] and we don't get paid as we should. I don't take new workers' compensation for this reason.*

- *Delays in processing. Long periods before reimbursement. Vague administrative paper work. Inadequate reimbursements.*

- *I have not participated with workers' compensation cases. The requirements for documentation, written communication/reports are tedious. Doctor patient relationships not always congenial. Compensation relatively poor for work required as per above.*

- *Workers' compensation fee schedules are simply too low. I'm currently only accepting patients from referrals from two surgeons.*

- *Workers' compensation fee is lower than local preferred provider organization (HMSA, HMAA, UHA). Workers' compensation and local preferred provider organization fees are lower than those in the mainland (BC, BS, Aetna, United Healthcare, --- etc.) while cost of doing business is higher in Hawaii. The most problem [sic] in Hawaii is that all insurance (workers' compensation, no fault, preferred provider organization) have used all kinds of excuses to deny or reduce payment for the last 10+ years.*

- *In my experience it has been very difficult to obtain reimbursement for my services. It is not unusual to wait anywhere from six months to a year. The reimbursement when received is so inadequate that I may have to stop providing care to workers' compensation patients.*

- *In an effort to lower workers' compensation premiums, the State has lowered fees and allowed the insurers to treat doctors roughly, such as through long delays in payment and third party auditing companies that will not allow payment unless a ridiculous level of documentation is received. As a result many doctors who treat non-workers' compensation patients won't accept workers' compensation anymore. Workers' compensation is increasingly the province of a small number of doctors who specialize in workers' compensation, have their practices organized around it, and perhaps are prepared to "do battle" with the insurers. This situation is bad medical care. So ...*

  (1) Increase reimbursement

  (2) Have a panel of doctors in charge of workers' compensation

  (3) Independent medical examinations hired by panel, not attorneys

  (4) No third party auditing companies

  The larger situation is that the Big Island is in a health care crisis, with doctors leaving as people (patients) are coming. We need:

  (1) Increased reimbursement

  (2) Strict curbs on managed care, with doctors reimbursed for all administrative duties imposed by insurers

  (3) State tax breaks

  (4) An agency to recruit and retain doctors

  (5) A "settlement" for past low pay and high frustration

- *Workers' compensation, HMSA etc., reimbursement amounts can be obtained from public records and/or the specific companies. The big problem with workers' compensation is that enormous burden of paperwork [sic], time delays in approval of tests and treatment, etc., that results in a net loss of income for me on every case.*

- *The 2007 Workers' Compensation Medical Fee Schedule in their Exhibit A increased reimbursement by up to 30% for many CPT codes but did nothing to increase anesthesia reimbursement for anesthesia ASA codes which correspond to the Surgical CPT codes. I have enclosed 10 ASA anesthesia codes. In all cases reimbursement for workers' compensation is less than 50% of reimbursement by HMSA, UHA, and MDX.*

- *Medicare/QUEST + HMO left out? Workers' compensation always takes longer, more paperwork, more time with patient, on phone with nurse manager, and on phone with adjustor which is not reimbursed at same code level. Also, downcoding is frequent which does not occur with private health plans. I prefer California workers' compensation due to less paperwork though payments are less.*

- *All reimbursement rates are low based on the cost of doing business in Hawaii and the amount of staff needed to process and follow up on claims and preauthorize and check insurance status on each patient for each visit. We are overburdened and underpaid.*

- *You guys are missing the big picture with this graph--Honest doctors do not do workers' compensation in Hawaii! Only dishonest doctors!! Figure it out! [illegible initials] This system is broken! Patients are being really hurt by the system. Doctors [illegible] and hired by insurance companies milk the system! It is a disgrace!*

Chapter 9

SUMMARY

The Bureau notes the following salient points, based upon the results of our informal, provider reimbursement survey and our other legal research:

1. It is estimated that medical fees for workers' compensation and no-fault automobile insurance in Hawaii account for approximately ten per cent of all medical fees. In other words, medical fees for workers' compensation alone appear to account for not more than ten per cent of all medical fees;

2. The Hawaii's workers' compensation statutes provide for two medical fee schedules;

3. The statutes establish the 110% Medicare fee schedule, specifying that charges shall not exceed one hundred and ten per cent of Medicare. This schedule is resource-based;

4. The statutes authorize the Director of Labor and Industrial Relations to establish a supplemental schedule if the Director determines that the Medicare amount is not reasonable or the service is not covered under Medicare;

5. The statutes specify that a supplemental fee schedule not exceed prevalent charges. Thus, this schedule is charge-based;

6. The Department of Labor and Industrial Relations indicates that under a best case scenario, the total time required to issue a new supplemental fee schedule, from the developing of a statistical survey of prevalent charges to the approval of the new supplemental fee schedule by the Governor, is eight to nine months;

7. The administrative rules provide that the maximum allowable fee for a CPT code is determined by the supplemental fee schedule, if maximum allowable fees for that CPT code are listed in both the supplemental fee schedule and the Medicare fee schedule. Otherwise, the statutes provide that the maximum allowable fee for a CPT code is determined by the 110% Medicare fee schedule, if maximum allowable fees for that CPT code are listed only in the Medicare fee schedule. Finally, the administrative rules provide that if maximum allowable fees for a CPT code are not listed in either the supplemental fee schedule or the Medicare fee schedule, then the maximum allowable fee is equal to the provider's lowest fee received for that service when rendered to private patients;

8. The Bureau sent surveys to about 300 medical doctors and osteopathic physicians, requesting data relating to reimbursements under the workers' compensation fee schedules. Responses came back from 50 providers. Forty-one responded that

they provided medical services to workers' compensation patients during the past year. Of these forty-one providers, the largest contingency was the nine who said they were medical doctors specializing in internal medicine;

9. The surveys were limited in scope to reimbursements for services rendered in a non-facility setting;

10. Seventy-nine different CPT codes were reported in the survey. Eighteen codes relate to evaluation and management. Sixteen relate to anesthesia. Twelve relate to surgery. Seven relate to radiology. Twenty-six relate to medicine. The sixteen codes relating to anesthesia were deemed outside of the scope of our study, which was limited to services performed in a non-facility setting. Our analyses focused on the remaining sixty-three codes;

11. The five most frequently reported CPT codes in the survey relate to evaluation and management. They are CPT codes 99213, 99214, 99203, 99212, and 99204;

12. The maximum allowable fees for a majority of the CPT codes reported in the survey are presently determined under the supplemental fee schedule;

13. In contrast, the maximum allowable fees for a majority of these codes were determined under the 110% Medicare fee schedule during the first two years of the implementation of that schedule, specifically, 1996 and 1997;

14. According to the Department of Labor and Industrial Relations, the supplemental fee schedule appears to be the primary schedule now, because the Medicare fee schedule may not be keeping pace with the cost of the services being rendered;

15. While the 110% Medicare fee schedule sets maximum allowable fees at about 110 per cent of the unadjusted Medicare amounts, the supplemental schedule sets maximum allowable fees that amount to about 136 per cent of the unadjusted Medicare amounts. Averaged together, the two fee schedules effectively set maximum allowable fees at about 130 per cent of the unadjusted Medicare amounts;

16. Actual reimbursements are about 89 per cent of the maximum allowable fees under the respective fee schedules. Actual reimbursements under the 110% Medicare fee schedule, which sets maximum allowable fees at 110 per cent of the unadjusted Medicare amounts, are about 93 per cent of the maximum allowable fees under the 110% Medicare fee schedule. In contrast, actual reimbursements under the supplemental fee schedule, which sets maximum allowable fees at 136 per cent of the unadjusted Medicare amounts, are about 88 per cent of the maximum allowable fees under the supplemental fee schedule;

17. According to the carriers, reasons for the differences between the maximum allowable reimbursements under the fee schedules and the actual reimbursements

received by the providers are attributable to factors such as: preferred provider organization or network contracts are discounted below the fee schedule; the provider is not using an appropriate or current fee schedule: the provider did not use the appropriate code for the service rendered; the provider "unbundled" services that should have been bundled; or the documentation provided did not support the level of service billed. It was noted that providers are required to bill for services in accordance with the fee schedule and administrative rules. Billed charges may be audited for compliance with the fee schedules and reduced to the maximum allowable amounts;

18. Actual reimbursements under both workers' compensation fee schedules are comparable to the total reimbursements received under employee group health plans. Specifically, the reimbursements under the two workers' compensation fee schedules are equivalent to about 99 per cent of the reimbursements from both carriers and patients under employee group health plans. Under the 110% Medicare schedule, actual reimbursements are about 110 per cent of the employee group health plan reimbursements. Under the supplemental fee schedule, actual reimbursements are about 96 per cent of the employee group health plan reimbursements;

19. Based upon the results of our informal survey, the maximum fees and actual reimbursements under the two fee schedules are such that the legislative intent of Act 234 from the regular session of 1995 appears to have been fulfilled. The intent of the measure with regard to the fee schedules was to adjust the level of workers' compensation medical fees downward so that the fees would be on par with the level of medical fees of prepaid health care plans. Today, actual reimbursements under workers' compensation are about 99 per cent, not 400 percent, of reimbursements under employee group health plans. Furthermore, maximum fees under both schedules are about 130 per cent, not 200 per cent, of medicare charges. Finally, Hawaii's maximum fees are about 102 per cent, not 142 per cent, of the national average, at least for the five most frequently reported CPT codes;

20. Providers commented through the survey that workers' compensation fees are inadequate, workers' compensation involves uncompensated time, payments are delayed, payments are denied or not made at all, payments are downcoded, and paperwork is inordinate;

21. CPT code 99455 is presently not listed in the supplemental fee schedule. It relates to workers' compensation. It covers work related or medical disability examinations by treating physician that includes completing medical histories, performing examinations, formulating diagnoses, assessing capabilities and stability, calculating impairment, developing future medical treatment plans, and completing necessary documentation/certificates and reports;

22. CPT code 99456 is presently listed in the supplemental fee schedule. It covers the same services as CPT code 99455, when performed by *other than* the treating physician. Presumably, it covers examinations by a physician retained by the employer or carrier to perform an independent medical examination;[1]

23. Hawaii's maximum allowable fees for the five most frequently reported CPT codes tend to fall in the middle band of the thirty-two states whose fee schedules we reviewed. Some of the fees are below the average, some are above the average, but all are within one standard deviation of the average. Hawaii's maximum fees are about 102 % of the average level of maximum fees of the thirty-two states whose fee schedules we reviewed;

24. For the five most frequently reported CPT codes, the highest fee levels nationwide are associated with states whose fee schedules are based on the relative values of the Medicare Resource-Based Relative Value Scale and whose fee schedules are required to be adjusted annually, using a specified mechanism such as the consumer price index or the statewide average weekly wage;

25. For the same five codes, the lowest fee levels nationwide are associated with states whose fee schedules are not necessarily required to be adjusted annually;

26. A few states have not established fee schedules. Nonetheless, their statutes generally require that charges basically be reasonable, and they define reasonableness as "prevailing charges," "usual and customary fees," or "actual charges;"

27. Most states, though, have established fee schedules. Of these states that have established fee schedules, some have fee schedules whose bases are specified. The others have fee schedules whose bases are not expressly specified. Of the states with fee schedules whose bases are specified, some have fee schedules formulated expressly around relative values, and some have fee schedules formulated expressly around charges. The states whose fee schedules are formulated expressly around charges have statutes that specify that fee shall be based on "prevailing charges in the same community" or "usual and customary charges";

28. Of the states that establish fee schedules based on relative values, the source of relative values for some states is specified as the Medicare Resource-Based Relative Value Scale. The source for others is specified as the Ingenix publication, *Relative Values for Physicians;*

29. Of the states with fee schedules whose source of relative values is specified as the Medicare Resource-Based Relative Value Scale, some states adopt the Medicare payment formula and apply a percentage to it. Other states adopt the Medicare Resource-Based Relative Value Scale relative values, but not the rest of the

1. See chapter eight, "A note on CPT code 99455."

payment formula, which includes the geographic practice cost indices, the Medicare conversion factor, and the budget neutrality adjustor. Instead, they multiply the Medicare Resource-Based Relative Value Scale relative values by their own conversion factors; and

30. Most of the states that have fee schedules also have statutes or administrative rules that require or authorize the periodic adjusting of those fee schedules. Generally, the schedules are authorized or required to be adjusted annually. Other specified periods of adjustment are quarterly, semi-annually, biennially, triennially, periodically, from time to time, as necessary, and as needed. Sometimes, the bases for the adjustments are specified. If the basis is specified, the basis is usually the consumer price index, in particular, the consumer price index--urban. Another basis used is the state average weekly wage. Other bases include the Medicare economic index, the year-over-year inflation rate, changes in levels of reimbursement, and prevalent charges.

Recommendation

In view of these salient points, the Bureau makes the following recommendation:

- We support the Director of Labor and Industrial Relations' position of considering the addition of CPT code 99455 to the supplemental fee schedule, in response to doctor and physician concerns that workers' compensation involves uncompensated time. No charges are listed for the code under the Medicare fee schedule, and the code specifically covers work related examinations performed by the treating physician, including completing medical histories, performing examinations, formulating diagnoses, assessing capabilities and stability, calculating impairment, developing future medical treatment plans, and completing necessary documentation/certificates and reports.

Appendix A

THE SENATE
TWENTY-THIRD LEGISLATURE, 2006
STATE OF HAWAII

S.C.R. NO. 77 S.D. 2 H.D. 1

SENATE CONCURRENT RESOLUTION

REQUESTING THE LEGISLATIVE REFERENCE BUREAU TO CONDUCT TWO STUDIES OF RECOMMENDED PROCEDURES THAT WILL ENSURE THAT STATE-FUNDED HEALTH CARE PAYMENTS ADEQUATELY REIMBURSE PROVIDERS WHO PROVIDE SERVICES FOR, FIRST, MEDICAID OR QUEST RECIPIENTS AND, SECOND, FOR INJURED EMPLOYEES UNDER WORKERS COMPENSATION INSURANCE.

WHEREAS, the critical financial condition of hospitals, long term care facilities, and other health care providers has been well-documented recently in a series of articles by Helen Altonn that were published by the Honolulu Star-Bulletin and an article by Rob Perez that was published by the Honolulu Advertiser; and

WHEREAS, these articles made the following points:

(1) Patients demand to be diagnosed and treated with the latest technology, which is very expensive;

(2) The need for expensive institutionalized long term care is substantial and is expected to grow as the "baby boomers" age;

(3) Health care facilities have incurred high costs related to potential terrorist threats and other emergencies;

(4) Providers are receiving insufficient payments for health care from government payers, private insurance payers, and patients who do not have insurance; and

(5) Hawaii's hospitals have incurred more than $500,000,000 in losses due to bad debt and charity care since 2000; and

WHEREAS, the State pays for a considerable amount of health care and also controls certain types of payments for health care made to providers; and

WHEREAS, it is in the public interest to ensure that health care payments made with state funds or controlled by the State are sufficient to cover the actual costs of care; now, therefore,

BE IT RESOLVED by the Senate of the Twenty-Third Legislature of the State of Hawaii, Regular Session of 2006, the House of Representatives concurring, that the Legislative Reference Bureau is requested to conduct two separate studies of recommended procedures that will ensure that state-funded health care payments adequately reimburse providers who provide services for, first, Medicaid or QUEST recipients and, second, for injured employees under workers compensation insurance for the actual cost of health care services; and

BE IT FURTHER RESOLVED that the Legislature requests that the first study conducted by the Legislative Reference Bureau include:

(1) Processes implemented by other jurisdictions or as recommended by experts that try to ensure that state-funded health care payments to Medicaid providers adequately reimburse them for their actual costs;

(2) A comparison of rates for the ten most frequently used services in Medicaid and QUEST health care services, actual costs of those services, and the amount reimbursed to the provider;

(3) A method of updating payments and reimbursements to health care providers every two years to keep pace with inflation; and

(4) A survey of nationwide benchmarks to see how Hawaii compares to other jurisdictions regarding provider payments and reimbursements for at least the ten most frequently used Medicaid and QUEST health procedures; and

BE IT FURTHER RESOLVED that interested parties are requested to submit relevant information and data applicable to determining reimbursement rates for providers of services for Medicaid or QUEST recipients to the Legislative Reference Bureau not later than May 31, 2006; and

BE IT FURTHER RESOLVED that the Legislative Reference Bureau is requested to report findings and recommendations as to the first study to the Legislature no later than twenty days prior to the convening of the Regular Session of 2007; and

BE IT FURTHER RESOLVED that the Legislature requests that the second study conducted by the Legislative Reference Bureau include:

(1) Processes implemented by other jurisdictions or as recommended by experts that try to ensure that state-funded health care payments to worker compensation providers adequately reimburse them for their actual costs;

(2) A comparison of rates for the ten most frequently used services in worker compensation services, actual costs of those services, and the amount reimbursed to the provider;

(3) A method of updating payments and reimbursements to health care providers every two years to keep pace with inflation; and

(4) A survey of nationwide benchmarks to see how Hawaii compares to other jurisdictions regarding provider payments and reimbursements for at least the ten most frequently used worker compensation health procedures; and

BE IT FURTHER RESOLVED that the Legislative Reference Bureau is requested to report findings and recommendations as to the second study to the Legislature no later than twenty days prior to the convening of the Regular Session of 2008; and

BE IT FURTHER RESOLVED that certified copies of this concurrent resolution be transmitted to the Governor, the Director of Health, the Director of Human Services, the

Insurance Commissioner, the Department of Labor and Industrial Relations, the Director of the Legislative Reference Bureau, the Chief Executive Officer of the Healthcare Association of Hawaii, and the Chief Executive Officer of the Hawaii Medical Association.

Appendix B

States' Workers' Compensation Medical Fee Reimbursement Methods: Language from Statutes, Administrative Rules, and Fee Schedules

State	Statute; Admin Rules	Fee Schedule (FS)	Methodology for Reimbursement: Direct Quotes from Statute, Admin Rule (*), or Fee Schedule (**)	Basis and Period of Adjustments: Paraphrased from Statute, Admin Rule (*)
Alabama	Ala. Code § 25-5-313	FS 2007	The fee for each service in the schedule shall be exactly equal to an amount derived by multiplying the preferred provider reimbursement customarily paid on May 19, 1992, by the largest health care service plan ... by a factor of 1.075, which product shall be the maximum fee for each such service.	Mandatory adjustment-- Annual: CPI
Alaska	Alaska Stat. § 23.30.097; Alaska Admin.Code title 8, § 45.082	FS 2004, extended thru 3/30/09	A fee or other charge for medical treatment or service may not exceed the lesser of (1) the usual, customary, and reasonable fees for the treatment or service in the community in which it is rendered, not to exceed the fees in the fee schedule specified by the board in its published bulletin dated December 1, 2004; ... (*) The board will publish annually a bulletin for the *"Workers' Compensation Manual,"* published by the department which gives the name and address of the organization whose schedule of providers' charge data must be used in determining the usual, customary, and reasonable fee for medical treatment or services for injuries that occur on or after July 1, 1988...The usual, customary, and reasonable fee must be determined based on the 90th percentile of the range of charges for similar services reported to the organization...	(*) Mandatory publication: Annual or semi-annual
Arizona	Ariz. Rev. Stat. § 23-908; Ariz. Admin. Code § 20-5-117	FS	The commission shall fix a schedule of fees to be charged by physicians ... attending injured employees ...	Mandatory review: Annual
Arkansas	Ark. Code Ann. § 11-9-508; 099.00.00-001 Ark. Code R. 30	FS, eff. 5/15/00	...the commission is authorized to: ...Establish fees for medical services as provided for in Rule 30 and its amendments. The commission shall make no distinction in approving fees from different classes of medical providers or health care providers for provision of the same or essentially similar medical services or health care services as defined herein.... (**) The official Medical Fee Schedule of the Arkansas Workers' Compensation Commission shall be based upon the Health Care Financing Administrations's [sic] (HFCA) Medicare Resource Based Relative Value Scale (RBRVS), utilizing HCFA's national relative value units and Arkansas specific conversion factors adopted by the AWCC. (**) The AWCC Official Fee Schedule can be calculated for any specific CPT code by multiplying the national "fully implemented non-facility total relative value units" (RVUs) by the conversion factor applicable to that *CPT*.	

State	Statute; Admin Rules	Fee Schedule (FS)	Methodology for Reimbursement: Direct Quotes from Statute, Admin Rule (*), or Fee Schedule (**)	Basis and Period of Adjustments: Paraphrased from Statute, Admin Rule (*)
California	Cal. Lab. Code § 5307.1; Cal. Code Regs. title 8, §§ 9789.10 to 9792	"OMFS 2003", Feb. 2007 Addendum, in admin rule, eff. 02/15/07	(a) ...Commencing January 1, 2004, and continuing until the time the administrative director has adopted an official medical fee schedule in accordance with the fee-related structure and rules of the relevant Medicare payment systems, except for the components listed in subdivision (j), maximum reasonable fees shall be 120 percent of the estimated aggregate fees prescribed in the relevant Medicare payment system for the same class of services before application of the inflation factors provided in subdivision (g) .... Upon adoption by the administrative director of an official medical fee schedule pursuant to this section, the maximum reasonable fees paid shall not exceed 120 percent of the estimated aggregate fees prescribed in the Medicare payment system for the same class of services before application of the inflation factors provided in subdivision (g)... (l) Notwithstanding subdivision (a), the administrative director, commencing January 1, 2006, shall have the authority, after public hearings, to adopt and revise, no less frequently than biennially, an official medical fee schedule for physician services. If the administrative director fails to adopt an official medical fee schedule for physician services by January 1, 2006, the existing official medical fee schedule rates for physician services shall remain in effect until a new schedule is adopted or the existing schedule is revised. (*) (b) 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 five (5) percent, except that those procedures that are reimbursed under OMFS 2003 at a rate between 100% and 105% of the Medicare rate will be reduced between zero and 5% so that the OMFS reimbursement will not fall below the Medicare rate. The reduction rate for each procedure is set forth as the adjustment factor in Table A. Reimbursement for procedures that are reimbursed under OMFS 2003 at a rate below the Medicare rate will not be reduced.... (d) (1) Except for anesthesia services, to determine the maximum allowable reimbursement for a physician service rendered on or after July 1, 2004 the following formula is utilized: RVU × conversion factor × percentage reduction calculation = maximum reasonable fee before application of ground rules. Applicable ground rules set forth in the OMFS 2003 and the "General Information and Instructions, Effective for Dates of Service on or after July 1, 2004," are then applied to calculate the maximum reasonable fee.... (f) For physician services rendered on or after February 15, 2007, the maximum allowable reimbursement amounts for procedure codes 99201 through 99205 and 99211 through 99215 are set forth in the February, 2007 Addendum to Table A, "OMFS Physician Services Fees for Services	Discretionary adoption and revision: Biennial, at least

State	Statute; Admin Rules	Fee Schedule (FS)	Methodology for Reimbursement: Direct Quotes from Statute, Admin Rule (*), or Fee Schedule (**)	Basis and Period of Adjustments: Paraphrased from Statute, Admin Rule (*)
			Rendered on or after February 15, 2007." The February, 2007 Addendum to Table A, "OMFS Physician Services Fees for Services Rendered on or after February 15, 2007", which sets forth individual procedure codes with the corresponding maximum reimbursable fees, is incorporated by reference.	
Colorado	Colo. Rev. Stat. § 8-42-101; 7 Colo. Code Regs. § 1101-3 (Rule 18)	FS, eff 10/01/06	The director shall establish a schedule fixing the fees for which all medical, surgical, hospital, dental, nursing, and vocational rehabilitation treatment rendered to employees under this section shall be compensated, and it is unlawful, void, and unenforceable as a debt for any physician, chiropractor, hospital, person, or institution to contract with, bill, or charge any patient for services, rendered in connection with injuries coming within the purview of this article or an applicable fee schedule, which are or may be in excess of said fee schedule unless such charges are approved by the director. (*) ...the Director promulgates this medical fee schedule to review and establish maximum allowable fees for health care services falling within the purview of the Act. The Director adopts and hereby incorporates by reference as modified herein the 2006 edition of the Relative Values for Physicians (RVP©), developed by Relative Value Studies, Inc., published by Ingenix ® St. Anthony Publishing, ... The incorporation is limited to the specific editions named and does not include later revisions or additions.	Mandatory review: Annual
Connecticut	Conn. Gen. Stat. § 31-294d; Conn. Agencies Regs. §31-280-3	FS, 2007 update, eff. 4/1/07	The pecuniary liability of the employer for the medical and surgical service required by this section shall be limited to the charges that prevail in the same community or similar communities for similar treatment of injured persons of a like standard of living when the similar treatment is paid for by the injured person. (*) Such Practitioner Fee Schedule shall be calculated from a data base consisting of current charge data (collected within the past year). Such data may be broadly based and may include health and accident claims as well as Workers' Compensation claims. Such data base shall include representative data from the entire State of Connecticut. Practitioner fees shall be uniform throughout the State...The Practitioner Fee Schedule for physicians shall be established as the 74th percentile level of the data base of statewide charges.	(*) Mandatory adjustment: Annual: Consumer price index for all urban workers
Delaware	Del. Code title 19, § 2322B	None	When completed, the payment system shall be published on the Internet at no charge... The payment system will set fees at 90% of the seventy-fifth percentile of actual charges within the geozip where the service or treatment is rendered, utilizing information contained in employers' and insurer carriers' national databases.	Mandatory adjustment: Annual: CPI-Urban

State	Statute; Admin Rules	Fee Schedule (FS)	Methodology for Reimbursement: Direct Quotes from Statute, Admin Rule (*), or Fee Schedule (**)	Basis and Period of Adjustments: Paraphrased from Statute, Admin Rule (*)
Florida	Fla. Stat. § 440.13 (12); Fla. Admin. Code Ann. r. 69L-7.020	FS, 2007 edition (2/27/07 draft)	Maximum reimbursement for a physician licensed under chapter 458 or chapter 459 shall be increased to 110 percent of the reimbursement allowed by Medicare, using appropriate codes and modifiers or the medical reimbursement level adopted by the three-member panel as of January 1, 2003, whichever is greater.	
Georgia	Ga. Code § 34-9-205	FS, eff. 4/1/07	Annually the board shall publish a list by geographical location of usual, customary, and reasonable charges for all medical services provided under subsection (a) of this Code section.	Mandatory publication: Annual
Hawaii	H.R.S. § 386-21; H.A.R. § 12-15-90	FS, eff. 1/01/07	Effective January 1, 1997, and for each succeeding calendar year thereafter, the charges shall not exceed one hundred ten per cent of fees prescribed in the Medicare Resource Based Relative Value Scale system applicable to Hawaii as prepared by the United States Department of Health and Human Services, except as provided for in this subsection. The rates or fees provided for in this section shall be adequate to ensure at all times the standard of services and care intended by this chapter to injured employees. If the director determines that an allowance under the medicare program is not reasonable, or if a medical treatment, accommodation, product, or service existing as of June 29, 1995, is not covered under the medicare program, the director, at any time, may establish an additional fee schedule or schedules not exceeding the prevalent charge for fees for services actually received by providers of health care services to cover charges for that treatment, accommodation, product, or services. If no prevalent charge for a fee for service has been established for a given service or procedure, the director shall adopt a reasonable rate that shall be the same for all providers of health care services to be paid for that service or procedure. (*) Charges for medical services shall not exceed one hundred and ten per cent of participating fees prescribed in the Medicare Resource Based Relative Value Scale system fee schedule (Medicare Fee Schedule) applicable to Hawaii or listed in exhibit A, ... entitled "Workers' Compensation Supplemental Medical Fee Schedule", dated January 1, 2007.	Mandatory updates: Triennial or annual: Charges or additions to RBRVS, statistically valid surveys of prevalent charges, information provided by the appropriate state agency having access to prevalent charges for medical fee information
Idaho	Idaho Stat. §§ 72-803, 56-136; Idaho Admin. Code r. 17.02.08.031	FS, eff. 3/15/07	... fees for physician services shall be set using relative value units from the current year resource based relative value system (RBRVS) as it is modified from time to time, multiplied by conversion factors to be determined by the commission in rule. (*) The following conversion factors shall be applied to the Relative Value Unit (RVU) found in the latest RBRVS, as amended, that was published before December 31 of the previous calendar year ...	Mandatory adjustment: Annual: Year over year inflation rate

State	Statute; Admin Rules	Fee Schedule (FS)	Methodology for Reimbursement: Direct Quotes from Statute, Admin Rule (*), or Fee Schedule (**)	Basis and Period of Adjustments: Paraphrased from Statute, Admin Rule (*)
Illinois	820 ILCS 305/8.2; Ill. Admin. Code title 50, § 7110.90	FS, 2007 table	... the maximum allowable payment shall be 90% of the 80th percentile of charges and fees as determined by the Commission utilizing information provided by employers' and insurers' national databases, with a minimum of 12,000,000 Illinois line item charges and fees comprised of health care provider and hospital charges and fees as of August 1, 2004 [sic] but not earlier than August 1, 2002. These charges and fees are provider billed amounts and shall not include discounted charges.	Mandatory automatic increases or decreases: Annual: CPI-urban
Indiana	Ind. Code § 22-3-3-5, 22-3-6-1 (j); 631 Ind. Admin. Code 1-1-25	None	The pecuniary liability of the employer for medical, surgical, hospital and nurse service herein required shall be limited to such charges as prevail ... in the same community ... for a like service or product to injured persons.	
Iowa	Iowa Code § 85.27	None	... charges believed to be excessive or unnecessary may be referred by the employer, insurance carrier, or health service provider to the workers' compensation commissioner for determination ...	
Kansas	Kan. Stat. § 44-510i; Kan. Admin. Regs. § 51-9-7	FS, eff. 12/01/05	The director shall prepare and adopt rules and regulations which establish a schedule of maximum fees for medical, surgical, hospital, dental, nursing, vocational rehabilitation or any other treatment or services provided or ordered by health care providers and rendered to employees under the workers compensation act ... The schedule of maximum fees shall be reasonable, shall promote health care cost containment and efficiency with respect to the workers compensation health care delivery system, and shall be sufficient to ensure availability of such reasonably necessary treatment, care and attendance to each injured employee to cure and relive the employee from the effects of the injury. The schedule shall include provisions and review procedures for exceptional cases involving extraordinary medical procedures or circumstances and shall include costs and charges for medical records and testimony. (*) Fees for medical, surgical, hospital, dental, and nursing services, medical equipment, medical supplies, prescriptions, medical records, and medical testimony rendered pursuant to the Kansas workers compensation act shall be the lesser of the usual and customary charge of the health care provider, hospital, or other entity providing the health care services or the amount allowed by the "workers compensation schedule of medical fees" published by the Kansas department of labor and dated December 1, 2005, including the ground rules incorporated in the schedule, which is hereby adopted by reference. This regulation shall be effective on and after December 1, 2005. (**) Some of the most important revisions that have been incorporated within this Schedule of Medical Fees are as follows: ...Incorporation of the RBRVS concept for improvement in the statistical validity is used for the unit values employed to determine maximum allowable fees.	Mandatory revision: Biennial, at least: current, reasonable and fair

State	Statute; Admin Rules	Fee Schedule (FS)	Methodology for Reimbursement: Direct Quotes from Statute, Admin Rule (*), or Fee Schedule (**)	Basis and Period of Adjustments: Paraphrased from Statute, Admin Rule (*)
			(**) To determine the maximum fee schedule amount for a procedure, it is necessary to multiply the unit value of the procedure by the dollar conversion factor applicable to the particular section in effect on the date the service was provided. Formula: unit value multiplied by conversion factor = maximum fee schedule amount.	
Kentucky	Ky. Rev. Stat. § 342.035; 803 Ky. Admin. Regs. 25:089	FS, June 2005 edition	... the executive director shall promulgate administrative regulations to adopt a schedule of fees for the purpose of ensuring that all fees, charges, and reimbursements ... shall be fair, current, and reasonable and shall be limited to such charges as are fair, current, and reasonable for similar treatment of injured persons in the same community for like services, where treatment is paid for by general health insurers. (*) The appropriate fee for a procedure covered by the medical fee schedule shall be obtained by multiplying a relative value unit for the medical procedure by the applicable conversion factor.	Mandatory review and update: Biennial
Louisiana	La. Rev. Stat. §§ 23:1034.2, 23:1203; La. Admin. Code title 40, § 5101 et al	FS, August 1994 edition, in admin rules current as of 03/06	The reimbursement schedule shall include charges limited to the mean of the usual and customary charges for such care, services, treatment, drugs, and supplies.	Discretionary adjustments: Annual
Maine	Me. Rev. Stat. title 39-A, § 209; 90-351-5 Me. Code R. § 1 et al	FS, eff. 11/05/06	In order to ensure appropriate limitations on the cost of health care services, the board shall adopt rules that establish: ... Standards, schedules or scales of maximum charges for individual services, procedures or courses of treatment. In establishing these standards, schedules or scales, the board shall consider maximum charges paid by private 3rd-party payors for similar services provided by health care providers in the State ... (**) The Maine Workers' Compensation Board Medical Fee Schedule incorporates portions of the following documents: ... Medicare RBRVS REPORT: The Physician's Guide 2005, copyright 2005, by the American Medical Association.	Mandatory adjustments: Annual: changes in levels of reimbursement made by private third-party payors for similar services
Maryland	Md. Code, Lab. & Empl. § 9-663; Md. Code Regs. 14.09.03.01	FS, eff. 6/05/06	Each fee or other charge for medical service or treatment under this subtitle is limited to the amount that prevails in the same community for similar treatment of an injured individual with a standard of living that is comparable to that of the covered employee. (**) To achieve standardization, the Commission amended COMAR 14.09.03.01, hereinafter referred to as Medical Fee Guide (MFG), which with some exceptions, uses the 2004 reimbursement methodologies, models, and values or weights used by the Centers for Medicare and Medicaid (CMS), including applicable payment policies relating to coding, billing, and reporting. (**) Except as provided in subsections (d) and (e), the conversion factor to be used for determining reimbursement in the Maryland workers'	Mandatory review and revisions: Biennial, at least: appropriate revisions

State	Statute; Admin Rules	Fee Schedule (FS)	Methodology for Reimbursement: Direct Quotes from Statute, Admin Rule (*), or Fee Schedule (**)	Basis and Period of Adjustments: Paraphrased from Statute, Admin Rule (*)
			compensation system is the effective conversion factor adopted by CMS for 2004 multiplied by 109%. [underscoring in original]	
Massachusetts	Mass. Gen. Laws ch. 152, § 13; ch. 118G, § 7; 114.3 Mass. Code Regs. 40.00	FS, eff. 9/01/04	The rate of payment by insurers for health care services adjudged compensable under this chapter shall be established by the division of health care finance and policy under the provisions of chapter one hundred and eighteen G [health care finance and policy]... Rates produced using these methods and standards shall be in conformance with Title XIX, including the upper limit on provider payments.	Mandatory determinations: Annual, at least
Michigan	Mich. Comp. Laws § 418.315; Mich. Admin. Code r.418.10106	FS, eff. 4/02/07	The rules promulgated shall establish schedules of maximum charges for the treatment or attendance, service, devices, apparatus, or medicine, which schedule shall be annually revised. (*) The formula and methodology for determining the relative value units shall be adopted from the "Medicare RBRVS Fee Schedule" as adopted by reference in R 418.10107 using geographical information for Michigan. The geographical information, (GPCI), for these rules is a melded average using 60% of the figures published for Detroit added to 40% of the figures published for the rest of the state.	Mandatory revisions: Annual
Minnesota	Minn. Stat. §§ 176.136, 176.645; Minn. R. 5221.4020	FS, in admin rule current as of 09/19/06	The commissioner shall adopt permanent rules regulating fees allowable for medical, chiropractic, podiatric, surgical, and other health care provider treatment or service, including those provided to hospital outpatients, by implementing a relative value fee schedule to be effective on October 1, 1993. The commissioner may adopt by reference the relative value fee schedule adopted for the federal Medicare program or a relative value fee schedule adopted by other federal or state agencies. (*) ...the maximum fee in dollars for a health care service subject to the medical fee schedule is calculated according to the following formula: maximum fee = relative value unit (RVU) × conversion factor (CF)...	Mandatory adjustments to conversion factors: Annual: Statewide average weekly wage
Mississippi	Miss. Code § 71-3-15; Rules of the Miss. W.C. Comm., General Rule 12	FS, eff. 7/01/07	All fees and other charges for such treatment or service shall be limited to such charges as prevail in the same community for similar treatment and shall be subject to regulation by the commission.	
Missouri	Mo. Rev. Stat. § 287.140; Mo. Code Regs. title 8, § 50-2.030, re: disputes	No	A health care provider shall not charge a fee for treatment and care which is governed by the provisions of this chapter greater than the usual and customary fee the provider receives for the same treatment or service when the payor for such treatment or service is a private individual or a private health insurance carrier.	
Montana	Mont. Code Ann. § 39-71-704; Mont. Admin. R. 24.29.1532,	FS, eff. 7/01/02	The department shall annually establish a schedule of fees for medical services not provided at a hospital that are necessary for the treatment of injured workers. Charges submitted by providers must be the usual and customary charges for nonworkers' compensation patients. The	(*) Mandatory establishment of conversion factors: (*) Annual: (*) state's average weekly wage

State	Statute; Admin Rules	Fee Schedule (FS)	Methodology for Reimbursement: Direct Quotes from Statute, Admin Rule (*), or Fee Schedule (**)	Basis and Period of Adjustments: Paraphrased from Statute, Admin Rule (*)
	24.29.1536		department may require insurers to submit information to be used in establishing the schedule. (*) The fee schedule is comprised of the following: ...The relative value scales given in the most current edition of the Relative Values for Physicians (RVP), published by Ingenix Inc. to be used by doctors of medicine, ...	
Nebraska	Neb. Stat. § 48-120; Rules of Procedure, Neb. W.C. Court, Rule 26	FS, eff. 7/01/06	The compensation court may establish schedules of maximum fees for such services. If the compensation court establishes such a schedule, it shall publish and furnish such schedule to the public. (*) The Nebraska Workers' Compensation Court Schedule of Medical And Hospital Fees, effective July 1, 2006, when used in conjunction with the instruction, ground rules, unit values, and conversion factors set out in such schedule hereby is adopted as a fee schedule to be used in setting maximum payments for medical, surgical, and hospital services in workers' compensation cases. (**) The fee for a particular service under this schedule is determined by multiplying the listed unit value by the dollar conversion factor for the section in which the service is located.	Mandatory review and changes: Biennial, at least
Nevada	Nev. Rev. Stat. § 616C.260; Nev. Admin. Code § 616C.145	FS	The Administrator shall, giving consideration to the fees and charges being billed and paid in the State, establish a schedule of reasonable fees and charges allowable for accident benefits provided to injured employees whose insurers have not contracted with an organization for managed care or with providers of health care services ....The Administrator shall designate a vendor who compiles data on a national basis concerning fees and charges that are billed and paid for treatment or services similar to the treatment and services that qualify as accident benefits in this State to provide him such information as he deems necessary to carry out the provisions of subsection 2. (*) Except as otherwise provided in this section, providers of health care who treat injured employees pursuant to this chapter and chapter 616C of NRS shall comply with the most recently published edition of or update to the *Relative Values for Physicians*, which the Division hereby adopts by reference.	Mandatory review and revisions: Annual: CPI, medical care component
New Hampshire	N.H. Rev. Stat. Ann. § 281-A:24; N.H. Code Admin. R. Ann. Lab. 506.02	No	The employer or the employer's insurance carrier shall pay the full amount of the health care provider's bill unless the employer or employer's insurance carrier can show just cause as to why the total amount should not be paid.	
New Jersey	N.J. Stat. Ann. § 34:15-15; N.J. Admin. Code § 12:235-1.1 et al	No	All fees and other charges for such physicians' and surgeons' treatment and hospital treatment shall be reasonable and based upon the usual fees and charges which prevail in the same community for similar physicians', surgeons' and hospital services.	

State	Statute; Admin Rules	Fee Schedule (FS)	Methodology for Reimbursement: Direct Quotes from Statute, Admin Rule (*), or Fee Schedule (**)	Basis and Period of Adjustments: Paraphrased from Statute, Admin Rule (*)
New Mexico	N.M. Stat. § 52-4-5; N.M. Code R. § 11.4.7.9	FS, eff. 12/31/05	The rates in the schedules of maximum charges shall not fall below the sixtieth percentile or above the eightieth percentile of current rates for health care providers.	Mandatory revisions: Annual
New York	N.Y. Workers' Comp. § 13; N.Y. Comp. Codes R. & Regs. title 12, § 329.3	FS, first ed. 8/96	All fees and other charges for such treatment and services shall be limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living. The chair shall prepare and establish a schedule for the state, or schedules limited to defined localities, of charges and fees for such medical treatment and care, and including all medical, dental, surgical, optometric or other attendance or treatment, nurse and hospital service, medicine, optometric services, crutches, eye-glasses, false teeth, artificial eyes, orthotics, prosthetic devices, functional assistive and adaptive devices and apparatus in accordance with and to be subject to change pursuant to rules promulgated by the chair. Before preparing such schedule for the state or schedules for limited localities the chair shall request the president of the medical society of the state of New York and the president of the New York state osteopathic medical society to submit to him or her a report on the amount of remuneration deemed by such society to be fair and adequate for the types of medical care to be rendered under this chapter, but consideration shall be given to the view of other interested parties.	
North Carolina	N.C. Gen. Stat. § 97-26; Rules of the N.C. Industrial Comm., Rule 407	FS, eff. 5/01/07	The Commission may consider any and all reimbursement systems and plans in establishing its fee schedule, including, but not limited to, the Teachers' and State Employees' Comprehensive Major Medical Plan (hereinafter, "State Plan"), Blue Cross and Blue Shield, and any other private or governmental plans. The Commission may also consider any and all reimbursement methodologies, including, but not limited to, the use of current procedural terminology ("CPT") codes, diagnostic-related groupings ("DRGs"), per diem rates, capitated payments, and resource-based relative-value system ("RBRVS") payments. The Commission may consider statewide fee averages, geographical and community variations in provider costs, and any other factors affecting provider costs.	Mandatory review and revisions: Periodic
North Dakota	N.D. Cent. Code § 65-02-08; N.D. Admin. Code § 92-01-02-27	FS, 1/01/07	All fees on claims for medical and hospital goods and services provided under this title to an injured employee must be in accordance with schedules of fees adopted by the organization.	
Ohio	Ohio Rev. Code § 4121.121; Ohio Admin. Code 4123-6-08	FS, eff. 2007	The medical section shall do all of the following: ... Assist the administrator in establishing standard medical fees, approving medical procedures, and determining eligibility and reasonableness of the compensation payments for medical, hospital, and nursing services, and in establishing guidelines for payment policies which recognize usual,	

State	Statute; Admin Rules	Fee Schedule (FS)	Methodology for Reimbursement: Direct Quotes from Statute, Admin Rule (*), or Fee Schedule (**)	Basis and Period of Adjustments: Paraphrased from Statute, Admin Rule (*)
			customary, and reasonable methods of payment for covered services; .... (**) The total RVU adjustor for each CPT code in BWC's payment system is carried out to five decimal places.	
Oklahoma	Okla. Stat. § 85-14	FS, eff. 1/01/06	Such charges and duration of treatment shall be limited to the usual, customary and reasonable payments and duration of treatment as prescribed and limited by a schedule of fees and treatment for all medical providers to be adopted, ... by the Administrator. Beginning January 1, 2006, the fee and treatment schedule for physician services shall be based on the most current Relative Value Units (RVU) produced by the Centers for Medicare and Medicaid Services (CMS) for the Medicare Physician Fee Schedule as of January 1 of the prior year. These relative values shall be multiplied by the appropriate conversion factors to be determined by the Administrator. The conversion factors shall be adjusted by the Consumer Price Index and shall be adequate to reflect the usual and customary rates for treatment of workers' compensation patients taking into consideration all relevant factors including, but not limited to, the additional time required to provide disability management. ... In no event shall the reimbursement rate for any single procedure be equal to an amount which is less than one hundred fifteen percent (115%) of the current Medicare reimbursement rate for the procedure.	Mandatory review: Biennial: CPI - Urban
Oregon	Or. Rev. Stat. § 656.248; Or. Admin. R. 436-009-0004, 436-009-0040	FS, in admin rule eff. 07/01/07	The Director of the Department of Consumer and Business Services ... shall promulgate rules for developing and publishing fee schedules for medical services ... These schedules shall represent the reimbursement generally received for the services provided. Where applicable, and to the extent the director determines practicable, these fee schedules shall be based upon any one or all of the following ... The current procedural codes and relative value units of the Department of Health and Human Services Medicare Fee Schedules for all medical service provider services included therein ... (*) The director adopts, by reference, the columns titled "CPT/HCPCS," "Mod," "Year 2007 Transitional Non-Facility Total," "Year 2007 Transitional Facility Total," and "Global" in the Centers for Medicare & Medicaid Services (CMS) 2007 Medicare Resource-Based Relative Value Scale (RBRVS) Addendum B and Addendum C, 71 Federal Register No. 231, December 1, 2006, as the basis for the fee schedule for payment of medical service providers except as otherwise provided in these rules. (*) Where the procedure is performed inside the medical service provider's office, use Year 2007 non-facility total column.... No other column applies.	Mandatory updates: Annual: CPI, statistically valid surveys of medical service fees, medical service fee information provided by health insurers, medical service fee information provided by persons or state agencies with access to medical service fee information

State	Statute; Admin Rules	Fee Schedule (FS)	Methodology for Reimbursement: Direct Quotes from Statute, Admin Rule (*), or Fee Schedule (**)	Basis and Period of Adjustments: Paraphrased from Statute, Admin Rule (*)
Pennsylvania	77 Pa. Stat. § 531; 34 Pa. Code §§ 127.101, 127.152	FS, in admin rule	For purposes of this clause, a provider shall not require, request or accept payment for the treatment, accommodations, products or services in excess of one hundred thirteen per centum of the prevailing charge at the seventy-fifty percentile; one hundred thirteen per centum of the applicable fee schedule, the recommended fee or the inflation index charge; one hundred thirteen per centum of the DRG payment plus pass-through costs and applicable cost or day outliers; or one hundred thirteen per centum of any other Medicare reimbursement mechanism, as determined by the Medicare carrier or intermediary, which ever pertains to the specialty service involved, determined to be applicable in this Commonwealth under the Medicare program for comparable services rendered. If the commissioner determines that an allowance for a particular provider group or service under the Medicare program is not reasonable, it may adopt, by regulation, a new allowance. (*) Generally, medical fees for services rendered under the act shall be capped at 113% of the Medicare reimbursement rate applicable in this Commonwealth under the Medicare Program for comparable services rendered. (**) The Pennsylvania Workers' Compensation Fee Schedule for Part B providers uses as its base fees the 1994 Medicare Fee Schedule. (From the Pennsylvania Department of Labor and Industry web page "Charge Classes by Zip Code").	Mandatory update: Annual: Statewide average weekly wage
Rhode Island	R.I. Gen. Laws § 28-33-7	FS, eff. 10/25/06	In setting the rate of reimbursement for any service or procedure, the director shall determine, based upon available data, the ninetieth (90th) percentile of the usual and customary fee charged by health care providers in the state of Rhode Island and the immediate surrounding area, and in no case shall the rate of reimbursement exceed that amount.	Mandatory update and revision: As necessary
South Carolina	S.C. Code § 42-15-70; S.C. Code Regs. 67-1302	FS	The pecuniary liability of the employer for medical, surgical and hospital service or other treatment required, when ordered by the Commission, shall be limited to such charges as prevail in the community for similar treatment of injured persons of a like standard of living when such treatment is paid for by the injured person ... (*) 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.	(*) Discretionary review and update: As needed
South Dakota	S.D. Codified Laws § 62-7-8 S.D. Admin. R. 47:03:05:02	FS, eff. 6/27/07	The department shall, by rule promulgated pursuant to chapter 1-26, establish standards and procedures for determining if charges for health services, including hospital services are excessive ... The department shall consult with the examining boards of all providers in establishing such standards and procedures. (*) Except as otherwise provided in this chapter, the definitions and	

State	Statute; Admin Rules	Fee Schedule (FS)	Methodology for Reimbursement: Direct Quotes from Statute, Admin Rule (*), or Fee Schedule (**)	Basis and Period of Adjustments: Paraphrased from Statute, Admin Rule (*)
			procedures for determining reimbursement for medical services or treatment are those set forth in **Relative Values for Physicians**, Relative Value Studies, Inc., 2007.	
Tennessee	Tenn. Code § 50-6-204; Tenn. Comp. R & Regs. 0800-2-18-.01, 0800-2-18-.02	FS, in admin rules eff. 5/01/06, and revised 3/07	The commissioner of labor and workforce development, in consultation with the medical care and cost containment committee and the advisory council on workers' compensation, is authorized to establish by rule, ... a comprehensive medical fee schedule ... In developing the rules, the commissioner shall strive to assure the delivery of quality medical care in workers' compensation cases and access by injured workers to primary and specialist care while controlling prices and system costs. The medical care fee schedule shall be comprehensive in scope and shall address fees of physicians and surgeons, hospitals, prescription drugs, and ancillary services provided by other health care facilities and providers. The commission may consider any and all reimbursement systems and methodologies in developing the fee schedule. (*) The Medical Fee Schedule is based upon the Centers for Medicare and Medicaid Services ("CMS") (formerly the Health Care Financing Administration's) ("HFCA") Medicare Resource Based Relative Value Scale ("RBRVS") system, utilizing the CMS' national relative value units and Tennessee specific conversion factors adopted by the Tennessee Division of Workers' Compensation in these Rules. (*) The Medical Fee Schedule maximum reimbursement amount for professional services is calculated for any specific CPT code by multiplying the national total relative value units ("RVUs"), unadjusted for the Geographic Practice Cost Indexes ("GPCIs"), by the appropriate conversion factor. Whether one uses the facility or nonfacility total RVU amount must be determined using the most current, effective Medicare guidelines and is dependent upon the location at which the service is provided.	Mandatory review and revision: Annual: (*) Medicare Economic Index
Texas	Tex. Lab. Code §§ 413.011, 413.012; 28 Tex. Admin. Code § 134.202	FS 2002, on Dept. of Ins. website	To achieve standardization, the commissioner shall adopt the most current reimbursement methodologies, models, and values or weights used by the federal Centers for Medicare and Medicaid Services, including applicable payment policies relating to coding, billing, and reporting, and may modify documentation requirements as necessary to meet the requirements of Section 413.053.... This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services. (*) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare	Mandatory review and revision: Biennial, at least: Fair and reasonable fees

State	Statute; Admin Rules	Fee Schedule (FS)	Methodology for Reimbursement: Direct Quotes from Statute, Admin Rule (*), or Fee Schedule (**)	Basis and Period of Adjustments: Paraphrased from Statute, Admin Rule (*)
			payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. (**) The Division reimbursement is 125% of the Medicare "participating" physician reimbursement amount as listed in the Medicare fee schedule." (from the website of the Texas Department of Insurance, Division of Workers' Compensation)	
Utah	Utah Code § 34A-2-407; Utah Admin. Code r. 612-2-5	FS, eff. 7/01/07	A physician attending an injured employee shall comply with rules established by the commission regarding ... fees for physician services ... The commission's schedule of fees may reasonably differentiate remuneration to be paid to providers of health services based on: (i) the severity of the employee's condition; (ii) the nature of the treatment necessary; and (iii) the facilities or equipment specially required to deliver that treatment. (*) The Labor Commission of Utah: ... Adopts and by this reference incorporates the National Centers for Medicare and Medicaid Services (CMS) for the Medicare Physician Fee Schedule (MPFS) Resource-Based Value System (RBRVS), 2007 Edition, as the method for calculating reimbursement and the American Medical Association's CPT, 2007 edition, coding guidelines. The non-facility total unit value will apply in calculating the reimbursement ... (**) The Centers for Medicare and Medicaid Services (CMS) Transitional Relative Value as published bi-annually in the Essential RBRVS by INGENIX has been selected as the method for calculating reimbursment using the 2007 AMA CPT-4 coded procedures for those providing care for inured workers under the Utah Workers' Compensation Act. [underscoring in original] (**) To determine the total amount for reimbursement, the RVU assigned to each CPT code is to be multiplied by each specialty's unique 2007 Utah Labor Commission's conversion factor to obtain the total reimbursement value. (**) The Utah Labor Commission has chosen NOT to use CMS's designated Utah's Geographic Practice Cost Indexes, (GPCI) adjustment, but to use the non-adjusted national RBRVS to calculate reimbursement values.	
Vermont	Vt. Stat. title 21, § 640; Dept. of Labor, Rule	FS, eff. 5/15/06	The reimbursement rate for services and supplies in the fee schedule shall include considerations of medical necessity, clinical efficacy, cost-effectiveness, and safety, and those services and supplies shall be	

State	Statute; Admin Rules	Fee Schedule (FS)	Methodology for Reimbursement: Direct Quotes from Statute, Admin Rule (*), or Fee Schedule (**)	Basis and Period of Adjustments: Paraphrased from Statute, Admin Rule (*)
	40		provided on a nondiscriminatory basis consistent with workers' compensation and health care law.	
Virginia	Va. Code § 65.2-605	None	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...	
Washington	Wash. Rev. Code § 51.04.030; Wash. Admin. Code 296-20-132, 296-20-135	FS, eff. 7/01/07	The director shall, in consultation with interested persons, establish and, in his or her discretion, periodically change as may be necessary, and make available a fee schedule of the maximum charges to be made by any physician, surgeon, ... rendering services to injured workers. (*) Conversion factors are used to calculate payment levels for services reimbursed under the Washington resource based relative value scale (RBRVS), ...	Discretionary changes: Periodic (*) Annual adjustments to conversion factors: (*) state's average wage
West Virginia	W. Va. Code § 23-4-3	FS, eff. 1/01/06	... the Insurance Commissioner, shall establish and alter from time to time, as it determines appropriate, a schedule of the maximum reasonable amounts to be paid to health care providers, ... for the rendering of treatment or services to injured employees under this chapter. (**) RBRVS-based procedure codes and fees	Mandatory alteration: From time to time
Wisconsin	Wis. Stat. § 102.16; Wis. Admin. Code DWD 80.72	None	The department shall determine that a disputed fee is reasonable and order that the disputed fee be paid if that fee is at or below the mean fee for the health service procedure for which the dispute fee was charged, plus 1.4 standard deviations from that mean, as shown by data from a database that is certified by the department under par. (h). The department shall determine that a disputed fee is unreasonable and order that a reasonable fee be paid if the disputed fee is above the mean fee for the health service procedure for which the disputed fee was charged, plus 1.4 standard deviations from that mean, as shown by data from a database that is certified by the department under par. (h), unless the health service provider proves to the satisfaction of the department that a higher fee is justified because the service provided in the disputed case was more difficult or more complicated to provide than in the usual case.	

State	Statute; Admin Rules	Fee Schedule (FS)	Methodology for Reimbursement: Direct Quotes from Statute, Admin Rule (*), or Fee Schedule (**)	Basis and Period of Adjustments: Paraphrased from Statute, Admin Rule (*)
Wyoming	Wyo. Stat. §§ 27-14-401, 27-14-802; Rules, Regs. and Fee Schedules, Wyo. Work. Safety and Comp. Div., chap. 9, § 1	FS	The director shall by rule and regulation ... provide fee schedules for all medical and hospital care rendered injured employees .... (*) The Administrator adopts the *Relative Values for Physicians (RVP)*, as published by Ingenix Inc., as authored by Relative Value Studies, Inc., insofar as it addresses medical matters compensable under the Act unless otherwise defined in this chapter. Such adoption shall be the current edition as of the first day of each calendar year unless the Administrator gives written notice to the contrary. ... Fees in all cases must conform to the applicable edition of the *Relative Values for Physicians*. This *RVP* establishes fees determined to be fair compensation with a usual time of follow-up for care to injured workers.	Discretionary changes: Quarterly intervals, at most

Appendix C

SURVEY OF REIMBURSEMENT UNDER THE WORKERS' COMPENSATION MEDICAL FEE SCHEDULES

This survey is being sent out by the Legislative Reference Bureau as part of the study directed by Senate Concurrent Resolution No. 77, House Draft 1 (2006), which requests the Bureau to conduct a study relating to the State of Hawaii workers' compensation medical fee schedules. This particular survey focuses on reimbursement under those fee schedules, in relation to other reimbursement systems. Your participation in this study is greatly appreciated. Please return the completed survey by August 20, 2007 to the Bureau in the envelope provided.

1. You are (or are answering on behalf of) a:

   ☐ Doctor of Medicine (M.D.)

   ☒ Doctor of Osteopathy (D.O.)

2. Your area of specialty or expertise is: _____.

3. Please confirm that you are licensed to practice medicine or osteopathy in the State of Hawaii and that you have provided medical services to workers' compensation patients under the State of Hawaii workers' compensation laws during the current year, beginning January 1, 2007:

   ☒ Yes

   ☐ No

   If you answered "yes", please continue on with the survey. If you answered "no", we thank you for your time and apologize for the inconvenience.

4. For the table below, please list up to ten CPT codes that reflect your type of medical practice and were utilized in billing for services provided since January 1, 2007 to workers' compensation patients in a non-facility setting (i.e., your office). For each of the CPT codes, please provide figures that reflect the reimbursements made under the State of Hawaii workers' compensation fee schedules. If the information is available, please also provide figures that reflect the carrier reimbursements and patient copayments for those same codes when made under employee group health plans, and amounts reimbursed for those same codes when made by uninsured patients.

(over)

CPT Code	Amount reimbursed under the workers' compensation fee schedules	Amount reimbursed by uninsured patients	Average amount reimbursed by the carrier under the employee group health plans of HMSA, HMAA, and UHA[1]	Average amount copaid by the patient under the employee group health plans of HMSA, HMAA, and UHA[2]

5. With regard to the question above, please feel free to provide comments or explanations on the differences, if any, in the reimbursement levels associated with workers' compensation, employee group health plans, and uninsured patients.

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Thank you for participating in this survey. Please feel free to attach any comments regarding the workers' compensation medical fee schedules. Please feel free to contact Dean Sugano, Legislative Researcher, at the Legislative Reference Bureau, by phone at 587-0674, or by email at sugano@capitol.hawaii.gov, if you have any questions.

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[1] Average amount of reimbursement made by the carrier under the three employee group health plans = (HMSA reimbursement + HMAA reimbursement + UHA reimbursment) ÷ 3.

[2] Average amount of copayment made by the patient under the three employee group health plans = (HMSA patient copayment + HMAA patient copayment + UHA patient copayment) ÷ 3.

Appendix D

References

United States	42 United States Code section 1395w-4 42 Code of Federal Regulations part 414, subparts A and B 71 Federal Register 231, pages 69623 to 70251 (December 1, 2006) Addendum B.--2007 Relative Value Units and Related Information Used in Determining Medicare Payments for 2007, 71 Federal Register 231, (December 1, 2006), pages 69789 to 70012 Addendum D.--2007 Geographic Practice Cost Indices my Medicare Carrier and Locality, 71 Federal Register 231 (December 1, 2006), pages 70016 and 70017 Addendum_-Proposed 2007 Geographic Practice Cost Indices by Medicare Carrier, on website of the Centers for Medicare & Medicaid Services, at http://www.cms.hhs.gov 2005 National Physician Fee Schedule Relative Value Scale, on website of the Centers for Medicare & Medicaid Services, at http://www.cms.hhs.gov Addendum B.--2002 Relative Value Units and Related Information Used in Determining Medicare Payments for 2002, 66 Federal Register 212, (November 1, 2001), pages 55334 to 55497 Addendum B.--1997 Relative Value Units and Related Information Used in Determining Medicare Payments for 1997, 61 Federal Register 227, (November 22, 1996), pages 59556 to 59711 Addendum B.--1996 Relative Value Units and Related Information Used in Determining Medicare Payments for 1996, 60 Federal Register 236, (December 8, 1995), pages 63190 to 63347
Alabama	Code of Alabama, section 25-5-313 Alabama 2007 Doctor Fee Schedule
Alaska	Alaska Statutes, section 23.30.097 Alaska Administrative Code, title 8, section 45.082
Arizona	Arizona Revised Statutes, section 23-908 Arizona Administrative Code, section 20-5-117
Arkansas	Arkansas Code, section 11-9-508 Arkansas Workers' Compensation Commission, rule 30, including the medical fee schedule
California	California Labor Code, section 5307.1 California Code of Regulations, title 8, sections 9789.10 to 9792 Official Medical Fee Schedule 2003, California Code of Regulations, title 8, section 9791.1 Table A February, 2007 Addendum: OMFS Physician Services Fees for Services Rendered on or after February 15, 2007
Colorado	Colorado Revised Statutes, section 8-42-101 7 Code of Colorado Regulations, section 1101-3 (Rule 18)
Connecticut	General Statutes of Connecticut, section 31-294d Regulations of Connecticut State Agencies, section 31-280-3
Delaware	Delaware Code, title 19, section 2322B
Florida	Florida Statutes, section 440.13(12) Florida Administrative Code Annotated, rule 69L-7.020 Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2007 Edition, Draft

Georgia	Georgia Code, section 34-9-205
Hawaii	Hawaii Revised Statutes, section 386-21
	Hawaii Administrative Rules, section 12-15-90
	Workers' Compensation Supplemental Medical Fee Schedule, Hawaii Administrative Rules, chapter 12-15, exhibit A, January 1, 2007
	Workers' Compensation Supplemental Medical Fee Schedule, Hawaii Administrative Rules, chapter 12-15, exhibit A, January 1, 2005
	Workers' Compensation Supplemental Medical Fee Schedule, Hawaii Administrative Rules, chapter 12-15, exhibit A, January 1, 2002
	Workers' Compensation Supplemental Medical Fee Schedule, Hawaii Administrative Rules, chapter 12-15, exhibit A, January 1, 1997
	Workers' Compensation Supplemental Medical Fee Schedule, Hawaii Administrative Rules, chapter 12-15, exhibit A, January 1, 1996
	Workers' Compensation Medical Fee Schedule, Hawaii Administrative Rules, chapter 12-13, Hawaii Administrative Rules, exhibit A, January 1, 1993 to December 31, 1995 (repealed January 1, 1996)
	Act 234, Session Laws of Hawaii 1995
	H.B. No. 2133 (1995)
	H.B. No. 2133, H.D. 1 (1995)
	H.B. No. 2133, H.D. 2 (1995)
	H.B. No. 2133, H.D. 2, S.D. 1 (1995)
	(H.B. No. 2133, H.D. 2, S.D. 1, C.D. 1 (1995) is Act 234)
	House Journal 1995: House Standing Committee Report No. 575, accompanied by floor debates, pages 265 to 266; House Standing Committee Report No. 955, accompanied by floor debates, pages 382 to 391; Conference Committee Report No. 112
	Senate Journal 1995: Senate Standing Committee Report No. 829; Senate Standing Committee Report No. 899, accompanied by floor debates, page 400
	Act 260, Session Laws of Hawaii 1996
	Governor's Task Force on Workers Compensation, Report and Recommendations, November 28, 1994
Idaho	Idaho Statutes, sections 56-136, 72-803
	Idaho Administrative Code, rule 17.02.08.031
Illinois	Illinois Compiled Statutes, 820 ILCS 305/8.2
	Illinois Administrative Code, title 50, section 7110.90
	Illinois Workers' Compensation Commission Fee Schedule, treatment year 2007
Indiana	Indiana Code, sections 22-3-3-5, 22-3-6-1(j)
	631 Indiana Administrative Code 1-1-25
Iowa	Iowa Code, section 85.27
Kansas	Kansas Statutes, section 44-510i
	Kansas Administrative Regulations, section 51-9-7
	Schedule of Medical Fees, Kansas Department of Labor, Workers' Compensation, December 1, 2005
Kentucky	Kentucky Revised Statutes, section 342.035
	803 Kentucky Administrative Regulations 25:089
Louisiana	Louisiana Revised Statutes, sections 23:1034.2, 23:1203
	Louisiana Administrative Code, title 40, section 5101, et al
	Maximum Reimbursement Allowances, Louisiana Administrative Code, title 40, section 5157

Maine	Maine Revised Statutes, title 39-A, section 209 90-351-5 Code of Maine Rules, section 1, et al Medical Fee Schedule, Maine Workers' Compensation Board, 90-351, chapter 5, Appendix III, effective November 5, 2006
Maryland	Maryland Code, labor and employment article, section 9-663 Code of Maryland Regulations 14.09.03.01 2004 Medicare Fee Schedule, dated June 10, 2004, applicable to locality 01 (Baltimore and surrounding counties)
Massachusetts	Massachusetts General Laws, chapter 152, section 13; chapter 118G, section 7 114.3 Code of Massachusetts Regulations 40.00 Fees, 114.3 Code of Massachusetts Regulations section 40.06(10), effective 9/01/04
Michigan	Michigan Compiled Laws, section 418.315 Michigan Administrative Code, rule 418.10106 Michigan Workers' Compensation Fee Schedule 2007, effective April 2, 2007
Minnesota	Minnesota Statutes, sections 176.136, 176.645 Minnesota Rules, chapter 5221
Mississippi	Mississippi Code, section 71-3-15 Rules of the Mississippi Workers' Compensation Commission, general rule 12 Mississippi Workers' Compensation Medical Fee Schedule, effective July 1, 2007
Missouri	Missouri Revised Statutes, section 287.140 Missouri Code of State Regulations, title 8, section 50-2.030
Montana	Montana Code Annotated, section 39-71-704 Administrative Rules of Montana, sections 24.29.1532, 24.29.1536
Nebraska	Nebraska Statutes, section 48-120 Rules of Procedure, Nebraska Workers' Compensation Court, rule 26 Schedule of Medical and Hospital Fees, Nebraska Workers' Compensation Court, effective July 1, 2006
Nevada	Nevada Revised Statutes, section 616C.260 Nevada Administrative Code, section 616C.145
New Hampshire	New Hampshire Revised Statutes Annotated, section 281-A:24 New Hampshire Code of Administrative Rules Annotated, labor 506.02
New Jersey	New Jersey Statutes Annotated, section 34:15-15 New Jersey Administrative Code, section 12:235-1.1 et al
New Mexico	New Mexico Statutes Annotated, section 52-4-5 New Mexico Administrative Code, section 11.4.7.9 New Mexico Workers' Compensation Medical Fee Schedule, effective December 31, 2005
New York	New York Consolidated Laws, workers' compensation, section 13 Official Compilation of Codes, Rules & Regulations of the State of New York, title 12, section 329.3
North Carolina	North Carolina General Statutes, section 97-26 Rules of the North Carolina Industrial Commission, rule 407 North Carolina Industrial Commission Medical Fee Schedule: CPT Codes and Fees, effective May 1, 2007
North Dakota	North Dakota Century Code, section 65-02-08 North Dakota Administrative Code, section 92-01-02-27 North Dakota Fee Schedules, January 1, 2007

Ohio	Ohio Revised Code, section 4121.121 Ohio Administrative Code, section 4123-6-08 Ohio Bureau of Workers' Compensation 2007 Provider Fee Schedule
Oklahoma	Oklahoma Statutes, section 85-14 Oklahoma Workers' Compensation Court Schedule of Medical and Hospital Fees, effective January 1, 2006
Oregon	Oregon Revised Statutes, section 656.248 Oregon Administrative Rules, sections 436-009-0004, 436-009-0040
Pennsylvania	77 Pennsylvania Statutes, section 531 34 Pennsylvania Code sections 127.101, 127.152 2007 WC Part B Fee Schedule
Rhode Island	Rhode Island General Laws, section 28-33-7 Rhode Island Workers' Compensation Fee Schedule, October 25, 2006
South Carolina	South Carolina Code of Laws, section 42-15-70 South Carolina Code of Regulations, section 67-1302
South Dakota	South Dakota Codified Laws, section 62-7-8 South Dakota Administrative Rules, section 47:03:05:02 Physician Fee Schedule, South Dakota Administrative Rules, chapter 47:03:05, appendix A, effective June 27, 2007
Tennessee	Tennessee Code, section 50-6-204 Official Compilation Rules & Regulations of the State of Tennessee, sections 0800-2-18-.01, 0800-2-18-.02
Texas	Texas Statutes, labor, sections 413.011, 413.012 28 Texas Administrative Code section 134.202
Utah	Utah Code, section 34A-2-407 Utah Administrative Code, rule 612-2-5
Vermont	Vermont Statutes, title 21, section 640 Department of Labor, rule 40.000 Medical fee schedule, rule 40.000, appendix I, table B, effective May 15, 2006
Virginia	Code of Virginia, section 65.2-605
Washington	Revised Code of Washington, section 51.04.030 Washington Administrative Code, sections 296-20-132, 296-20-135 Professional Services Fee Schedule, Washington State Department of Labor & Industries, effective July 1, 2007
West Virginia	West Virginia Code, section 23-4-3 Workers' Compensation Schedule of Maximum Allowed Medical Reimbursement, RBRVS-Based Procedure Codes and Fees, effective January 1, 2006
Wisconsin	Wisconsin Statutes, section 102.16 Wisconsin Administrative Code, DWD section 80-72
Wyoming	Wyoming Statutes, sections 27-14-401, 27-14-802 Rules, Regulations and Fee Schedules of the Wyoming Workers' Safety and Compensation Division, chapter 9, section 1
Non-governmental	Current Procedural Terminology: cpt 2002, Standard Edition, American Medical Association Current Procedural Terminology: cpt 2007, Standard Edition, American Medical Association Relative Values for Physicians, Relative Value Studies, Inc., 2006 edition, Ingenix