



# **Power Up with a Review of the 2020 Medical Fee Schedule (MFS) & E-billing Regulation October 29, 2019**

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Virginia Workers' Compensation Commission



# **2020 Medical Fee Schedule**

# Agenda

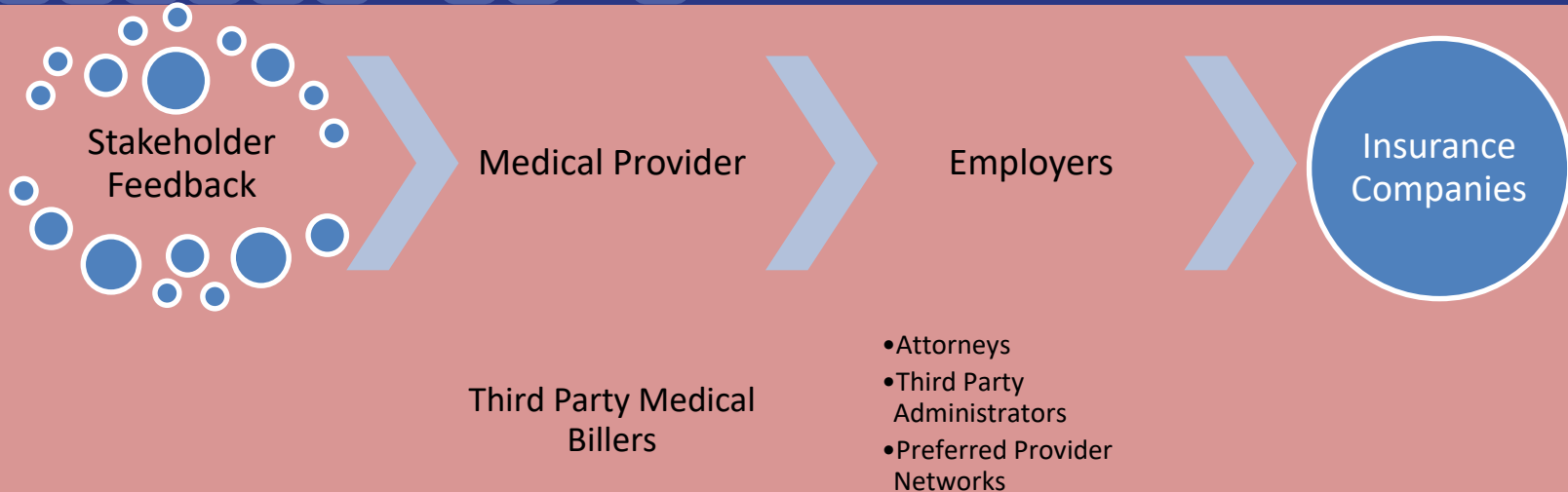
A workshop to highlight the upcoming 2020 Medical Fee Schedule that will be effective 01.01.2020 and significant considerations resulting from electronic medical billing rule making. The presentation will cover substantive topics such as:

- **Commission consideration in compliance with the requirements defined in § 65.2-605 Subsection D**
  - MFS Review Process
    - Stakeholder Feedback
    - Regulatory Advisory Panel Recommendations
    - Overview of changes
      - Schedules
      - Ground Rules
- **Discuss impacts of electronic medical billing rule making found in 16VAC30-16-10.**
  - What does electronic really mean?
  - E-billing standard
  - Are there any exceptions?
  - Where can I get additional information?

## § 65.2-605.

D. The Commission shall review Virginia fee schedules during the year that follows the transition date and biennially thereafter and, if necessary, adjust the Virginia fee schedules in order to address (i) inflation or deflation as reflected in the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) for the South as published by the Bureau of Labor Statistics of the U.S. Department of Labor; (ii) access to fee scheduled medical services; (iii) errors in calculations made in preparing the Virginia fee schedules; and (iv) incentives for providers. The Commission shall not adjust a Virginia fee schedule in a manner that reduces fees on an existing schedule unless such a reduction is based on deflation or a finding by the Commission that advances in technology or errors in calculations made in preparing the Virginia fee schedules justify a reduction in fees.

# Review Process



## Stakeholder experience feedback channels:

- **Public Comments received**
- **Customer Contact**
- **MFS Dispute Resolution Process**
- **Direct emails to**  
[medicalfeeservices@workcomp.virginia.gov](mailto:medicalfeeservices@workcomp.virginia.gov)

# Regulatory Advisory Panel Review and Recommendations

The Advisory Panel made decisions on several items that required further clarification.

This resulted in identification and review of 14 tasks associated with various aspects of the schedules.

2018 MFS Transition Review Matrix

General Category			
Code Updates			AP Comments
Deleted Codes/No longer in use	Advisory Panel members determined codes would be retained in this MFS schedule update. Codes will remain; however, max fees will not be trended as they are no longer active and in most cases have been replaced with an updated code with a more recent max fee listed.	Yes	Codes will remain on the schedule will be added, and no further action codes are identified as deleted longer in use.
W analysis of 2016/2017 CPT codes	Advisory Panel members determined the 2016/2017 codes with a manual rate that did not get transferred to the final version of the fee schedule would be included as part of the transition review.	Yes	All agreed
New Codes - effective 2018	Advisory Panel members discussed defining max fee values for new codes using existing methodology (except otherwise indicated in the data or trending sections). RVU's for 2019 are not expected to be available, therefore no manual rates will be established as a part of the transition review.	Yes	All agreed
Data			
Provider categories other than HI	Advisory Panel members discussed using NCCI (2016/2017) data to define max fees for new code values.	Yes	If manual rate cannot be developed experience present in current schedule new (2016/2017 NCCI data) if applied.
Hospitals (HI)	Advisory Panel members discussed there would not be a new data call to stakeholders for HI data. New HI codes developed using current schedule values for family of codes.	Other	It was discussed that changes are not frequent as CPT/HCPCs codes. AP requested summarization of change review.
Trending			
			The Commission determines CPI-U and requested additional information <b>***Deliverables***</b> 1. AP members will provide their views to Drema on single vs. multi

# Fee Schedule Impacts (FSI)

(i) inflation or deflation as reflected in the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) for the South as published by the Bureau of Labor Statistics of the U.S. Department of Labor;

## Commission Issued Policy Statement

- Limited 1<sup>st</sup> review of the MFS to a single year adjustment.
- Subsequent years would result in CPI adjustment for two years



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### Policy Statement

#### Subject: Inquiry from the Regulatory Advisory Panel:

With the first mandated review of the Medical Fee Schedule (MFS), we have been called upon by the Regulatory Advisory Panel (RAP) to interpret the following statutory language:

The Commission shall review Virginia fee schedules during the year that follows the transition date and biennially thereafter and, *if necessary, adjust the Virginia fee schedules in order to address (i) inflation or deflation as reflected in the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U) for the South as published by the Bureau of Labor Statistics of the U.S. Department of Labor . . .*<sup>1</sup> Va. Code § 65.2-605(D) (emphasis added)

Two questions are posed, both relating to the periods in which the statutorily defined inflation factor will be considered for the purposes of potential adjustments to the MFS. The questions are as follows:

1. In contemplating adjustments for the review following the transition date, will the Commission limit consideration of inflation to the period since January 1, 2018 or, should inflation be considered for the additional years of 2016 and 2017?
2. As regards to the biennial reviews, should inflation be considered for the two preceding years or just one?

Various representatives of the RAP have submitted comments with their respective positions, predictably falling along party lines. That is, the medical providers argue for the application of inflation in a manner anticipated to maximize its impact on reimbursements for services rendered. Representatives of the payors advance arguments for contrary results. We have reviewed all the submissions and considered their arguments.

<sup>1</sup> The statutory language continues: "(ii) access to fee scheduled medical services; (iii) errors in calculations made in preparing the Virginia fee schedules; and (iv) incentives for providers." Item (ii), generically referred to as "access to care" is addressed in some of the correspondence received. Items (iii) and (iv) are not relevant to the questions before us.

# FSI conti.



**§ 65.2-605. Subsection A identifies the use of applicable numerical coding descriptions for fee scheduled medical services.**

- New Codes
- Deleted Codes
- Cross walked Codes
- 2018 MFS Omitted Codes



# Ground Rules Impacts

## **General Information Source providing instruction on how to interpret the 2020 MFS.**

- Detailed description for Applicable Code Changes
- Additional Definitions were added describing terminology related to application of the schedules.
- Fee scheduled medical services payment rules further defined.
- Identifies several changes made in the billing and payment section for application of the schedules.

VIRGINIA WORKERS' COMPENSATION 2020  
MEDICAL FEE SCHEDULES  
GROUND RULES

ADOPTED BY THE COMMISSION ON  
JULY 18, 2019



# MFS Ground Rules Documents

## Definitions Section

- Add definition for Physician dispensed (as defined by the Virginia Board of Pharmacy)
- Add definition for Retail or mail order prescription drugs (as defined by the Virginia Board of Pharmacy)
- Add definition for “New Type of Procedure”
- Update Diagnosis Related Group (DRG) – add language regarding other versions that are now included
- Add reference to Traumatic Injury (see *Level I or Level II Trauma Center*)
- Add definition for Taxonomy Code (reference Surgeon)

## Reimbursement of Non-Physician Practitioners

No adjustment shall be applied to the applicable maximum fee appearing on the MFS, regardless of whether the NPP bills for the service under the physician’s NPI or their own for *non-surgical* procedures, beyond those outlined in the CPT/HCPCS Modifiers section below.

## CPT/HCPCS Modifiers Section

*Correction-*

- Services provided by an assistant surgeon in the same specialty as the primary surgeon, as identified by the presence of modifier 80, 81, or 82 but without the presence of modifier AS on the claim line, shall be reimbursed at 50 percent due to the primary physician performing the surgery.
- A nurse practitioner or physician assistant serving as an assistant-at-surgery, as identified by the presence of modifier AS on the claim line, shall be reimbursed at 20 percent of the reimbursement due to the physician performing the surgery.

## Billing and Payment Section

*Change-* Nothing in these rules preclude the separate negotiation of fees between a provider and a payer to which the MFS do not apply *or payment for medical services provided* under the act to which an applicable code with maximum fee reimbursement for medical services provided is not listed in the medical fee schedule.

*Change-* Any health care provider located outside of the Commonwealth who provides health care services under the Act to a claimant shall be reimbursed as the principal place of business of the employer if located in the Commonwealth or, if no such location exists, then the location where the Commission hearing regarding the dispute is conducted.



# **E-billing Regulation Update**

## **Regulatory Mandate**

This chapter applies to all medical services and products provided to injured workers in accordance with § 65.2-603 of the Code of Virginia on or after July 1, 2019. For medical services and products provided prior to July 1, 2019, medical billing and processing shall be in accordance with the rules in effect at the time the medical service or product was provided; however, providers and payers may voluntarily comply with the provisions of this Chapter beginning on December 31, 2018.

# What does electronic really mean?

"Complete electronic medical bill" means a medical bill that meets all of the criteria listed in 16VAC30-16-50 C.

DATE OF SERVICE	CODE	DESCRIPTION OF SERVICE	CHARGES	PAYMENTS	BALANCE
01/11/17	01234	Emergency Room Visit	\$750.00		\$750.00
01/15/17	56789	MR	\$828.95		\$828.95



"Electronic" means communication between computerized data exchange systems that complies with the standards in this chapter.



# Standardized Method

- International Association of Industrial Accident Boards and Commissions (IAIABC) Standard
  - See the Companion Guide on the Commission Website

Virginia Workers' Compensation  
Commission

Electronic Billing and Payment  
Companion Guide

Based on ASC X12 005010 and NCPDP D.0



Virginia Workers' Compensation Commission Electronic Billing and Payment Companion Guide Page 1

- ASC X12 Standards for Electronic Data Interchange
  - Billing Transaction
  - Acknowledgement Transaction

# Are there any exceptions?

## **B. Exemptions.**

- 1.** A health care provider is exempt from the requirement to submit medical bills electronically to a payer if:
  - a. The health care provider employs 15 or fewer full-time employees; or
  - b. The health care provider submitted fewer than 250 medical bills for workers' compensation treatment, services or products in the previous calendar year.
  
- 2.** A payer is exempt from the requirements to receive and pay medical bills electronically if the payer processed fewer than 250 medical bills for workers' compensation treatment, services or products in the previous calendar year.

# Where can I get additional information?



[www.workcomp.virginia.gov](https://www.workcomp.virginia.gov)



[medicalfeeservices@workcomp.virginia.gov](mailto:medicalfeeservices@workcomp.virginia.gov)



804-205-3050



# Summary

**I have listened nicely...**

**What do I really need to remember?**

- **New schedule and New Ground Rules**
- **2020 Medical Fee Schedule effective 01.01.2020.**
- **Stakeholder feedback should be forwarded to the Commission via [medicalfeeservices@workcomp.virginia.gov](mailto:medicalfeeservices@workcomp.virginia.gov)**
- **Electronic medical billing includes the bill, medical documentation (records), and payment and is required.**
- **If there is an issue with e-billing the payor and medical provider should work together to resolve.**





**Questions?**