

RESPONSE TO PUBLIC COMMENT 2017 FEE SCHEDULE & BILLING INSTRUCTIONS

The proposed changes to the WCA Healthcare Provider Fee Schedule were released for public comment on October 3, 2016. The public comment period was from October 3, 2016 through November 2, 2016. In addition to written comments, the WCA held a public hearing on October 19, 2016 to accept oral comment.

The WCA received several comments critical of the proposed 2017 hospital ratios. Opponents of the proposed ratios expressed concern that the amount of reduction in reimbursement to hospitals was significant and too much to shoulder in a single year. Several commenters noted that such a drastic, sudden and unanticipated reduction would have considerable impact on the stability and predictability of hospital operations, especially for hospitals already trying to absorb Medicaid payment cuts. One commenter argued that New Mexico's current hospital reimbursement ratios lag behind neighboring states and further expressed concern that health care provider fees were increased, in some cases by 30%, while hospital reimbursement ratios were significantly decreased. One commenter recommended that the WCA postpone the proposed hospital ratio changes for a year, and suggested that any warranted reductions should be phased in over four to five years. Another commenter recommended a review of the assumptions for the underlying formula to assure consistency with the current healthcare financing realities.

Response: The established methodology for setting hospital ratios has not been strictly followed since 2006. For 2017, the WCA endeavored to return to the established methodology that is based on a simple "cost-to-charge ratio" calculated using expenses and revenues annually reported by hospitals. The WCA has carefully considered the implications of adopting the existing cost-to-charge ratios for hospitals and has elected to strike a balance in applying the established methodology. Based on comments, the WCA is making the following adjustments to the 2017 assigned hospital ratio methodology.

New hospitals will be assigned a ratio of 0.67 in accordance with WCA regulation, 11.4.7.9(B)(1). For subsequent years, new hospitals will be assigned an initial ratio that represents the median ratio of all listed hospitals. For established hospitals that failed to submit their annual HCFA/CMS 2252 G-2 worksheet in accordance with 11.4.7.9(B)(3) NMAC, these hospitals will be assigned a ratio equal to the minimum ratio for all listed hospitals. Assigning the lowest possible reimbursement ratio to non-compliant hospitals should encourage annual reporting as required by agency regulations. For established hospitals that submitted their annual HCFA/CMS 2252 G-2 worksheet, these hospitals will be assigned a "cost-to-charge" ratio. However, these hospitals' ratio reductions will not exceed ten percentage points from the prior year's ratio effective January 2017 and thereafter. While the current methodology and assumptions are being reviewed, the WCA will phase in the adjusted ratios over a three year period.

The WCA received public comment expressing concern that 550 CPT codes designated as By Report (BR) could lead to an increased use and abuse of BR codes.

Response: The concern that more BR codes will lead to increase or abuse of BR CPT codes is not supported by data. For the group of CPT codes that were designated as BR in 2015 and again in 2016, the WCA did not see an increase in the use of those codes.

The WCA also received public comment asking for clarification on the 60/40 rule and whether it would apply to diagnostic procedures if the CPT code was outside the range for laboratory or radiology services.

Response: The WCA has revised the fee schedule and billing instructions to clarify payment for CPT codes that have a technical component or professional component or both. The fee schedule shows the maximum amount indicated by CPT code. For CPT codes with both a technical and professional component, the bill will be split 60% for the technical component and 40% for the professional component based on the total. The 60/40 rule also applies to diagnostic procedures that include a technical component even if the CPT code is not in the range for pathology/laboratory or radiology services.

The WCA received public comment requesting clarification of the time frame to provide pre-authorization when a worker is hospitalized. Under the proposed billing instructions, pre-authorization must be provided within 24 hours of the request. One commenter requested clarification of the required time frame when the request is made on a weekend or holiday and the payer's office may be closed.

Response: Based on comments received, the WCA will revise the billing instructions as follows: "DME shall be pre-authorized by payer within 72 hours after receipt of all supporting documentation, except that authorization must be given within 24 hours if the worker is hospitalized. If a worker is hospitalized and the request is made when the payer's place of business is closed, such as on weekends and holidays, authorization shall be given by the close of business on the next business day. Authorization will be presumed if adjuster does not reply in the allotted timeframe."

The WCA received public comments questioning the validity and enforceability of regulations setting a maximum amount and quantity for reimbursement of medical cannabis. The commenter noted that marijuana remains classified as a Schedule I controlled substance by the federal government, which conflicts with the regulation providing for reimbursement of medical marijuana. The commenter also stated that there are no generally accepted medical standards or evidence based guidelines to support the safety or efficacy of medical cannabis as a reasonable or necessary treatment for work place injuries.

Response: The WCA previously addressed similar comments in the Director's Response to Public Comment on the 2016 health provider fee schedule and billing instructions. The WCA is not advocating for the use of medical cannabis as a treatment method for work place injuries by establishing a maximum reimbursable amount and quantity for medical cannabis or by collecting data on quantities purchased or payer reimbursements. Rather, based on court decisions, the WCA has an obligation to set a fee schedule and to properly collect data in order to document and analyze reimbursement trends and patterns of medical cannabis use in the New Mexico workers' compensation system. Whether medical cannabis is reasonable and necessary for treatment of a work place injury will depend on each individual case. As with any other dispute under the Act, the parties may utilize the WCA's dispute resolution process to resolve any disagreement regarding the reasonableness and necessity of medical cannabis in a given case. The WCA will continue to monitor medical cannabis usage among the workers' compensation population and will consider changes in the future as needed.

The undersigned appreciates all of those who took the time to offer comments on the 2017 Fee Schedule and Billing Instructions. The final schedule will be available by December 1, 2016, and the schedule will go into effect on January 1, 2017.


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Date: December 1, 2016