

September 9, 2002

California Orthopaedic Association

**SUMMARY of STATE and FEDERAL
LEGISLATIVE/REGULATORY ISSUES
2001-2002 LEGISLATIVE SESSION**

WORKERS' COMPENSATION

Bill Review – AB 1179 (Calderon)

COA was successful in sponsoring legislation, AB 1179, which requires:

- 1) Workers' Compensation carriers to make available to their bill review entities, the documentation which the physician has submitted with the bill;
- 2) physicians to submit any written authorizations for services billed that they may have received at the time of the billing;
- 3) bill review entities to obtain additional information from the claims administrator rather than calling the physician;
- 4) bill review entities to review the documentation before the bill can be altered; and
- 5) if the reviewer does not recommend payment as billed, they must provide the physician with a specific explanation as to why the reviewer altered the billing.

This new law will take effect January 1, 2002.

Why was this bill necessary? Physicians' offices have become copy centers for Workers' Compensation carriers and their agents. The documentation submitted by the physician is routinely separated from the billing in the mailroom. The report is used to resolve indemnity issues while the billing is sent through the bill review process on its own without any documentation. Bill review entities either review the bill without any documentation or routinely call physicians' offices to request another copy. This has caused enormous additional overhead costs for physicians.

COA will be monitoring the carriers' and bill reviewers compliance with this bill.

After January 1, 2002, if bill reviewers continue to call your office to request duplicate copies of your previously submitted reports, we want to hear from you.

Fax the COA office – (916) 454-9882 indicating: 1) which bill reviewers are still calling your office; 2) which carrier(s) they represent; and 3) a contact person and phone number for each entity. We will follow-up and contact them to see why they have not complied with this new law.

Disability Benefit Increase—SB 71 (Burton)/AB 1176 (Calderon)/AB 749 (Calderon)

For the last several years, labor has sought an increase in disability benefits for injured workers. While there is consensus that California's benefits are too low, business and Workers' Compensation carriers have opposed these increases without corresponding reductions to offset the additional costs. Physicians worry that legislators will look to the Official Medical (Treatment) Fee Schedule to find some of the savings.

The discussions focused on reductions in the dispensing fees for pharmaceuticals, establishing an outpatient surgical fee schedule, eliminating the presumption of correctness of the primary treating physician, and increasing utilization review guidelines as ways to offset the disability increases. In 2001, the disability benefit package sent to the Governor was several times higher than the Governor had indicated he would support and once again he has vetoed both bills.

AB 749 was introduced in 2002 to renew efforts to increase disability benefits and this bill was ultimately signed into law. In addition to increasing disability benefits, AB 749:

- Provided incentives for employers to implement an early return-to-work program.
- Repealed the treating physician's presumption of correctness unless the PTP is pre-selected.
- Allows additional Medical-Legal reports.
- Requires a study of rising costs of medical treatment and utilization of services.
- Requires a pharmaceutical fee schedule by 7/1/2003 which would contain a single dispensing fee.
- Requires the Administrative Director to make several findings before implementing an outpatient surgery fee schedule which would have to take into consideration access to care and providers' actual costs.

Official Medical Fee Schedule Medical-Legal Fee Schedule

Technical Changes

The Division of Workers' Compensation finalized "technical changes" to the Official Medical and Medical-Legal Fee Schedules effective July 12, 2002. One important technical change included is a clarification that physicians are not required to put their results of x-ray and other diagnostic tests on a separate sheet of paper. These reports may be included in a separate clearly identified section of their Evaluation and Management report. This change became important when Corvel in Orange and Los Angeles Counties insisted that they would not reimburse physicians for the professional component of an x-ray service unless the physician generated the x-ray report on a separate sheet of paper.

Transitioning the OMFS to a RBRVS system

The Division of Workers' Compensation and the Industrial Medical Council continue discussions on transitioning the Official Medical Fee Schedule to Medicare's RBRVS system. This would not necessarily mean that the Medicare conversion factor would be used, however, COA is concerned that this transition could result in significant reductions in reimbursement for major orthopaedic procedures. Reimbursement for other more office-based orthopaedic procedures could be increased. Obviously, the conversion factor will be all important in these discussions.

The first IMC report on the impact of transitioning the OMFS to a RBRVS system was released on October 18. The Lewin report indicates that a conversion factor of \$44.73 would result in a budget neutral transition. For your information, Medicare's 2001 conversion factor is: \$38.26. The proposed values for the OMFS would represent a conversion factor of 117% of Medicare reimbursement levels. **This, however, is only the beginning estimate. None of the ground rule changes that are integral to the value of the procedures have yet been considered.**

There were no real surprises in the results of this study – evaluation and management and office-based procedures will be increased and the more complex surgeries will be reduced. The report projects that overall orthopaedic procedures would be reduced 5.1%.

While this estimate may be accurate if the orthopaedic office billed the full range of orthopaedic procedures, COA believes that the reductions will actually be more severe for our members who specialize in certain practice areas. For instance, when we looked at arthroscopic procedures, we found that a range of 115% to 215% of Medicare reimbursement levels would be necessary to maintain current reimbursement levels for these codes. The following chart illustrates Medicare's current reimbursement levels for the San Francisco area versus the current CA Official Medical Fee Schedule reimbursement levels.

Arthroscopic procedures

		RBRVS 2001 SF Reimbursement	Current OMFS Reimbursement	% of Medicare to be Budget Neutral
Shoulder –	29822 *	\$806.30	\$1,148.00	142%
	29823 *	\$864.66	\$1,561.00	180%
	29826 *	\$933.14	\$1,561.00	166%
Elbow –	29838	\$730.99	\$1,576.00	215%
Wrist –	29848 *	\$601.32	\$689.00	115%
Knee –	29876 *	\$815.46	\$1,346.00	165%
	29877 *	\$748.47	\$1,193.00	160%
	29879 *	\$805.06	\$1,377.00	170%
	29880 *	\$842.79	\$1,652.00	195%
	29881 *	\$782.05	\$1,362.00	175%
	29888 *	\$1,305.39	\$2,417.00	185%

* Included on CWCI's list of top 100 surgical procedures performed in CA Workers' Compensation system.

On these codes alone, the surgical conversion factor would have to be set in a range of 115%-215% of Medicare's reimbursement levels to be budget neutral with the OMFS current reimbursement levels. This is only a sampling of the effect that a single surgical conversion factor could have on reimbursement for surgical procedures during the RBRVS transition.

The DWC has not yet convened work groups to discuss the Medicare ground rules that are integral to the value of a procedure. The multiple surgery rule is one important rule that COA believes should be adopted in this transition and will allow for 100%/50%/50% instead of the current Workers' Compensation rate of 100%/50%/25% for multiple procedures. Once these discussions take place, the Lewin Group will be asked to remodel their report to incorporate these changes. We will then have a better idea of the conversion factor that will be proposed.

Determining Whether There is Additional Physician Work and Practice Expense in Treating an Injured Worker Versus Other Patients

Other important IMC-commissioned studies have also been undertaken by the Lewin Group to determine whether there are additional costs of treating and evaluating an injured worker versus other patients. There are two separate studies – one focused on additional physician work costs and the other on additional practice overhead costs. Originally the IMC proposed only the Physician Work Study. The IMC agreed to expand the studies to include the Practice Overhead Expenses at the insistence of COA.

In June, 1997 and again in April, 2002, COA conducted a survey of our members to assess the additional time involved in treating an injured worker versus other types of patients. More than 200 orthopaedic

surgeons involved in California's Workers' Compensation system responded to the survey. We found that the average time spent by physicians and staff was as follows:

- additional **physician time** was **5 hours and 18 minutes** on average over the course of treatment, and the
- additional **staff time** was **4 hours and 1 minute** per patient.

The Physician Work study was completed in July, 2002 and found that, on average, the Evaluation and Management (E&M) services need to be increased 13.95% to reflect the additional physician work involved in treating an injured worker versus other patients. This would represent an increase of over \$7 million or 3.25% increase in overall treatment costs.

The Practice Expense study is expected to be completed in September, 2002. We believe that this study will also show significant additional practice overhead expenses in dealing with injured workers versus other patients. **While COA supports an increase to the E&M codes, any increases in E&M services are expected to be reduced from surgical fees. We believe that if surgical fees are reduced, physicians will refuse to treat injured workers and result in severe access problems and delays in receiving medical services.**

After the studies are completed, we expect that DWC will begin to hold formal hearings on the proposed transition to RBRVS.

COA sees two options:

1. If the DWC insists on adopting RBRVS, they must also concurrently adopt Medicare rules which affect reimbursement amounts or a physician's ability to participate in the program such as: uniform claim form, electronic claim and report submission and payment, no prior authorizations, payment within 15 days consistent with Medicare, uniform coding rules that are open to review and comment, etc.
2. Abandon efforts to adopt RBRVS and focus on problems within the current fee schedule. Increase E&M services consistent with the findings of the Lewin Group and put in place a mechanism for future updates to the fee schedule.

Additional information will be provided to you as the details of the specific proposals are known.

Outpatient Surgical Facilities Fee Schedule

Workers' Compensation carriers have complained for the last several years about the variability of facility fees that they are charged by outpatient surgical facilities. Some carriers report that one facility will charge \$1,500 for a procedure and other facilities \$5,000. They fail to see why the fees vary so much from one facility to another. The California Commission on Health and Safety and Workers' Compensation (CHSWC) commissioned a study on this subject which called for as much as an 88% reduction in the fees currently charged by outpatient surgical facilities. The report before the Commission recommends that the facility fee schedule be established at 120% of the Medicare reimbursement levels.

At the last IMC meeting Richard Gannon, Administrator of the Division on Workers' Compensation, expressed skepticism that he would have the resources to devote to the development of this fee schedule at this time.

Should a fee schedule be proposed for outpatient surgical facilities, COA would be seeking to ensure that the fee schedule is set at rates which adequately reimburses facilities so as to protect orthopaedic surgeons' ability to schedule Workers' Compensation patients at these facilities.

Inpatient Hospital Fee Schedule

The same CHSWC report on Outpatient Surgical Facilities also addresses the Inpatient Hospital Fee Schedule that was adopted by DWC in April, 1999. Because the fee schedule was set so low for some procedures-not even covering the instrumentation costs-orthopaedic surgeons have been prohibited by their hospital from taking certain procedures to their hospital. This has created an access problem not only for the surgeons, but also the injured worker whose surgery is delayed. DWC implemented some emergency regs which exempt instrumentation costs from the spine DRGs and this has again opened up access for these patients.

DWC continues, however, to discuss the appropriate reimbursement levels for inpatient stays. The CHSWC study also recommends that the hospital inpatient fee schedule be set at 120% of the Medicare reimbursement levels. Hospitals remain opposed to this proposal.

Again while not directly involved in these discussions, COA is seeking to have the inpatient fee schedule set at levels which will maintain access for injured workers and orthopaedic surgeons.

Scope of Practice Issues

Podiatric Expansion

The California Podiatric Medical Association introduced AB 2728 (Washington) which was a bill which would have:

1. expanded the podiatric scope of practice to the entire lower extremity including dermatological procedures;
2. allowed podiatrists to perform amputations including the entire foot;
3. allowed podiatrists to advertise themselves as “physicians and surgeons”;
4. allowed podiatrists to be the “assistant surgeon” in any type of surgeries; and
5. eliminated the requirement that a podiatric resident complete their postgraduate and podiatric surgical training in an acute care hospital.

COA was adamantly opposed to this expanded scope of practice and defeated the bill. We were joined in our opposition by the California Society of Dermatology and Dermatologic Surgery, California Society of Anesthesiologists, and the California Medical Association.

Acupuncturists – Disability Evaluations

SB 1705 (Burton) was a bill that would have allowed acupuncturists to perform disability evaluations. This concept had also been proposed in 1999. At that time, COA opposed the bill, but developed amendments to remove our opposition. The amendments would have limited an acupuncturist’s ability to perform disability evaluations only within their scope of practice. The amendments were rejected in 1999 and again this year. Due to opposition from COA and the CMA, the bill was defeated this year.

Certification for Treating Physicians

AB 1808 (Richman) would have required all physicians treating injured workers to be certified by the Industrial Medical Council as a Qualified Workers’ Compensation Physician. COA opposed this bill. The bill has failed passage.

ER On-Call Services

COA has been actively involved in the emergency room on-call issue. Our members are adamantly opposed to any statewide mandate that orthopaedic surgeons take call and believe that the local communities should work out appropriate on-call arrangements with their hospitals for their area.

In these discussions, COA’s primary role has been to help our members obtain information that can be helpful to them in their negotiations with their hospitals. While indeed some hospitals are losing money, many are not. The entire tone of the negotiations change once the physicians realize that their hospital is

profitable. Hospital financial information is public information and COA has been instrumental in getting that information out to our members. In communities where hospitals have been unwilling to work out acceptable on-call arrangements with the specialists, some hospitals are keeping open their ER department without specialty coverage or they are arbitrarily assigning specialists to their on-call schedule. COA is investigating remedies that are available to orthopaedic surgeons should their hospitals be taking these actions. COA has also developed a list of attorneys knowledgeable in hospital by-law issues to assist them in their negotiations.

The Centers for Medicare and Medicaid Services has clarified that specialists could be on-call at several hospitals at the same time and require hospitals to have in place a mechanism to handle situations where the on-call specialist may not be available. This will help ease the on-call problem, but COA continues to oppose any legislative mandate to require physicians to serve on call panels.

Physician Continuing Medical Education Requirements

AB 487 (Aroner) Required Physician CME

This bill requires physicians to obtain 12 hours of CME in pain management and end of life issues within the next 4 years. Radiologists and pathologists are exempted from this requirement. It also requires the Medical Board of California to develop standards for the investigation of complaints of overmedication or undermedication of a patient's pain.

In its original form, the bill declared it unprofessional conduct for a physician to undermedicate or overmedicate a patient's pain. At the request of the California Medical Association, the bill was amended deleting this language. The amendments to the bill, however, then required all physicians to obtain 20 hours of CME in pain management and end of life issues. This version of the bill was supported by CMA in spite of opposition from physicians, primarily by neurological surgeons and neurologists.

COA joined them in opposing this bill as we objected to the Legislature, for the first time, mandating physician CME requirements. This year it is pain management, next year it may be HIV infection, and the following year another issue. Eventually physicians will have little discretion over their CME courses.

Ultimately the following professional medical organizations opposed AB 487: California Association of Neurological Surgeons, Association of California Neurologists, California Society of Plastic Surgeons, California Academy of Ophthalmology, American Academy of Pain Management, California Urological Association, and the COA. In spite of the opposition, CMA remained in support of the bill.

Due to this opposition, the CME requirement was reduced to 12 hours within the next 4 years – a one-time requirement. In this form, the bill passed and was signed into law. COA will be incorporating pain management sessions into its Annual Meeting to satisfy this CME requirement.

Radiologic Certification

The Radiologic Health Branch of the Department of Health Services has implemented regulations which require radiologic technologists, x-ray technicians, and physicians who hold a radiologic or fluoroscopic certification to obtain continuing education credits in subjects related to the application of x-ray to the human body that are accepted by their professional licensure entity. Radiologic technologists and x-ray technicians are required to obtain 24 hours of CEU every two years and physicians are required to obtain 10 hours every two years prior to their recertification. Level I CME hours that are accepted by the Medical Board of California can fulfill this requirement if the continuing medical education included instruction related to x-rays and diagnostic testing. COA will be incorporating radiologic CME hours at our Annual Meeting to satisfy this CME requirement.

Disaster Management

AB 1921 (Richman) would have required physicians to obtain continuing medical education credits in disaster management. COA opposed this new CME requirement and the bill has failed passage.

Disclosure of Malpractice Settlements

SB 1950 (Figueroa), as introduced, would have required the Medical Board of California to disclose to the public all malpractice settlements. The Medical Board was in support of this bill. COA and other health care professionals opposed the bill as often physicians will settle nuisance lawsuits rather than fight them.

Those settlements are not reflective of whether there was any malpractice on the part of the physician and would be misleading to the public should they be disclosed. This disclosure would also discourage physicians from settling these cases, which will drive up litigation costs and ultimately malpractice premiums. We felt that the Medical Board should review the settlements and only release to the public, settlements that involved medical malpractice.

Due to heavy opposition from the Doctor-owned insurance carriers and the California Medical Association, the bill has been amended several times. In its current version, the bill would only allow the board to publish settlements on its Web site if a physician in a “low-risk” specialty, such as family practice and has three or more settlements of more than \$30,000 in a 10-year period. Doctors in a “high-risk” specialty, such as orthopaedic surgery, would need four or more settlements in a 10-year period to trigger disclosure. As amended, CMA removed its opposition. The bill is pending before the Governor.

Disclosure of Medical Groups’ Financial Information

SB 260—Medical Groups’ Financial Information

The Office of Managed Care had recently sought to release financial information on medical groups involved in contracting with managed care plans. CMA objected to the release of this information as they felt it would put the medical groups at a disadvantage when negotiating contracts with the managed care plans and successfully sued to prevent the disclosure of the data.

Health plans are now requesting a copy of the SB 260 filings directly from the medical groups. CMA Legal Counsel advises that medical groups are under no obligation to release this confidential financial information to the health plans.

To get around this discussion of financial solvency of these groups, COA worked with other medical specialty organizations and sponsored a resolution at CMA’s 2002 House of Delegates to require health plans, medical groups/IPAs, and other third party payers to obtain insurance to protect patients’ access and physicians’ reimbursement for services should these entities file bankruptcy. The resolution was supported in concept, but was amended to just re-enforce that physicians should be paid for their services. Governor Gray Davis has indicated that he would support requiring physicians to care for these patients for as long as a year under the continuity of care provisions without reference as to whether the physician would be paid for their services and at what rate. This would be financially impossible for physicians and would certainly limit patient’s access to medically necessary services.

Medi-Cal Reimbursement

Reimbursement rates for Medi-Cal services have been slated to receive significant reductions in the 2002-2003 State Budget. The Governor has proposed that fees be rolled back to 2000 levels, taking back the gains made in the 2000-2001 Budget. CMA has opposed these reductions and has introduced AB 3006 to repeal the reductions. COA is in support of AB 3006.

The Budget passed by the Legislature and ultimately signed by the Governor continues to call for these reductions estimated to be \$15 million. The CCS program was exempted from the reductions. The Department of Health Services has discretion as to how to achieve these reductions. It is expected that the Department will convene meetings with providers to discuss their options. The Governor also indicated a willingness to restore these monies in his revised 2002-2003 Budget which will be released in January, 2003.

DHS California Children Services (CCS) Program

Maridee Gregory, M.D., Chief of the Department of Health Services Children's Medical Services Branch has contacted COA enlisting our help in encouraging orthopaedic surgeons to participate in the CCS program. Dr. Gregory indicates that few orthopaedic surgeons are currently participating in the program statewide and that there is a real crisis in the Riverside and Los Angeles County areas. COA representatives met with Dr. Gregory and we have developed a list of problems with the CCS program from our viewpoint. Dr. Gregory has appointed an orthopaedic work group to discuss these issues and recommend changes. The goal of the group is to streamline the program and remove physician hassles so that more orthopaedic surgeons are willing to participate. One significant change being considered is establishing a global authorization for common orthopaedic conditions so that the orthopaedist would not have to seek authorization for each needed service.

Osteoporosis Testing

AB 2692 would have required health plans to cover osteoporosis testing for conditions specified in the bill. While COA supported coverage for osteoporosis tests, we were unsure whether the legislation should specifically list conditions for which coverage would be allowed. Others expressed similar concerns. The bill was not heard this year.

California Task Force on Youth and Workplace Wellness

Senator Tom Torlakson has been instrumental in forming a Task Force on Youth and Workplace Wellness. Originally the Task Force was focused on obesity issues. We have asked that the focus be expanded to include injury prevention of musculoskeletal injuries in the workplace and schools. Senator Torlakson has agreed that these are also important issues which should be addressed by the Task Force. He has introduced SCR 99 to expand the composition of the Task Force to include additional health care providers. COA will be nominating Dr. Clarence Shields to this Task Force.

Federal Legislation – HR 4600/S 2793

COA has joined the AAOS in supporting federal legislation – HR 4600 and S 2793 which would enact federal tort reform modeled after California's MICRA on a national level. Efforts to enact MICRA on the federal level have been supported by the House of Representatives in the past and generally opposed by the Senate. This year, however, President Bush has also publicly supported efforts to enact federal tort reform so efforts have again been renewed. This is particularly important legislation as many states are facing skyrocketing increases in medical malpractice premiums.