STATE OF TENNESSEE

Chair: David H. Lillard, Jr.
State Treasurer
david.lillard@tn.gov

Members:
J. Anthony Farmer
Jack A. Gatlin
Jerry Lee
Bob Pitts
Dan Pohlgeers
Gary Selvy
Paula Claytore
David Davenport
Bruce D. Fox
Keith B. Graves
Abbie Hudgens
Lynn Vo Lawyer
Kenny McBride
Jerry Mayo
Sam Murrel, M.D.
Gregory Ramos

Advisory Council on Workers' Compensation

TREASURY DEPARTMENT
ANDREW JACKSON BLDG., 9TH FLOOR
502 DEADERICK STREET
NASHVILLE, TENNESSEE 37243-0248
Telephone: (615) 741-4358 Facsimile: (615) 401-6816

Ex Officio Members:
Commissioner Julie Mix-McPeak
Commissioner Karla Davis
Senator Jack Johnson
Representative Jimmy Eldridge

Lynn Ivanick, Administrator

September 28, 2011

The Honorable Karla Davis, Commissioner
Department of Labor & Workforce Development
State of Tennessee
220 French Landing Dr.
Nashville, TN 37228

Re: Comments on the Proposed Amendments to the Rules regarding the Medical Fee Schedule

Dear Commissioner Davis:

At the August 22, 2011 meeting of the Advisory Council on Workers' Compensation (ACWC), Landon Lackey presented information on the Department of Labor and Workforce Development's (TDLWFD) emergency rules and proposed permanent rule changes to the Medical Fee Schedule. Copies of all proposed amendments were distributed to the Council. In addition, Dr. David McCord and Mr. Nathan Green spoke to the Council to express concerns regarding the proposed rules changes.

On September 20, 2011, the Advisory Council met to consider the proposed amendments as required by *Tennessee Code Annotated* § 50-6-121(f)(1). Attorney Lackey answered questions from Council members regarding the proposed amendments to the rules. The Advisory Council members also heard public comments from Ms. Becky Farmer and Dr. Merrill White. Council members David Davenport and Dr. Keith Graves provided formal positions from their respective fields of practice.

After discussion, the Advisory Council as a whole did not take a position on the proposed rules pursuant to a vote of the Council. However, the Council requested that I provide to you the comments expressed by individual members of the Council for your consideration in connection with the public hearing by your Department today. As such, I have attached a transcript of the comments for your review and consideration, as well as other information presented at the meeting.

This letter fulfills the statutory responsibility of the Workers' Compensation Advisory Council concerning the Rules proposals. If you have any questions concerning this or if you require any additional information, please do not hesitate to contact me.

Sincerely yours,

David H. Lillard, Jr.
State Treasurer
Chair, Advisory Council on Workers' Compensation

Attachments:
Transcript of Comments from Meetings
Patient examples from Becky Farmer Practice Manager
Position Letter from The Neuro-Spine Committee
Position Letter from Tennessee Physical Therapy Association
Portion of Report of Workers' Compensation Medical Fee Schedules
New Findings & Implication for California, submitted by Dr. Keith B. Graves
Position Letter from Medtronic Inc.

The Advisory Council comments regarding the DLWFD proposed rules amendments in chronological order of their presentation:

PUBLIC COMMENT FROM AUGUST 22, 2011 MEETING

J. Nathan Green with RobinsonGreen representing orthopedic doctors and physicians spoke:

You've heard the technical explanation and I'd like to add the human factor. We have a physician here on the front row. This medical fee schedule change will have a significant impact on physicians who participate in WC, as Landon said, and we are going to communicate with every department head and every agency that will be considering this matter to let them know of our concerns. WC is an important program and a lot of our physicians gladly and honorably participate in such a program, but ultimately we're going to continue to discount and push back the important role that physicians across the state play in WC by cutting fees and creating additional administrative nightmares to the point that the standard of care in this state is going to be impacted. And it might not be tomorrow and it might not be next week, but ultimately it will be.

I will pledge to you and urge you, let's look at this not just from these spreadsheets and the numbers on that and how it all translates to those injured workers' who we're trying to get back in the workplace and to that physician who is primarily responsible in making sure that worker gets back to work and is a productive citizen. Let's not forget about the physician. I urge you not to do that and I urge the Department to do that and as we go along in the next month we're going to continue shouting that as much as we possibly can. We consider this to be a significant set-back for physicians across the state and we look forward to working with anybody to see if there's a way we can ease this blow, but this will have greater impact than we might be able to see or translate onto a spreadsheet at this particular time and I urge you to keep that in consideration and we'll see you next month.

Dr. David McCord, an orthopedic surgeon who practices Orthopedics in Nashville, Tennessee at the Tennessee Spine Center spoke:

Thank you very much. This is sort of new for me and there's a lot of information and apparently a pretty complicated deal and I think we are all here to try to take care of injured workers. That's what this is all about and it sounds like there are some financial issues that have to be dealt with and I understand that too. I have to say there is just an awful lot of stuff on these graphs that I scratch my head with – what I'm taking away from today is that it is a cyclical business, there's probably a little bit of self-inflicted issues with it, but, at the same time, at the end, we do have to grapple with how to cover these workers and keep the access to care. Now, I'm a surgeon, that's what I've done for the last 20 years. I'm generally speaking, pretty a-political. My job has always been just to take care of people and that's it and leave everything else to you folks, but the world is changing, and that's why I came down. I can tell you this, as a surgeon, I see people and they need a procedure and they fall into two categories. One of those categories is emergent and when it's emergent that means we have to go right now. You pull the trigger and the circumstances and the solution are rarely as good as they can be if you take a little bit more time, do a little bit more planning, get the best team going, get everybody together and talk. That's how you really solve this sort of thing, so my whole gist in this is that I'm scratching my head after what I've heard on these slides as to this emergency part of it. I don't get it. September 28th and then we'll have a meeting the next day, and that's it? I would just suggest to

you that its' important to all of us. We want to get it right and I think you'll find the physicians, myself included, I'll listen and be part of the solution too. Thank you very much.

PUBLIC COMMENT FROM SEPTMEBER 20, 2011 MEETING:

Ms. Becky Farmer, Practice manager of the Center for Sports Medicine & Orthopaedics in Chattanooga, TN.

We have 18 Orthopedists with over 200 employees and significant workers' compensation business. Our customers include Coca-Cola, Covenant Transport, Unum, Blue Cross Blue Shield of TN, Mickey Bakery and Lazy Boy. We also have a walk in clinic where injured workers can come in and be seen at the time of their injury and be seen the same day. We realize something needs to be done and we want to do our part. However, it's not just about the fee schedule, but also about the labor costs and the resources it takes to see a workers' comp patient. Small sample size with examples of what it takes for them to get through the system. From a stack of charts on just one desk where no approval had yet occurred or where care had been denied to see the difference between the time delay and cost of following medical treatment recommended by the physician. (attachment) The hoops that we have to go through, the number of denials, layers of cost. There are multiple phone calls for WC patients versus a 2 minute online process for commercial carrier patients. Consider allowing a collaborative approach to not only looking at the fee schedule, but looking at how the patients are managed. How the care is or is not provided and look at a comprehensive approach to what needs to happen in the State of Tennessee.

In response to query from Council member Dr. Samuel Murrell, Ms. Farmer indicated that she could eliminate one scheduler and 4-5 clinic staff and it would free up a significant amount of the physician's time if their office didn't have to deal with all the WC paperwork, hoops, calls, denials, issues.

Dr. Merrill White, President of the Tennessee Orthopedic Society and member of the Neuro-Spine Committee 200+ orthopedic and neurosurgical spine surgeons in the State of Tennessee.

As President of the Tennessee orthopedic clinics of Knoxville Tennessee, represents 22 orthopedic surgeons in and around the Knoxville area. President elect of the Tennessee orthopedic Society 600 + orthopedic surgeons across the state of TN.

There is no general consensus among all those people about what should be done, but, having said that, WC system is generally viewed as inefficient and cumbersome. With extraordinary effort when compared to commercial insurances, it can be made to work. Most of us continue to tolerate it and the current reimbursement is barely adequate. Proposed reduction of 11% to those surgeons caring for WC patients. Speaking for the 22 orthopedic surgeons in my group in Knoxville, I can tell you with certainty that if that goes through 100% will drop out of the WC system. Speaking for Orthopedic surgeons across the state, my thought is that between 50-75% will drop out if those reductions go through as they are currently written. The lack of care that would result will result in long delays in access to care. It will result in prolonged return to work. It will result in higher PPI ratings and greater limitations to those people that ultimately return to work. It will also result in increased costs to the employers of the State of Tennessee and it will make TN a less viable environment for employers that wish to come into the state. Frankly, across that population, people have been accepting of a reduction in terms of

5%, but even at that number there's going to be a drop out of physicians from the WC System and whether the WC system remains viable from that point remains an open question.

Secondly, the administration burden placed on physicians and their offices in the current system are excessive and a significant source of dissatisfaction for the physician, their patients, and certainly the office staff. The burden takes many forms and is not limited to excessive demands for peer reviews at all steps along the way of patient care, to include recommendations for PT, imaging and certainly for surgical treatment. The comments I have encountered are voiced like this "if you don't trust me to take care of your patients, then don't send them to me. I'd rather not see them than be beat up at every step along the way as I'm trying to take care of them." Everyone doesn't feel that way, but I've heard that on more than one occasion. It's also important to recognize that when I see a WC patient at my office, it's not just the patient that I am concerned with – it's at least 3 entities that are involved in that conversation. There is the patient, the employer and the insurance company. The insurance company may be represented in that office by a nurse case manager, it is more commonly represented by an adjuster who is offsite and not readily available. In fact there may be a fourth participant in that conversation, the attorney that's involved. So, the amount of time caring for the WC patient is probably double that of a patient with private insurance.

Another burden in caring for WC patients is the delay in approving care. It is not uncommon that we see patients back in our office and we've made recommendations for care or therapy or imaging and the plan is to move forward based on the results of that recommendation. When they return to the office, that recommendation has not been carried out, so you start back and it's a further delay in care.

In short, I think the physicians in TN are willing to do their part. We would like to see a collaborative effort between physicians and WC administrators to streamline the current system and make it less costly to administrate as well as improving the patient, physician, employer satisfaction with the system. We do not feel that physicians should bear the burden of reconciling the state budget by themselves. We do feel like in this conversation, other interested parties include hospitals insurance companies and others would be involved in this conversation. If there is a burden to be borne, it should be shared by all rather than borne by the physicians. The solution cannot be to steal our services through unilateral action.

COMMENTS OF ADVISORY COUNCIL MEMBERS FROM SEPTEMBER 20, 2011

Mr. Bob Pitts, Advisory Council Member:

I want to get it on the record as to what the difference between the emergency rule and the permanent rule – and that nothing affects physicians. The permanent rule does include some things that are not in the emergency rule – what are they?

Mr. Landon Lackey, DLWFD Attorney:

The Permanent rule includes the emergency rule as it is. Plus we are updating the drug free workplace panel to match that used by the DOT. Allow chiropractors to bill office visit along with a manipulation so as not to delay care on initial visit. Repackage drugs – NDC # - no average wholesale price, so it becomes a price that is made up – help from pharmacy people. Ambulance 150% of Medicare reimbursement. Can't regulate the air ambulance as it is

preempted by federal law. Clarifying billing procedures – not affecting anybody's fees, putting some of fee schedule which has proven tricky, into the actual language.

Mr. Pitts: What about the sections dealing with institutional care.

Mr. Lackey: There are no substantive changes to hospital fee schedules. There is a clarification as to when an in-patient visit begins from an out-patient, because of different billing.

Mr. David Davenport, Tennessee Physical Therapy Associates and member of the Advisory Council introduced a letter (attached) regarding the impact of the proposed rule changes on physical therapy providers.

Of primary concern is the combined effect of the fee schedule which has some incorrect methodology with the application of the multiple procedure price reduction in the way that's applied to physical therapy, where the practice expense component of the RVU has already been discounted, but then with the NPPR, it's proposed to be discounted further. Another comment made on the DLWFD website is that TN has a maximum allowable fee. That is what is being used to determine the effects on the insurance company, but what is actually being reimbursed is much less than that (20-50% lower than that maximum allowable fee) – so the numbers being used aren't accurate. 25 states medical price tracking – TN providers have a lower price today for medical treatment than it was in 2002. During that time, the frequency was increased in 2009, and also some severity increase which would account for the overall increase in medical cost while not representing an unfair overpayment of medical providers. So we as providers are overall, being paid less for our services than we were in 2002.

That report also went on to compare TN to the median study states within that group and found, on average, that fee schedule states within that group experienced a (2002-2010) increase of 10% whereas TN actually decreased. Those of us in the health care industry are suffering the same budget constraints and economic times as the rest of the employers and as we look at further decreases as we are being asked to increase the volume of care we are providing, it produces a difficulty we have with continuing with the administrative burden of providing that care at an ever declining price.

To end with an analogy, we took a contract with a manufacturer in the area just under 2 years ago. We came in with a bid that was higher than the provider that we displaced by about 20%. In that 2 year period while we were providing a higher quality of care, we saw their WC costs decrease from about $4.5 Million per fiscal year to about $2.5 million. We also saw their amount of loss time decrease and their number of light duty days decrease by about 50%. Now that's not entirely attributed to what we were doing in the PT clinics, but there will come a point in the declining prices that quality providers that can show that kind of cost reduction will opt out and will go to other business that we can continue to provide with the 2 minute administrative burden vs. the 20 minute.

Mr. Lackey: Specifically, about that WCRI study: It does show that TN is lower than 2002, but we're getting close to that 2002 level. Our fee schedule didn't become effective until 2005, so just the fact that we're getting close to those 2002 levels is troubling to us. Another thing is that study uses data up to June 2010 and we saw a big spike when Medicare dropped their conversion factor at the beginning of this year and ours was still frozen at the 08 levels. So I would suspect

that if we saw a report about this time next year that took into account 2011 prices, you'd see a little bit fuller picture of where we are right now.

Mr. Davenport: Sharp decline when 2004 reform was put into place. One of medical providers' biggest problems is not knowing what we're dealing with because we're not dealing with a state fee schedule. We're dealing with a fee schedule and multiple bill review and multiple PPO's that change. We can file with Liberty Mutual today and have one bill review and we can file with Liberty Mutual a month from now and have a totally different fee schedule and bill review. It makes it difficult for us to know how to plan our business and how to go about positioning ourselves to provide that care and going into new markets. Letter submitted made part of the record.

Mr. Pitts: My sense is that it's probably going to be unproductive for this group to take a vote on this issue. My sense is that there may be some desire to make some comments and those comments get forwarded to the commissioner for whatever they deem appropriate in their consideration of the final rule. For all the parties in the room, when I make the comment that no one wants to be here with this issue today, you've got to put it in context, we're pitted brother against brother here, what I mean is that Doctors are here, they had a fee increase and they feel it is being taken away from them. There's another piece of that argument that says yes there was an increase, but it was never costed by NCCI and NCCI wasn't made aware of it and all of a sudden it dawns on somebody, here's a significant impact, so everyone needs to take that into consideration. Some of you will not agree with me and this is speaking only for me. One of my concerns about the fact that that "happened" and it has created a crisis across the state is that the fact still remains that in the high end specialties, our WC reimbursement system is reimbursing you among the highest in this region and I think you ought to bear that in mind as you think through what your reaction to this is. I guess what I'm saying is this group sitting here does not want to vote on an issue that was discovered and has now proceeded between the implementation of an emergency rule and what, in fact, would be a permanent rule. I think all of us need to know the context in which it got here.

Perhaps among the comments I would like to pass on to the commissioner, I've heard a lot of conversation about how we need to reevaluate the reimbursement system in this state regarding to medical providers. I would encourage that the first place that start is within the department and I would encourage them to look at our surrounding and southeastern states and see how we stack up with the understanding that in most instances that is going to be some derivative of a Medicare cost driven system because that is was most of them do.

The second suggestion I would make is since there seems to be a great deal of frustration regarding additional paperwork and administrative burden in connection with WC. As a part of that search of the other states, one of the things I think it would be helpful to find out, has anybody got a magic wand? Has anybody got an approach that is less burdensome and less intrusive than what we're doing in TN.? If it is, we ought to think about it, we ought to consider it. And finally, with respect to the former, while they're doing the search, it would be interesting to know how many of our sister states have any kind of Medicare floor or any protection built into their reimbursement system that impacts in the event that at the federal level various actions are taken, that is further reductions in Medicare reimbursement. I think that's essential information to be collected, would encourage the department to do it, because I feel very

confident that that isn't the last of this conversation and that is going to be important information to have in future discussions.

Finally, on the permanent Rule, I have heard some rumors, I don't think the department concurs, have asked for some validation and that has not occurred yet, that there might be a circumstance under this proposed rule that could also have significant cost impact on the medical system in the state (non-physician). So my encouragement to the Commissioner, my final point would be, that they be real sure that we have NCCI cost this final rule to be sure that we're not missing anything, because if we ever get through this crisis that's before us, I would hate to, in 4-5 months find out that we have another one. So, Mr. Chairman, those are my comments that I would like to pass on to the Commissioner.

Chairman David Lillard: O.k., Mr. Pitts' comments will be made part of the record.

Ms. Abbie Hudgens, Administrator of Dept. of Labor and Workforce Development and Commissioner Davis' designee as an Advisory Council Member:

We appreciate the comments we've heard today, they have been very instructive. We have begun to look at some of the issues that Mr. Pitts suggested and we intend to continue that, so we are not turning a deaf ear to this, we are trying to look into this as soon as possible.

Mr. Daniel Pohlgeers Advisory Council Member:

I agree with Mr. Pitts and am pretty confident that we wouldn't have a 4-0 vote. With respect to the rest of the committee, we are all extremely passionate about making sure that our system is as efficient as possible. I think we are all equally as passionate about making sure that rules changes and legislative issues don't negatively impact any part of that system and making sure that the system continues to run as efficiently as possible. One of my concerns and I pass this concern also to the Department of Labor, is that it appears to me that, in discussions that I've had with other voting members that it may have been haste that got us into this position and it almost appears to me that haste is trying to get us out of this position in the form of an emergency rule.

I'm not sure that 90 days is all that long of a time to make sure that we get it right. And I think that there've been some very serious questions, or should be some very serious questions raised about the questions and comments of today. While I agree that it's very unfortunate that NCCI didn't have appropriate communication between the Department of Labor for the last 3 years on the fee schedule, I will point out to everybody in the audience and the members, that the fee schedule is published and I can assure you that their insurance members knew what the fee schedule was because they're the ones that have to pay it. I think just that, in and of itself, we need to step back and decide are we going to make decisions based on the haste of a previous decision and why not make this a non-emergency rule change so that we can look at all the issues that have been brought up today and in our last meeting concerning the NCCI report and the other actuary reports, so that we're sure that what we're getting is accurate information so that we can continue to have an efficiently run, or as efficiently as possible run system.

Dr. Keith Graves, Chiropractor and Advisory Council Member:

I want to elaborate on a comment that I made at the last meeting that may have been taken out of the spirit in which it was intended and one of the doctors that spoke earlier spoke up on this and one of the things that you have to think about the train coming down the track is

participation, and so I went out and pulled some research articles and if you'll just indulge me for a few paragraphs, I'd like to read to you what a couple of these studies showed.

Ultimately the major research points to several different conclusions. First and foremost, low-multiple, unmodified RBRVS fee scales do not maintain specialist participation. Every state that has adopted a low-multiple RBRVS workers' Compensation fee schedule has experienced a subsequent rapid and dramatic drop in neurologist and orthopaedist participation levels. In each of the study states, specialist participation levers were reduced by half of more within two years of the adoption of the low-multiple RBRVS fee schedule. Specialist participation levels continued to decline in Hawaii and West Virginia more than a decade after the low-multiple fee schedules were first adopted.

This trend away from unmodified RBRVS fee schedules may be driven by evidence which suggests that once specialists choose to leave the workers' compensation system they are slow to return even when reimbursement rates increase. States that have been down this path and ultimately decided to increase fees in an attempt to lure specialists back to workers' compensation demonstrate that it is far easier to maintain physician participation than to rebuild it.

And one of the comments that this study went on to say is that it is worth noting that of the three most recent major workers' compensation fee schedule changes (in Hawaii, Tennessee and Illinois), each of the states elected to adopt fee schedules with higher values for specialty providers in order to maintain and restore provider access. I've got stacks of them, but I won't take any more time. I appreciate you letting me read that.

Dr. Samuel Murrell, Orthopedic surgeon and Advisory Council Member:

I think it's pretty clear that on both sides people are a bit concerned about this rule change. I think in many ways, one of the root problems is our reliance on the Medicare fee schedule. I realize that many people think that's a simple easy fix when coming up with a fee schedule and I think in 2004, it may have been appropriate because, in a sense, our backs were up against a wall; we needed to find something because we were moving forward. We've seen this create a lot of issues. The amount of work that's required on a Medicare patient is not the same as the amount of work that's required on a workers' compensation or injured worker. The expectations of the system is not the same, the payors are not the same. The way it's funded is different. So this persistence on trying to use a fee schedule, whose goals are not parallel to our own in the workers' compensation system, may not make sense and I think we've heard the term collaborative effort thrown out. I think that would be a good starting point. I think we certainly have time to sit down and do this. I think there are people that have been trying to work things out and I would encourage the department to continue those efforts, to sit down and work with those people and find some sort of common ground that works for all parties involved and in the end, ensures that we have a workers' compensation system that works.

I have the honor of treating patients from Mississippi and Arkansas since I am from Memphis. They do have different fee schedules. Their system is drastically different. Some things about their system work, some things work horribly and I think if we were to unleash their fee schedule on our system we would find that we have a disastrous problem. And so while I know people like to look at the other adjoining states and say, "well gee they're paying this much for this", I think it's kind of putting on blinders and sending us down a path that may find that we have a system that works for no one.

I certainly have the concerns about health care providers leaving the system. I think we overestimate that paying providers a premium of Medicare will keep them in the system. I think we fail to realize that Medicare represents a much larger percentage of practioners' practice than work comp ever will or could and that if work comp went by the wayside because of the administrative, for lack of a better term, hassles and nuisance, then I think we would find that those providers would quickly fill their schedules with commercial patients and that we can't ignore the comments from Dr. White that says frankly that his group would be willing to walk away from it and that we would find ourselves without a panel. And unlike Medicare, where patients can just walk into an emergency room and obtain treatment, and Medicare will pay a Medicare fee schedule, or someone out of network, if they're not Medicare and that patient's responsible, what are we going to do for injured workers? Because they can't just walk into an ER and then expect that, although they'll get care, that issue of payment won't be resolved.

Patient example #1

Injury Date: 07/21/2010

1st Appt. w/CSMO: 08/03/2010
Date of Surgery/Procedure: 01/24/2011
Patient off work: 0

09/28/2010 Request, office notes faxed to Kiema Lewis, adjuster.

11/08/2010 Kiema Lewis/Adjuster left message they received request for approval of surgery. Stated Denise Johnson would be the NCM calling with approval or denial

12/21/2010 Patient seen in office. Physician would like to schedule surgery. Call to Dept. of Labor - Sandra Williams said they have not recv'd any records after 10/26/10 visit. All notes after that date were faxed. She said once Dr. Kirkpatrick receives them he has 25 days to make decision but with holidays it will take longer.

12/28/2010 Disc Arthroplasty denied twice. Faxed oupatient visit note with auth Request to adjuster and left message on vm. Adjuster is out all week

01/05/2011 Spoke with Kiema Lewis to check status of approval for ACDF. She stated adjuster is now Jabrina Lemay - she said request has to go to precert and will forward all info including mri and I should have response in 48hrs.

1/7/2011 Call received from Nancy Johnson w/Intracorp wanting to clarify requested surgery. Explained to her that the Arthroplasty was denied/we are wanting to proceed with approval for ACDF. She stated she is the one working on utilization review. She will forward to Physician for review. We should have response by 1/11/11.

01/12/11 Spoke with Nancy Johnson - she states that case went to physician review - due back on 1/13/11 after 2pm. Rec'd call from TN Dept of Labor requesting 12/21/10 office notes to be faxed.

01/14/11 Rec'd written auth. Per fax from Nancy Johnson. Left message with adjuster (Jabrina Lemay) with date of surgery.

Patient example #2

Injury Date: 01/13/1999

1st Appt. w/CSMO:
Date of Surgery/Procedure: Denied
Patient off work: Disabled since 2000

12/08/2009 Surgery added on for 12/9/09. Left 2 messages for adjuster for approval. Per Joan Hendrickson she will not authorize surgery for 12/9. She forwarded to Coventry for precert

12/09/2009 Rec'd call from Coventry precert requesing med. Records. Faxed.

12/15/09 Rec'd call from Coventry precert - sending for peer review.

12/31/09 Rec'd denial from Coventry workers comp on 12/18

01/06/10 Informed patient workers comp denied surgery. Patient has retained an attny

03/29/10 Faxed orders and office notes to workers comp adjuster requesting approval for ct myelo l-spine, emg/ncs and psy consult

02/16/10 Coventry wants to know if SDH has recommended any further treatment. He continues to recommend surgery. Asked me to fax surgery request to them.

03/05/10 Rec'd call from Coventry Workers Comp that surgery denied. Several things not addressed for patient: PT, normal exam findings; ct/myelogram results; weight; smoking, anxiety depression and need for psych screening. All issues were addressed and SDH states all were addressed and we will not pursue or appeal.

04/02/10 Letter from TN Dept of Labor - Dr. Kirkpatrick agrees with the UR done by Coventry workers comp service on 12/18/09.

05/07/10 Faxed orders and current ofc notes to adjuster

05/12/10 Spoke to adjuster - stated she would have to review everthing and call me back

05/12/10 Spoke to Joan Hendrickson - she stated they would not pay for any more tests or surgery. She sent to UR review and they denied and state denied it too.

05/28/10 Request - 5/20/10 office notes and demographics - faxed to Joan Hendrickson.

04/20/2011 Faxed req for workers comp approval to adjuster for surgery

Patient example #3

Injury Date: 06/17/2010
1st Appt. w/CSMO: 11/15/2010
Date of Surgery/Procedure: 07/21/2011
Patient off work: 0

3/16/11 faxed a request to workers comp for surgery approval
4/19/11 left message for adjuster re: approval
5/3/11 faxed request for workers comp approval to adjuster for surgery

6/16/11 received voicemail from Gallagher Bassett that surgery not authorized. Case is on hold.
6/29/11 Received fax from patient - workers comp benefits stopped on 6/21/11. Have received formal denial. Can proceed with surgery under private insurance.

Patient example #4

Injury Date: 05/10/1999

1st Appt. w/CSMO: 01/09/2003
Date of Surgery/Procedure: 08/08/2011 (Patient has had multiple surgeries)
Patient off work: 0

1/25/10 Faxed requested 1/14/10 office note & demographics to Tim Holt

5/27/10 Rec'd voicemail from Amtrust on 5/24. Called back left voicemail.
6/23/10 Rec'd voicemail from Amtrust today. Called back left voicemail

7/12/10 Approved per workers comp. Called in to OCM.
7/13/10 Rec'd appt. notification from Ocm. Patient scheduled at COC on 7/13/10

Patient example #5

Injury Date: 11/03/2010

1st Appt. w/CSMO: 11/03/2010
Date of Surgery/Procedure: 08/31/2011
Patient off work: 0

8/8/11 Voicemail from Genex - no response from case manager. Needs to know if emg/ncs was repeated after 3/11, needs prior clinical notes faxed.
8/12 Received denial from Genex but adjuster overrode and approved surgery
8/15 no answer at patients numbers. Informed Robin Howell, NCM of status. Scheduled surgery through her -she will notify patient.

Patient example #6

Injury Date: 11/10/2009

1st Appt. w/CSMO: 03/21/2011
Date of Surgery/Procedure: PM approved 8/22/11
Patient off work: 0

4/22/11 Faxed request for workers comp approval to adjuster for PM to Dr. Musick

5/2/11 left voicemail

8/19/11 left voicemail for status of request

8/22/11 Received voicemail from workers comp stating they were approving PM referral but wants to know if JEJ will still be treating patient

Patient example #7

Injury Date: 07/06/2009

1st Appt. w/CSMO: 02/03/2010
Date of Surgery/Procedure: pending
Patient off work: 0
Left Knee Scope and Right Total Knee
5/5/11 Faxed request for authorization for surgery to Gallagher Bassett - Bill Goldring.
5/5/11 Left message with Bill re: status of approval
6/2 Left message with Bill re: status of approval
7/14 Left message with Bill re: status of approval

	Patient #1	Patient #2	Patient #3	Patient #4
1st Appt. with CSMO	09/06/2011	09/08/2011	09/02/2011	08/11/2011
2nd Appt. with CSMO	09/13/2011	09/20/2011		
Date of MRI:	09/10/2011	09/13/2011	09/08/2011	08/20/2011
Diagnosis Code:	727.65	719.46 & 719.06	719.41 & 726.19	836.1
Online Pre-Cert:	09/10/2011	09/13/2011	09/03/2011 (1st ins.) 09/03/2011 (2nd ins.)	18-Aug
Approximate time:	2 min.	5 min.	3 - 4 min. (1st ins.) 3 - 4 min. (2nd ins.)	2 min.
Surgery Date:			09/14/2011	08/26/2011
Online Pre-cert:			09/12/2011	08/24/2011
Approx. Time			3 - 4 min.	3 - 4 min.
Primary Ins.	BCBS of Alabama	Independence Blue Cross Seventh Adventist	United Health Care	BCBS of TN

September 20, 2011

Department of Labor & Advisory Council on Worker's Compensation,

The Neuro-Spine Committee is comprised of health care providers and practices that treat patients requiring care of brain and spine injuries.

In light of the specialty, patients seeking treatment of injuries through the Worker's Compensation process are frequently part of our clinic and surgical population. Obviously, the Neuro-Spine Committee has followed the Emergency Rule as declared by the Department of Labor with great interest.

After attending meetings of your group, the Advisory Council on Worker's Compensation and the Medical Care and Cost Containment Committee, the NSC understands that an 11% cut in reimbursement is being recommended by an insurance entity. This cut in provider reimbursement for the same services is intended to offset an expected increase in premiums to businesses' worker's compensation premiums.

While we acknowledge the difficult financial and economic times for our state and for businesses, we are at a loss that our practices that range in size of 10 to over 200 employees are not considered small businesses. Our practices expect an *additional* cut from the federal government related to Medicare patients that could reach 29% as publicly announced to take effect in 2012.

The Neuro-Spine Committee members have indicated through surveys, calls, and other communications the support of the following:

1. Cuts in reimbursement during this Emergency Rule of no more than 5% to allow our small businesses to continue participation
2. A reduction in the administrative burden that translates into a cost that exists due to insurance demands that exceeds that of commercial or Medicare plans
3. A commitment to join the efforts with other providers and stakeholders in the process of care for these patients to address a long-term solution for TN's program

The Neuro-Spine Committee appreciates the work of the Advisory Council on Worker's Compensation, the opportunity to make public comments and the work of the Department of Labor to address the needs of *all* small businesses.

Respectfully Submitted,
The Neuro-Spine Committee

Neuro-Spine Committee
neurospinecommittee@gmail.com

TPTA
TENNESSEE
Physical Therapy Association

4205 Hillsboro Road, Suite 317
Nashville, Tennessee 37215
615/269-5312
Fax: 615/297-5852
Email: tpta@tptatn.com

September 20, 2011

Mr. David Lillard, Chair, Treasurer
Tennessee Advisory Council on Workers' Compensation
600 Charlotte Avenue
First Floor State Capitol
Nashville, TN 37243

Subject: Emergency rulemaking hearing for proposed changes to the Medical Fee Schedule

Dear Chairman Lillard:

The Tennessee Physical Therapy Association (TPTA) represents over 7,000 physical therapists and physical therapist assistants licensed in Tennessee. The Mission of the Tennessee Physical Therapy Association, a member driven organization, is to represent and advocate for the profession of physical therapy and promote excellent, ethical practice, which serves the culturally diverse population of Tennessee. The TPTA is concerned about the potential impact of proposed changes to the Workers' Compensation Medical Fee Schedule on those providers who are already working to render care to a population that requires a high level of expertise and resource.

Specifically, we are concerned that the changes proposed in SS-7037 are predicated on invalid assumptions and unfairly apply reductions to the Medicare Fee Schedule that will place an undue burden on physical therapy providers. Our concerns are based on the combined effect of the change to most current Medicare Fee Schedule, Multiple Procedure Payment Reduction (MPPR) for therapy services, and limitation of no more than 4 procedures/modalities per session. Additionally, most physical therapy providers are dealing with multiple PPO and Bill Review reductions that add cost to care while reducing payment to the provider. That combination makes it difficult to continue providing the level of care that we as a profession feel is appropriate for our patients.

Currently, the Workers' Compensation Medical Fee Schedule is the basis for payment for physical therapy services rendered to the injured workers of Tennessee. This Fee Schedule is based currently on the March 2008 Medicare Fee Schedule and is paid at a maximum of 130% of the Medicare Fee Schedule. This is outlined in the Tennessee Workers' Compensation Fee Schedule Information document posted on the TN Department of Labor website. Page 6 of that document states, "Unlike fee schedules in some other states, Tennessee's Medical Fee Schedule does not set an absolute fee for services, but instead, sets a maximum amount that may be paid. Providers and payers are encouraged to negotiate amounts below the maximum set in the Medical Fee Schedule, but shall not pay an amount above the Fee Schedule maximum amount." This is important because, while Tennessee does have one of the higher Workers' Compensation

Fee Schedules compared to others in our geographic region, the Tennessee Fee Schedule does not represent an absolute fee but a maximum fee, and prices paid to the provider are generally much lower than those allowed by the Tennessee Fee Schedule. In fact, a report released by the Cambridge, Massachusetts based Workers Compensation Research Institute (WCRI) in August of this year compared the Medical Price Index (MPI) of Tennessee to a group of 25 states that they have studied for years. WCRI studied medical prices paid for Emergency Services, Evaluation and Management, Major Radiology, Minor Radiology, Neurological Testing, Physical Medicine, Major Surgery, and Pain Management Injections. They found, interestingly, that the medical prices paid to Tennessee providers was lower in 2010 than it was in the baseline year of 2002 in all areas combined and in individual study areas with the exception of Emergency (103%) and Evaluation and Management (149%). In fact, Tennessee was the only state listed whose overall MPI was less than 100% when comparing 2010 prices to 2002 prices, demonstrating that there has not been an increase in medical prices paid to Tennessee healthcare providers as is the popular opinion. Meanwhile, prices of one study state rose more than 40%. The median of fee schedule states rose just over 10%, and non-fee schedule states rose just under 30%. WCRI also ranked study states with regard to the average MPI and found Tennessee to rank at or below the median MPI for the 25 study states in all areas except for Evaluation and Management and Non-Hospital Emergency Services.

The August 8, 2011 release from the Department of Labor and Workforce Development stated, "In 2011, Medicare reimbursement rates have undergone changes that have caused a severe increase in the Tennessee Medical Fee Schedule rates. On August 2, 2011, increases in medical costs led the National Council on Compensation Insurance ("NCCI") to file a premium rate increase of 6.3% with the Commissioner of Commerce & Insurance. Such a rate increase will result in Tennessee employers paying significantly higher workers' compensation insurance premiums than was originally anticipated. At a time when the national and state economies are struggling to recover, it is imperative that the Department take all necessary steps to keep premiums at an appropriate level," erroneously associating the changes in the Medicare 2011 Medical Fee Schedule to increases in Tennessee Workers' Compensation premium rates and failing to recognize that the same factors that are causing public entities to struggle with budget issues are causing difficulty for healthcare providers as well. Treatment of the Workers' Compensation patient requires medical providers to utilize more intensive and more expensive resources than are needed to treat a similar volume of commercially or publicly insured patients. There is also greater requirement for reporting and greater resource required for billing and collections. As a group, healthcare providers have seen increasing costs associated with providing services while being expected to continue providing the same quality at a lower fee. While there have been modest increases in the Medicare Physician Fee Schedule for 2011, the Workers' Compensation Fee Schedule remains pegged to the March 2008 Medicare Fee Schedule and protects employers, insurers, and providers from unforeseen changes to the Medicare Fee Schedule. According to NCCI and WCRI data there has been a slight increase in medical prices over the past two years, but proposed changes reflect a drastic reduction to the current payment for Workers' Compensation medical providers and are based on incorrect assumptions and methodology.

Multiple Procedure Payment Reduction (MPPR) is a component of the 2011 Medicare Physician Fee Schedule and has the potential to unfairly reduce payment to physical therapy providers

based on erroneous application of the Practice Expense (PE) component of the Relative Value Unit (RVU) used in calculation of payment for physical therapy services. CMS incorrectly assumes that duplicate clinical labor and supplies are included in the PE RVU when multiple therapy services are furnished to a single patient in a single session. When initially set; however, the PE RVU for certain "therapy only" services was adjusted to 50% of the comparable PE RVU for physician office visits based on the assumption that these therapy services are almost always provided in combination and not in isolation. The time spent pre-service and post-service for typical physician office visit was set at 3 minutes, and therapy procedures are set at 1.5 minutes, with modalities set at 0 minutes. Thus a typical treatment that consists of two procedures and one modality results in the correct PE RVU of 3 minutes. On the other hand, if a patient receives one procedure and one modality, the PE RVU is only 1.5 minutes and is thus an under payment according to the 2011 MPPR. More significantly, if a patient is seen by multiple disciplines in multiple locations on the same day, the same MPPR applies, and the practice(s) with lower PE RVU are discounted by 20% for each additional procedure, a methodology that can result in a significant reduction in fees paid to that provider.

Ultimately, for the continued welfare of the Tennessee worker, employers, medical providers, and insurers, there needs to be a fair system of medical care and payment of services. The combined effect of transition to the current Medicare Fee Schedule methodology along with the 4 procedure/modality rule, however, place an unfair burden on the physical therapy providers in Tennessee, and the result will be a smaller pool of quality providers willing to serve this challenging population. This will come as the cost of providing care continues to rise and the payment continues to decline. The result may well be an increase in costs as lower quality providers make up a larger proportion of the workers' compensation market. Outcomes will diminish and lengths of stay will increase, resulting in workers being treated longer but with less ability to return to their prior level of function and work.

In summary, the TPTA recognizes the need of employers in Tennessee to have affordable options for worker's compensation insurance. The proposal to cut payment to medical providers across the board by unfairly reducing payment through the combined effect of MPPR, continued four unit limit per day, and multiple PPO and Bill Review reductions fails to recognize one of the strongest opportunities for cost savings. This bill ignores the established fact that quality physical therapy drives down the cost of care by reducing the length and degree of disability, and further reductions in payment to physical therapy providers will reduce the available pool of quality physical therapists willing to treat Tennessee's injured workers.

Sincerely,

Scott Newton, PT, DPT, OCS, CWS
President
Tennessee Physical Therapy Association

SEP-20-2011 08:40 PM KEITH E GRAVES DC +1536389857 P.02

WORKERS' COMPENSATION MEDICAL FEE SCHEDULES

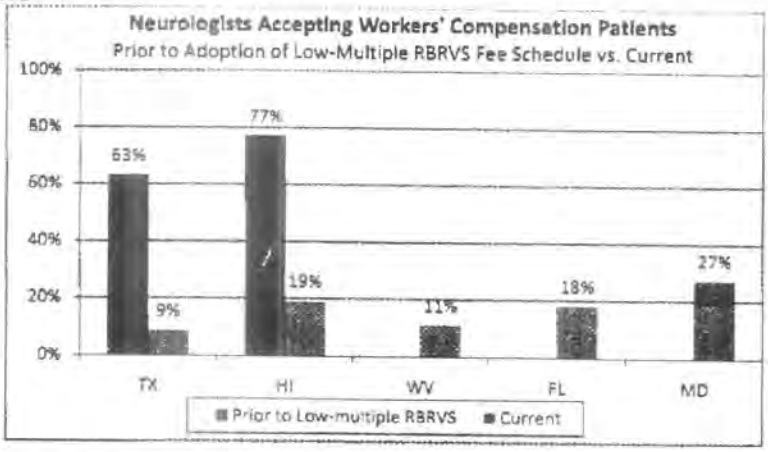
NEW FINDINGS & IMPLICATIONS FOR CALIFORNIA

STEVEN E. LEVINE, M.D., PH.D., F.A.A.N.
CLINICAL PROFESSOR OF NEUROLOGY
DAVID GEFFEN SCHOOL OF MEDICINE AT UCLA

RONALD N. KENT, M.D., PH.D.
CLINICAL PROFESSOR OF NEUROLOGY
DAVID GEFFEN SCHOOL OF MEDICINE AT UCLA

participation levels continued to decline in Hawaii more than a decade after it first adopted its low-multiple fee schedule. In Florida, where fees were raised three years ago to a low-multiple RBRVS level, participation among neurologists nevertheless continued to decline. Two states, Texas and West Virginia, now have neurologist participation rates of approximately ten percent. In contrast, participation in Texas was documented to be 63% a year before the adoption of a low-multiple (125%) RBRVS fee scale in 2003.

Figure 2



The results also demonstrate that specialist workers' compensation participation after the adoption of a low-multiple RBRVS fee schedule was strikingly less than for lower-paying alternatives such as Medicare and Medicaid. This appears largely due to additional administrative and regulatory burdens associated with workers' compensation that are not sufficiently compensated by low-RBRVS fee schedules. An analysis of physician offices in the Los Angeles metropolitan area showed that the hourly practice expense for offices accepting workers' compensation patients was 2.5 to 3 times higher than the Medicare practice expense rate.

The telephonic surveys also revealed significant differences in the qualifications of neurologists who continued to treat workers' compensation patients after the adoption of a low-multiple RBRVS fee schedule. Only 33% of those who continue to accept workers' compensation patients in Texas and West Virginia attended a U.S. medical school and are board-certified, while more than 50% of those who do not accept injured workers have these qualifications.

The dramatic departure of physicians from workers' compensation systems in states with low-multiple RBRVS fee scales appears to have been precipitated in all cases by decreases in reimbursement for specialist procedures, regardless of changes in other fees. For example, in Texas, the RBRVS conversion, which dramatically lowered specialty fees, also raised office visit fees 36%. It is worth noting that of the three most recent major workers' compensation fee schedule changes (in Hawaii, Tennessee and Illinois), each of the states elected to adopt fee schedules with higher relative fees for specialty providers in order to maintain or restore provider access.

The present survey also indicates that in California, specialist participation has already begun to decline. While 92% of orthopaedists and 80% of neurologists reported accepting workers'

CONCLUSIONS

Ultimately the present research points to several major conclusions. First and foremost, low-multiple, unmodified RBRVS fee scales do not maintain specialist participation. Every state that has adopted a low-multiple RBRVS workers' compensation fee schedule has experienced a subsequent rapid and dramatic drop in neurologist and orthopaedist participation levels. In each of the study states, specialist participation levels were reduced by half or more within two years of the adoption of the low-multiple RBRVS fee schedule. Specialist participation levels continued to decline in Hawaii and West Virginia more than a decade after the low-multiple fee schedules were first adopted.

In addition, the workers' compensation system is far less attractive to specialists than lower-paying alternatives such as Medicare or Medicaid. This appears largely due to the additional administrative and regulatory burdens associated with workers' compensation, which apparently are not sufficiently compensated by the slightly higher fees paid per procedure. Overhead costs are far higher for workers' compensation practices than is generally recognized, driven by common system-specific requirements such as utilization review, case management and medical provider networks.

There are also clear demographic and professional qualification differences between providers who choose to leave the workers' compensation system and those who continue to treat injured workers under low multiple RBRVS fee schedules. Physicians who choose to exit the workers' compensation system are much more likely to be board-certified and to have been educated at an American medical school.

It is worth noting that none of the three most recently adopted workers' compensation state fee schedules elected to employ an unmodified RBRVS system. Hawaii abandoned 110% of Medicare RBRVS after 11 years, and increased specialist fees in an attempt to restore access, raising average fees to about 135% of Medicare. Tennessee adopted a multiple conversion factor RBRVS fee scale with higher fees for specialty codes that average 177% of Medicare (slightly above the median state average of 160% of Medicare). Finally, Illinois adopted a charge-based scale with higher relative fees for specialty procedures as it's first ever workers' compensation fee schedule.

This trend away from unmodified RBRVS fee schedules may be driven by evidence which suggests that once specialists choose to leave the workers' compensation system they are slow to return even when reimbursement rates increase. States that have been down this path and ultimately decided to increase fees in an attempt to hire specialists back to workers' compensation demonstrate that it is far easier to maintain physician participation than to rebuild it.

The dramatic departure of physicians from workers' compensation systems in states with low-multiple RBRVS fee scales appears to have been precipitated in all cases by decreases in specialist procedure fees.

There are a variety of ways to mitigate the impact of a low-multiple RBRVS fee schedule on medical access in California: 1) Initially maintain existing specialist fees, allowing gradual decreases due to inflation, while access is monitored; 2) Use an RBRVS base, but with higher fees for specialty codes reflecting other fee data, as was done recently in Hawaii; or 3) Use multiple RBRVS conversion factors, higher for specialty areas, as has been done in Tennessee, Oregon and many other states.

Regardless of the particular approach, modification of the low-multiple RBRVS fee structure would appear prudent. The approaches suggested would potentially allow implementation of a low-cost RBRVS-based fee scale for California, while reducing the likelihood of substantial declines in medical access.

Medtronic

Medtronic, Inc.

September 16, 2011

Lynn Ivanick, Esq.
Administrator, Advisory Council on Workers' Compensation
Tennessee Treasury Department
Andrew Jackson Building, 9th Floor
502 Deaderick Street
Nashville, Tennessee 37243-0248

Re: Proposed Changes to the Medical Fee Schedule

Dear Ms. Ivanick:

We appreciate the opportunity to comment on the proposed changes to the Medical Fee Schedule for the workers' compensation program in Tennessee. It is our understanding that the changes, due to take effect December 1, 2011, to the calculation of the conversion factor for the Medical Fee Schedule will result in an 11% reduction in reimbursement.

We are writing to you on behalf of Medtronic Spinal and Biologics Division and Medtronic Neuromodulation. Medtronic is the world's leading medical technology company, specializing in implantable therapies that alleviate pain, restore health, and extend life. Medtronic Spinal and Biologics Division is based in Memphis employing over 1500 Tennesseans. We manufacture products that treat a variety of disorders of the spine. These products are utilized by spinal and orthopedic surgeons to treat patients and restore their quality of life. Medtronic Neuromodulation manufactures a number of implantable neurostimulation and drug delivery systems used to treat conditions that include chronic pain, movement disorders, and severe spasticity. We are interested in the proposed changes to the medical fee schedule, and ensuring that patients in Tennessee retain access to physicians, surgeons and interventions that are warranted and needed.

As mentioned above, it is our understanding that the changes to the Medical Fee Schedule, including elimination of the 2008 conversion factor and replacement with the current Medicare rate, will result in an approximately 11% reduction in reimbursement for physicians. Utilizing the 2008 Medicare rate has provided stability and predictability to physicians treating injured workers. These patients are more labor intensive for physician practices due to the additional paperwork, legal proceedings and communication required, and thus warrants a reimbursement to match the work load. Insufficient reimbursement leaves physicians to absorb unaccounted-for costs. In similar situations in other states, rate reductions of this significance have resulted in a decrease in the number of specialty providers available to care for injured workers. We are concerned that the cuts effective in December will have the same effect in Tennessee.

Before any rate reduction takes place in December, we would ask that the Department call together the impacted physician organizations to discuss other alternatives. Above all, we want to ensure fair reimbursement for workers' compensation providers and appropriate access to care for injured workers.

Thank you for your consideration of these comments. If you have any questions, please feel free to contact us.

Sincerely,

Dena Scearce, JD
Director, State Government Affairs
Medtronic, Inc.
Spinal and Biologics Division
2600 Pyramid Place
Memphis, TN 38132
Cell: 901.428.3516
dena.l.scearce@medtronic.com

Mary E. Ryan
Senior Manager, State Government Affairs
Medtronic Inc.
7000 Central Avenue, RCE 395
Minneapolis, MN 55432
Office: 763-526-8194
Cell: 763-229-5049
mary.e.ryan@medtronic.com